St Brelades Retirement Homes Limited

The Cumberland

Inspection report

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Kent
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out on 18 April 2018 and was unannounced.

The Cumberland is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Cumberland accommodates up to 29 people living with dementia in one adapted building. There were 25 people using the service at the time of our inspection. The Cumberland exclusively offers a service to women.

Rating at last inspection

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Rating at this inspection

At this inspection we found the service remained Good.

Why the service is rated Good

The registered provider had oversight of the service. The registered manager and management team checked that the service met the standards they required and worked to continually improve the care people received.

Staff felt supported by the management team, they were motivated and enthusiastic about their roles. A member of the management team was always available to provide the support and guidance staff needed. Staff worked together to support people to be as independent as they wanted to be. All the staff and community professionals we spoke with told us they would be happy for their relatives to live at The Cumberland. Records in respect of each person were accurate and complete.

Staff were kind and caring and treated people with dignity and respect. One relative told us the care the staff provided had "Allowed me to go back to being a daughter again". Staff had taken time to get to know each person well and provide the care they wanted in the way they preferred. People received the care and support they wanted at the end of their life. Since our last inspection the provider had begun to implement the Gold Standards Framework (GSF) for end of life care. The GSF is a recognised approach to ensuring that everyone receives appropriate and individualised care which takes account of their wishes and preferences at the end of their life.

Staff knew the signs of abuse and were confident to raise any concerns they had with the management team. People were not discriminated against and received care tailored to them. People and their relatives were confident to raise any concerns they had. A process was in place to investigate and resolve any complaints or concerns received. People had enough to do during the day, including taking part in activities they had enjoyed.

Assessments of people's needs and any risks had been completed and care had been planned with them and their relatives, to meet their needs and preferences and keep them safe. One person's relative had commented, 'It was a lovely experience seeing her so happy'.

Changes in people's health were identified quickly and staff contacted their health care professionals for support. People were encouraged to stay as physically and mentally active as possible. People's medicines were managed safely and people received their medicines in the ways their healthcare professional had prescribed. People were offered a balanced diet of food they liked and that met their cultural needs and preferences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The registered manager knew when assessments of people's capacity to make decisions were needed.

There were enough staff to provide the care and support people needed when they wanted it. Staff were recruited safely and Disclosure and Barring Service criminal records checks had been completed. Staff were supported to meet people's needs and had completed the training they needed to fulfil their role. Staff were clear about their roles and responsibilities and worked as a team to meet people's needs.

The service and equipment were clean and well maintained. The building had been adapted to meet people's needs and make them feel comfortable. People were able to use all areas of the building and grounds and were encouraged to make their bedroom feel homely.

The registered manager had informed CQC of significant events that had happened at the service, so we could check that appropriate action had been taken.

Services are required to prominently display their CQC performance rating. The provider had displayed the rating in the entrance hall and on their website.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Cumberland

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 April 2018 and was unannounced.

The inspection team consisted of one inspector. Before the inspection we reviewed the information about the service the provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

Before the inspection we asked for feedback on the service from community professionals and other visitors to the service who had involvement with the service and staff. We received information from the representatives of two churches, a chiropodist, a pharmacist, a dietician and a clinical nurse specialist for older people who has supported the registered manager and staff.

We looked at three people's care and support records, associated risk assessments and medicine records. We looked at management records including three staff recruitment, training and support records and staff meeting minutes. We observed people spending time with staff. We spoke with the provider who is also the registered manager, ten staff, and 18 people who use the service and their relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People's relatives told us they felt their loved ones were safe at The Cumberland and they were confident they were always well cared for.

There were enough staff on duty to meet people's needs and support them to do things for themselves. People's relatives commented; "My loved one never has to wait for an unreasonable amount of time for support" and "There are a lot of staff. I was surprised how many there are every day". The registered manager continued to consider people's needs and the skills of the staff when deciding how many staff to deploy at different times of the day. Staff were not rushed and supported people to do things at their own pace. For example, people who required support to drink were supported by a staff member who concentrated solely on them and waited until they were ready to drink before assisting them.

