St. Andrew's Residential Care Home Limited

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Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 2nd and 6th June 2016. It was an unannounced inspection.

St Andrew's is a care home located close to Oxford town centre. The home is registered to provide accommodation for up to 23 people who require care and support. On the day of our inspection 23 people were living at the home. The majority people were living with dementia.

There was a registered manager in post. 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.

We were greeted warmly by the registered manager and staff at the service who seemed genuinely pleased to see us. The atmosphere was open and friendly.

People told us they felt safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff who were knowledgeable about people's needs and provided support with compassion and kindness. People received high quality care that was personalised and met their needs.

Where risks to people had been identified risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicines as prescribed. However, accurate records of medicine stock were not always maintained. The registered manager took immediate action to resolve our concerns.

There were sufficient staff to meet people's needs. Staffing levels were consistently maintained. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act (MCA) and all staff applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected, this included Deprivation of Liberty Safeguards (DoLs).

The service had systems to assess the quality of the service provided. Learning needs were identified and action taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care. However,

systems used to monitor the quality of service did not identify our concerns relating to inaccurate medicine stock levels.

Staff spoke positively about the support they received from the registered manager. Staff supervisions and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

People and their relatives told us the service was friendly, responsive and well managed. People knew the registered manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risk and keep people safe. People received their medicine as prescribed.

Is the service effective?

Good

The service was effective. People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring. Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and gave clear guidance for staff on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make

sure their needs could be met.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had systems in place to monitor the quality of service. However, these systems had not identified our concerns relating to medicine stock levels.

People knew the registered manager and spoke to them with confidence.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

St Andrew's Residential Care Home Limited

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 the 2 and 6 June 2016. It was an unannounced inspection. This inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with six people, two relatives, four care staff, the chef and the registered manager. We looked at five people's care records, medicine and administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's route through the service and getting their views on it. 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.

Before the inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included; "I certainly feel safe here, the place is quite secure really", "Yes, I do feel very safe with the staff. The staff tend to give you confidence", "I do feel very safe with them" and "I feel safe enough here. The staff are here to help if needed and they do". One person's relative said, "Yes, my husband does feel very safe here".

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns immediately to the registered manager. Staff were also aware they could report externally if needed. Staff comments included; "I'd go straight to the manager or I can whistle blow. I can also call the local authorities", "I would report to the manager or I would call you guys (Care Quality Commission) or the local safeguarding team" and "I'd talk to them (person) and contact the manager or the local authorities".

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at risk of falls. The risk assessment identified the person required minimal support with their mobility and they used a walking frame to mobilise independently. However, staff were advised to supervise the person and assist them if they were struggling. They were also guided to ensure the person's frame was within easy reach. We went to this person's room and saw their frame was next to them. We later observed the person walking with their frame. A member of staff was next to them offering encouragement and support.

Another person was at risk of pressure ulcers. The person had been referred to healthcare professionals who had provided guidance for staff to safely support this person. This included the use of pressure relieving equipment and regular monitoring of the person's skin. Records evidenced the person's skin was checked twice a day and we saw pressure relieving equipment was in place. The person did not have a pressure ulcer.

People told us there were sufficient staff to meet their needs. People's comments included; "Oh yes, there are more than sufficient staff to look after us", "I think the home is probably well staffed, there always seems to be someone around", "I have used my bell and they respond to it quickly I have to say" and "I used the call bell and they did respond very quickly indeed".

Staff told us there were sufficient staff to support people. Comments included; "Yes there is enough staff. We rarely have to cover extra shifts because of shortages", "There is adequate staffing here" and "I think staffing levels are very good. Sometimes it seems as if I am a spare member of staff which means we can do so much more for residents".

There were sufficient staff on duty to meet people's needs. The registered manager told us staffing levels were set by the "Dependency needs of our residents". Staff were not rushed in their duties and had time to sit and chat with people. People were assisted promptly when they called for help using the call bell. Staff rota's confirmed planned staffing levels were consistently maintained.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

People's safety was maintained through the maintenance and monitoring of systems and equipment. We established that equipment checks, water testing, fire equipment testing, hoist servicing, electrical and gas certification was monitored by the maintenance staff and carried out by certified external contractors. We saw equipment was in service date and clearly labelled.

People had their medicines as prescribed. The staff checked each person's identity and explained the process before giving people their medicine. Medicines were stored securely and in line with manufacturer's guidance. Staff were trained to administer medicine and their competency was regularly checked by the registered manager. We observed a medicine round and saw correct procedures were followed ensuring people got their medicine as prescribed.

However, records relating to medicines were not always accurate. We checked the stock levels for three medicines and found they did not tally with stock records. We raised this with the registered manager who took immediate action. On the second day of our visit we saw new records had been put in place with a new system and procedure for maintaining records. This included a revised monitoring and audit system. We checked four people's medicine stock levels, all of whom received multiple medicines, and found them to be correct.

People told us they received their medicine as prescribed. People's comments included; "I am on various tablets. The staff do trust me to take them but also check up to make sure that I've been a good girl", "I am on medication. The staff come around and give them to me and watch me take them" and "I do have to take pills. They bring them to me and then they watch me take them".

Good

Is the service effective?

Our findings

People told us staff had the skills to support them effectively. People's comments included; "Yes, the staff are very well trained, they know what they're doing alright. They come up to see me regularly during the day and do what they're supposed to do so they must be well trained" and "I think the staff here are very well trained so they should be able to help me ok. They cope quite well and I feel confident with them". A person's relative said, "Oh yes, they're well trained and experienced so they can meet his (person's) needs quite well".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they had received an induction and completed training when they started working at the service. Induction training included fire, moving and handling and infection control. Staff also shadowed an experienced member of staff for two weeks before working unsupervised at the service. One member of staff said, "The induction was good. I've had all the training which I have found useful".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one member of staff said, "I get supervisions and appraisals which are helpful. I am definitely supported here". Staff received supervisions every three months and records confirmed staff had development opportunities through supervision. For example, one supervision highlighted a staff members need for further training relating to the Mental Capacity Act 2005 (MCA). We saw this training was provided. Another staff member had requested training in health and social care in a national qualification. This was also provided and the staff member had achieved a level two qualification. Records also confirmed staff received training updates from healthcare professionals. For example, a physiotherapist provided training relating to moving and handling.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager was knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected. Where people were thought to lack capacity mental capacity assessments were completed.

People were supported by staff who had been trained in the MCA and applied it's principles in their work. Staff offered people choices and gave them time to decide before respecting their decisions. Staff demonstrated an understanding of the MCA. Staff comments included; "This is about people's ability to make decisions for themselves. I let them choose and if they are struggling I just prompt them", "It's important not to make assumptions. People still have choices they can make and we mustn't make blanket judgements. It's decision specific and their capacity can fluctuate" and "This is about safeguarding people's

choices and decisions. I think it is a really good thing".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the supervisory body. The registered manager told us they continually assess people in relation to people's rights and DoLS.

Staff demonstrated a good understanding about how to ensure people were able to consent to care tasks and make choices and decisions about their care. Throughout our visit we saw staff offered people choices, giving them time to make a preference and respecting their choice. For example, during the lunchtime meal we saw people's preferences regarding food and drink were respected. We spoke with staff about consent. One member of staff said, "I simply ask all the time". Another member of staff said, "I explain what needs to be done, offering choices and checking they understand. I always ask and consider consent to be an ongoing theme".

The service sought people's consent. Some people used bedrails to keep them safe in bed. We saw where people used bedrails the risks had been discussed with them and their families. People had signed the risk assessments consenting to the use of bedrails. Where people were unable to sign we saw their best interests had been considered.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, care home support service (CHSS) and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans.

People told us they enjoyed the food. Comments included; "The food isn't bad at all. You're usually given a choice but it isn't what I'd call a wide menu. If you want a snack outside normal mealtimes, the staff are quite happy to bring you food and drink", "I like the food. It's well cooked and it's interesting. I'm given a choice so I get variety. I don't usually eat between my meals but if I asked for a snack, I know I'd get it. They do it for the others. There's always drink of some sort available" and "The staff more or less know what I like and dislike with the food. If they give me something and I don't like it, they'll change it straight away. I don't like too much of anything. I'm not a big eater. I like marmalade on my toast but not too much. The breakfast is very nice. The dinner, I tend to pick out the bits I like and leave the rest. They give me hot milk when I go to bed. It helps me to sleep".

We observed the midday meal experience. This was an enjoyable, social event where the majority of people attended. Food was served hot from the kitchen and looked 'home cooked', wholesome and appetising. People were offered a choice of drinks throughout their meal. People were encouraged to eat and extra portions were available. Where people required special diets, for example, pureed or fortified meals, these were provided.

People received effective care. For example, one person was diabetic and their condition was managed through their diet. The person's care plan noted they did not take sugar in their hot drinks and could have 'cakes and puddings in moderation'. The person's blood glucose levels were regularly monitored and the person was weighed every month. Accurate records of blood glucose levels and weight were maintained and confirmed the person's condition was being managed effectively.

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home and benefitted from caring relationships with the staff. People were extremely positive with their praise for staff. Comments included; "The staff are quite caring and considerate", "Oh yes, they're definitely very nice people and they treat me very well. They're not at all rude or anything like that. I quite like them really", "They're certainly very caring here. They can't do enough for you. Always happy to do that little bit extra for you", "I would say that they're caring, yes" and "When I'm in my room, they're always poking their head around the door and asking me if I'm ok and do I want anything. That's nice". One person's relative said, "The staff here are most certainly very caring to him (person). They can't do enough for him. I've never seen anybody do anything out of order here".

Staff told us they enjoyed working at the service. Comments included; "It's really good here, I have learnt so much. It's friendly and we all look after each other", "I get on really well with all my residents. I know how to calm people and use their life histories to connect with them", "I definitely have good relationships with residents. As I have got older my empathy has increased" and "I love my residents, I look forward to seeing them every day".