There were consistent numbers of staff on duty during the day and night. Many staff had worked at the service for several years and knew the people very well. Staff turnover continued to be low. Care staff were supported by ancillary staff including cleaners, cooks and maintenance staff so that they were free to spend time with people and provide the support they needed. Cover for sickness and annual leave was provided by other members of the team. The registered manager and other members of the management team were on call out of hours to provide any advice and support staff needed.

A new call bell system had been installed since our last inspection and people used this to call for staff assistance when they required it. Staff responded promptly when people rang for assistance. The new system allowed staff to use pressure mats to monitor people who were at risk of falling and offer them support quickly.

Risks to people had been identified and they had been involved in planning how to manage these. The risk of people falling had been assessed and action had been taken to keep them safe. Staff had identified when people were at greater risk of falling such as when they were tired or their physical health changed. They followed guidance about people's care when they saw signs that the risk had increased such checking for infections. Prompt action taken by staff had reduced the risk of people falling.

The risk of people developing skin damage had been identified and action had been taken to mitigate the risks. People used pressure relieving equipment such as special cushions and mattresses to help keep their skin healthy. Staff made sure that the equipment was set correctly and people used it at all times when they were in bed and sitting in chairs. No one at the service had a pressure ulcer.

Accidents and incidents continued to be recorded and action had been taken to prevent them from happening again, including encouraging people to use equipment to maintain their independence when walking. The clinical manager analysed accidents and incidents to look for patterns and trends. Their analysis showed and accident records confirmed that accidents did not happen often and were one off occurrences.

People and their relatives told us the staff were approachable and they were confident to raise any concerns about their safety with them. They told us that people were not discriminated against and were treated equally. One person's representative told us, "The staff respect people's backgrounds, they speak to everyone differently but in an equally kind way". Staff knew how to keep people safe. They were trained and understood how to recognise signs of abuse and what to do if they suspected incidents of abuse. Staff were confident that the management team would take any action that was needed if people were at risk of abuse or being discriminated against. Staff were aware of the whistle blowing policy and their ability to take any concerns to outside agencies if they felt that situations were not being dealt with properly.

Plans were in place and understood by staff about how to support people in an emergency. These included supporting people to move to other parts of the building or evacuating to the provider's other service which was close by. Staff had completed fire warden training and told us they were confident to use the evacuation equipment. Regular checks were completed on all areas of the building and equipment, including fire alarms and hoists to make sure they were safe. The service was clean and staff followed infection control processes, including using disposable gloves and aprons. They had completed infection control and food hygiene training.

People's medicines were managed safely and effective systems were in place to order, store, administer, record and dispose of medicines. The temperatures where medicines were stored, including those requiring refrigeration, were recorded daily and were within the safe range. We observed staff administering people's medicines safely, for example, staff checked each medicine and records before administering it.

Staff followed guidance when supporting people with their 'when required' medicines, including pain relief. Guidance included how people would tell staff they needed their medicine, the minimum gap between doses and the maximum the person could take in 24 hours. Some people were prescribed variable doses of medicines and staff recorded how many people took on each occasion. Staff had completed medicines training and their competency to administer medicines safely had been assessed.

Before our inspection a pharmacist told us about both of the provider's services, "We are in regular contact and have built up an excellent working relationship with the registered manager and their team". Some people received their medicines without their knowledge crushed and disguised in food, known as 'covert medicine administration'. The pharmacist and people's GPs had been involved in making decisions to administer medicines covertly and their advice was recorded and followed by staff.

The registered manager continued to consider staff's attitudes, including kindness and respect, as well as their skills and competence when making recruitment decisions. The required recruitment checks including Disclosure and Barring Service (DBS) criminal record checks continued to be completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

Good

Is the service effective?

Our findings

The registered manager met with people and their representatives to talk about their needs and wishes before they moved into the service. This included gathering information from other service providers when people moved from another residential service into The Cumberland. A detailed assessment was completed which summarised people's needs and how they liked their support provided, including their likes and dislikes, religious and cultural beliefs, relationships and family, and personal history. This helped the registered manager make sure staff could provide the care and support the person wanted. Staff were given detailed information about each person before they moved into the service. We observed staff chatting to new people about their life and interests when they began using the service to help them get to know the person better.

Further assessments of people's needs were completed, in line with best practice, when they moved into the service. These included malnutrition universal screening tool (MUST) assessments to identify risk of people losing weight. These were reviewed regularly to identify any changes in people's needs and were used to plan their care and support. People's weights were taken and analysed each month. When people lost weight they were referred to the dietician. Before our inspection a dietician told us, staff contacted them promptly when people had lost weight and followed their advice. This included offering people food and drinks fortified with high fat foods including double cream. We observed one person who was at risk of losing weight drinking a milkshake fortified with additional calories. People's weight records showed their weight had increased.

People told us they liked the food at the service including the homemade cake which they described as 'lovely'. People had enough to eat and drink. Meals and drinks were prepared to people's preferences and needs, including dietary needs and cultural preferences. People who had chosen to lose weight or needed a low sugar diet continued to be offered the same foods as everyone else but made with sweetener rather than sugar. Meals were balanced and included fresh vegetables. Soft or pureed foods were prepared for people at risk of choking and were presented in an appetising way. People had been involved in planning the menus.

If people wanted something which was not on the menu the chef prepared it for them. One person told staff they did not want a cooked lunch and staff offered them a variety of sandwiches which they enjoyed. Staff knew the person liked sweet foods and offered them a second helping of pudding which they also enjoyed.

We observed people being supported to make choices about all areas of their lives. For example, people were offered a variety of sandwiches and staff showed them the tray of assorted sandwiches and explained what each one contained. People chose the sandwiches they wanted.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and

whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection we found that assessments of people's capacity to make the decisions had not been recorded. Action had been taken and assessments of people's capacity were now recorded. Records of how best interest decisions had been made and by whom were kept. Staff knew when people needed help to make decisions and offered them the information in ways they understood.

The registered manager was aware of their responsibilities under DoLS and had made applications to the local authority. Some people had DoLS authorisations in place and others were waiting for assessments. No one had a condition on their DoLS. People were not restricted and were free to come and go as they pleased, including with staff, friends and family. One person's representative told us how staff supported them to take their friend out and we observed other people going out with their relatives during our inspection.

Staff supported people to maintain good health. A doctor continued to hold a weekly surgery at the service and provided telephone consultations and home visits when people needed them. Staff supported people to see health professionals and attend appointments. Staff accompanied and stayed with people to offer them reassurance and helped them tell their health care professional about their needs. People had regular health care checks including eye tests.

People were encouraged to stay active and mobile for as long as possible. They were encouraged to start the day with gentle stretching and take part in regular physical activities such as gentle armchair exercises. People were encouraged to move about the service to different parts of the building during the day, including to the dining room for meals and the garden in the warmer weather.

Staff had received the training they needed to complete their roles. They completed an induction to get to know people, their preferences and routines. This included shadowing staff the registered manager considered to be "outstanding" and completing the Care Certificate. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. Training was arranged to support staff to meet people's specific needs, including dementia care and communication. Staff's competency to complete tasks was assessed to check they had the required skills, including medicines management. Staff had either completed or were working towards recognised adult social care vocational qualifications.

Staff had completed training to meet people's needs, including taking their vital signs. They completed these checks before contacting people's GPs and shared the information to assist the doctor to make a more informed decision about people's care and treatment. One staff member was trained to take blood samples. Some people were more confident to have blood taken by someone they knew and the staff member had been able to take samples other healthcare professionals had not.

Staff told us they felt supported by the management team and were able to discuss any concerns they had with them. Staff received regular group supervisions to discuss their practice and an annual appraisal which included discussing plans for their future development.

A handover was completed between staff on each shift to make sure they had up to date information on people and their needs. This was recorded and staff referred to it to catch up when they returned from a day off. Tasks were allocated to staff at the beginning of each shift, for example, staff working together to assist people who needed two staff to support them.

The service was decorated in a homely way and an on-going programme of redecoration was underway.

There was a safe outside space which was accessible to people and their visitors.

Good

Is the service caring?

Our findings

At the previous inspection the service was rated outstanding for meeting people's needs in a caring way. At this inspection the ways in which the service was caring was good. The service had not demonstrated innovative practice or made continued improvements and developments as to how they met people's individual needs.

Everyone we spoke with before and during our inspection told us staff were kind, caring and had time to spend with people. One person smiled and told us, "Everyone is so nice to me". We observed one person having their hair done. The hairdresser was very gentle with the person. The person was calm and relaxed and fell asleep while having their hair washed. Another person's relative told us their relative had enjoyed a hand massage and manicure shortly before our inspection. They showed us photographs of their relative looking relaxed and told us, "She was so happy and relaxed, she looked 10 years younger".

People's friends and relatives were encouraged to visit their loved ones and spend time with them as often as the person wished. Staff supported people to go out with their relatives when they wanted to. During our inspection several people's friends and relatives visited and told us they did this regularly. Some people's loved ones visited them daily and spent time caring for them as they had done before the person moved into the service. This helped people maintain their relationships.

People's friends and relatives brought pets into the service for the people to meet. During our inspection and we observed people smiling while talking to a dog and stroking it. Arrangements were made so people could enjoy meals with their friends and relatives in private if they wanted. People and the relatives told us they enjoyed being able to continue to have meals together. One person's relative told us staff supported their loved one to send them a card on their birthday. This was something that the person had always done and was important to them.

The registered manager asked people and their friends and relatives to provide them with a detailed personal history before they moved into the service, including jobs they had and things that were important to them like pets and places. This information was available to staff in people's care records and staff used this information to get to know them. During the inspection staff supported people to tell us about jobs they had held and members of their family.

People and their relatives told us they had privacy. Staff described to us how they maintained people's privacy including using privacy curtains in shared bedrooms and keeping people covered while they helped them to get washed. Staff maintained people's privacy during our inspection. The registered manager knew about the new general Data Protection regulations and kept personal, confidential information about people and their needs safe and secure.

People told us they were treated with dignity and had told staff what dignity meant to them. Their comments included 'Make me feel comfortable in my own home', 'Respect at all times" and "Treated as an individual". Three staff were dignity champions. Dignity champions are staff that believe that being treated

with dignity is a basic human right and not an optional extra. All the staff we met at the service held these values. Dignity workshops were planned to support staff to develop their empathy with people by caring for each other. We observed one staff member supporting a person to have a drink. They supported the person at their own pace and waited for the person to tell them they were ready to drink. They chatted to the person about their new outfit and commented, "Your daughter buys you lovely things" and "I'll move this up, (showing the person an apron), we don't want anything to get on your lovely blouse". All the interactions we observed between staff and people were positive and respectful. Another staff member said to a different person "I'm going to take this apron off so we can see your pretty blouse. You look beautiful in blue [person's name]".

People had been given opportunities to discuss their sexual orientation or gender identity and their responses were respected. Staff gave people time to chat privately about their personal relationships if they wanted to. People were treated as individuals and their choices and lifestyles were respected. For example, everyone had a name plate on their bedroom door that included the person's preferred title, such as Mrs, Ms or Sr. People were referred to by their preferred names and were relaxed in the company of each other and staff.

People were actively involved in making decisions about their care. We observed one person ask a staff member for a biscuit. The staff member immediately offered the person a plate of different biscuits and the person chose several.

People were supported to maintain their independence. For example, some people used adapted cutlery and crockery to eat and drink without support. Other people required assistance at meals times and were supported at their own pace, by a staff member who concentrated solely on them. Staff told us what people were able to do for themselves, such as washing their face and torso and the support they needed from staff. This information was recorded in people's care plans for staff to refer to.

Information about when people may need reassurance was included in their care records and was followed by staff. We observed that everyone was calm and relaxed during our inspection. Staff were in the lounges and other areas of the home with people all the time and responded promptly to people's requests and questions. One person's relative told us that staff always responded in a calm way when their relative became anxious or agitated and this helped them to remain calm. When people became confused, staff did not challenge the person's beliefs and diverted them to other things. For example, one person told staff their husband was coming to pick them up to take them home. Staff offered the person a cup of tea and a cake while they were waiting. The person enjoyed their drink and forgot that they thought they were going home.

People had brought pictures and other items into the service to make their bedroom more homely. People had been involved in choosing how their bedroom was decorated before they moved into the service.

From April 2016 all organisations that provide NHS or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. The provider was meeting the Accessible Information Standard and had developed accessible ways of communicating with people, such as photographs, to support people to tell staff about their needs and wishes and be involved in planning their care. The provider was working to make further improvements to make sure people had easy access to all the information they needed.

Some people were able to share their views about all areas of their life with staff and others involved in their

care. However, when people required support to do this they were supported by their families, solicitor or their care manager. The management team knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf

Good

Is the service responsive?

Our findings

People and their relatives told us they had been involved in planning and reviewing their care with staff and had seen their care plans. People's care plans had been reviewed and updated and contained detailed information. For example, care plans for people living with diabetes included their usual blood sugar levels and what may cause these to increase such as an infection and the support they needed to keep their feet healthy. Records showed that staff had followed people's diabetic care plans and contacted their GP and diabetic nurse promptly when they noted any changes in their health.

Staff knew the support people needed and how they liked their care provided. One person's relative told us staff always told them if their relative was worried or anxious when they arrived at the service and this helped them when they spoke with their relative. They told us that their relative did not like lots of people around them when they were upset and this was included in their care plan. They told us staff followed this guidance and this helped their relative remain calm. We observed this during our inspection.

Staff asked people about their preferred time to get up and go to bed and supported them to continue with their routine at The Cumberland. The routines at the service were flexible to people's needs and wishes. For example, one person chose to have a rest in their bedroom in the afternoon rather than joining in with the activities as they usually did.

Since our last inspection the provider had begun to implement the Gold Standards Framework (GSF) for end of life care. The GSF is a recognised approach to ensuring that everyone receives appropriate and individualised care which takes account of their wishes and preferences at the end of their life.

Staff had begun training and were putting what they had learnt into action. People and their representatives had been invited to chat to staff about things that were important to them at the end of their life, including where they wanted to be and who they wanted to be with them. One person's relative was assured that their relative had a 'home for life' and would not have to leave at the end of their life. People's spiritual needs were recorded and staff knew who to contact to make sure people received the spiritual support they wanted. One priest we contacted confirmed that they had visited people at the end of their life to offer them 'last rites'. Medicines to support people to remain comfortable at the end of their life had been obtained when necessary and were administered by visiting healthcare professionals.

People's relatives had complimented the staff on the care they had provided at the end of people's lives. Their comments included, 'Thank you for all the kindness shown to [person's name]. It was a great comfort to know she was cherished in The Cumberland" and "You all helped to make her life so obviously happy, she was always singing and content". Staff stayed in contact with people's families to support them to grieve.

People continued to take part in a range of activities and pastimes including listening to music, and were supported by staff and two activities coordinators. People told us they had enough to do each day. During our inspection people spent time singing songs they enjoyed and we observed people laughing together as they did this. Some people also enjoyed sitting out in the garden reading books and listening to poetry.

An activities plan was in place and was flexible to people's choices. For example people chose not to do art and craft on the afternoon of our inspection but to sit in the garden and enjoy the warm weather. The activities plan included visits from outside entertainers. One person's relative told us one singer had learnt their loved ones favourite song and sung it with them each time they visited. The person told us they enjoyed this.

The provider considered complaints and feedback as 'opportunities to learn from, adapt, improve and provide a high-quality service'. The process to respond to complaints had been reviewed since our last inspection and was available to people and their representatives but was not available in an easily accessible format. The provider had plans in place to address this. However, staff supported people to raise any concerns they had. People and their relatives told us they had not found it necessary to complain to the service and staff listened to any minor concerns they raised and took action to address them to their satisfaction.

No formal complaints had been raised for over a year and the registered manager and staff continued to immediately address any concerns raised with them. Everyone we spoke with told us the registered manager and staff were approachable and they would be confident to raise any worries they had with them.

Good

Is the service well-led?

Our findings

One of the providers was also the registered manager and had been working at the service for a number of years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Community professionals we contacted told us the service was well led by the registered manager.

The provider had a clear vision and philosophy of care which included, 'Each person will be enabled to live as full a life as possible, regardless of age, physical and mental disabilities and that each individual has the right to exercise choice over their lives'. Staff shared the provider's philosophy and delivered the service as the provider required. The registered manager told us the clinical manager had 'very high standards' and made sure all the staff worked to these. All of the staff and visiting professionals we spoke with told us they would be happy for their relative to receive a service at The Cumberland. One staff member told us, "This is the best, most comfortable service I have worked in".

The registered manager continued to have oversight of the service and completed random checks on care records to make sure staff had identified any changes in people's needs. The clinical manager completed monthly checks on the care people received and their care records, including care plans. Food and fluid intake charts daily were checked daily and people's care was changed if risks, such as a low fluid intake were noted. The clinical manager worked alongside staff and observed their practice to check people received care and support to the standard they required. Any shortfalls identified by the checks were addressed immediately and discussed at staff supervision meetings and shift handover. An analysis of accidents and incidents to identify any trends, for example when and where accidents occurred and the different nature of these accidents was completed and action was taken following each accident to reduce the risk of it happening again.

There was a culture of openness; staff and the registered manager spoke with each other and with people and their relatives in a kind and respectful way. Staff told us the management team were approachable and supportive and always available to give them advice and guidance. People and their relatives agreed.

Staff were clear about their roles and responsibilities and the management team held them accountable. For example, the clinical manager checked staff were applying people's creams correctly. When necessary they had reminded some staff not to apply creams thickly as this did not improve their effectiveness but could increase the risk of infection. The provider's policies and processes were accessible to staff when they needed to refer to them.

The registered manager and clinical manager kept their skills and knowledge up to date, and had booked to attend wound management and sepsis workshops provided by the local clinical commissioning group. They continued to work in partnership with community professionals, including a Clinical Nurse Specialist for Older People, to ensure people received the care and treatment they needed. The Clinical Nurse Specialist

confirmed the registered manager and other staff asked for advice and guidance when it was required and acted on it.

Staff were motivated and enjoyed working at the service. They told us they felt valued and appreciated by the management team. Staff told us they worked together as a team and they felt supported by their colleagues. We observed staff working together throughout the day to decide who would support each person.

The registered manager encouraged people, visitors, staff and community professionals to feedback their experience of the service and had told them what they would do in response. A quality assurance survey had been sent out in December 2017 and the feedback had been collated. People's responses to the survey had been positive and people and their relatives told us their opinions were listened to.

The clinical manager encouraged staff to suggest ways to resolve any problems they found. Staff told us suggestions they made to improve people's care and support were listened to and implemented. For example, staff had noted that a number of staff who administered medicines had booked to take leave at the same time. They had suggested that other staff who had completed the training were supported to administer medicines by experienced staff so that when they needed to provide cover they were confident and competent to do so. This suggestion had been implemented. One staff member told us, "[The clinical manager] is very open to suggestions".

Records of people's needs and the care they had received were accurate and up to date. All staff had access to information about people when they needed it and told us care plans reflected people and their needs and preferences. The provider was introducing electronic care records to reduce the time staff spent completing records and improve the management information they had about the quality of the service. Staff had been involved in planning the implementation and plans were in place to introduce the new system gradually so people and staff could get used to it.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. The registered manager knew when notifications needed to be sent and we had received notifications when they were required.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the entrance to the service and on their website. The rating was known by people and their relatives.