People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives. Staff spoke with people about their careers, families and where they had lived. During our visit we saw numerous positive interactions between people and staff. For example, one person was being offered a choice of drinks by a staff member, who crouched down in front of the person. The person reached out and the staff member took the person's hand and smiled. The person responded with smiles and said "I'd like a tea please". As the staff member went to get the tea the person reach out again, took the staff members hand and said "I love you". The member of staff crouched down again and said "I love you too". There was clearly a genuine warmth and affection between the two.

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. People were given options and the time to consider and choose. For example, one person came into the lounge and staff asked them where they would like to sit. The person considered this for a moment before pointing at a particular chair. They were then supported to their choice of chair and made comfortable by staff.

People's independence was promoted. For example, one person struggled with their personal hygiene and required support from staff. The care plan noted the person could wash their hands, arms and face and staff were guided to prompt the person to do this. We spoke to a member of staff who supported this person. They said, "This resident is able to do some things themself so I remind and encourage them to do it. You don't want to take away what ability they have got left". Another staff member said, "You get to know what residents can manage. I help them to feel capable and maximise their potential, I don't take over".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. The service displayed a '10 dignity do's' which gave staff guidance relating to people's dignity. This included

'treating people as individuals' and 'respecting people's right to privacy'. The registered manager was certified as a 'Dignity Champion' by the Nation Dignity Council. One member of staff had received an 'excellence' award for dignity from 'Age UK'. We observed staff treating people with dignity and respect throughout our visit.
People told us staff promoted their dignity and respected their privacy. One person said, "I think that they do respect my privacy & my dignity. They knock before they come into my room and will always check first that I'm decent before they walk into the bathroom. I like that and I like them". Another person said, "They certainly treat us all with great respect and they also make sure that your dignity is preserved. They make sure that I get to the toilet with my frame and then they go away until I've finished then get me back to my seat again".

We spoke with staff about promoting people's dignity and respecting their privacy. Comments included; "I close doors and draw curtains to keep things private. I also give them options so they are in charge", "I always make sure doors are closed, I cover them up and offer them choices" and "I knock on doors, say hello and remind them who I am. I'm respectful and polite and I make sure personal care is done in private".

People were involved in their care. People were involved in care reviews and information about their care was given to them. People had also provided personal information enabling the service to involve them on a personal level. People's birthdays were recorded and celebrated and personal information was used by staff to allow them to engage with people. For example, where people became anxious or upset staff referred to people's histories or interests to reassure them or distract them. We saw this approach calmed people.

People's wishes relating to 'end of life' care were recorded and respected. Advanced care plans recorded people's preferences and wishes. For example, whether people wished to be buried or cremated, funeral and family arrangements and their choice of music for funerals. Staff we spoke with were aware of these wishes and told us people's preferences were always respected.

People's spiritual and religious needs and preferences were assessed and recorded. Records evidenced people were supported to follow their chosen religion. This included services held in the home in addition to attending local church services. One person said how they were supported to follow their individual spiritual beliefs, including attending regular meetings and how staff members support them to do this. They also told us how they appreciated this support as their friends from the group visited them at the home. They said "I love to see them".

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person had stated they liked football. Another person had stated they were 'very sociable'. We saw this person being supported by staff to attend a social activity. Care plans were detailed, personalised, and were reviewed regularly.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person required staff support with their mobility. They had asked that staff only supported them where they needed support. The care plan guided staff to only assist the person where necessary. We spoke to a member of staff who supported this person. They said "[person] is very independent so I only help when [person] asks or is clearly struggling. It is important to them they remain as independent as possible so I follow their wishes".

Care plans and risk assessments were reviewed to reflect people's changing needs. Staff completed other records that supported the delivery of care. For example, where people needed topical creams applied, a body map was in use to inform staff where the cream should be applied. Staff signed to show when they had applied the cream and there was a clear record of the support people received. Where people's needs changed the service sought appropriate specialist advice. For example, one person required medicine for their condition. When their condition changed the service referred the person to the GP who prescribed a new medicine. Records confirmed the new medicine was being administered.

People received personalised care. For example, one person could present behaviours that may challenge. The person could become agitated and become resistant to personal care. The person had been referred to the mental health team and as a result their medicine had been changed. Staff were guided to monitor person's mood and offer them choices. Triggers to this behaviour were recorded in the care plan and included the quivering of their bottom lip and puffing of their cheeks. Staff were guided to distract the person when triggers were identified. One staff member told us, "I have a very good relationship with [person] and I can calm them when they get upset. Because I know their past I talk to them about past people or events and that really works well at distracting them from what has upset them".

People were offered a range of activities including games, sing a longs, arts and crafts, keep fit, talks with guest speakers, visiting musicians and gardening. People were encouraged to go out with families and friends where they were able and trips to the shops, local places of interest and the pub were arranged. Religious services were regularly provided for people to attend. The home also had large, well maintained garden areas for people to enjoy. Access to the garden was unrestricted and accessible for people who used wheelchairs. BBQs were regularly held for people and their families to attend and local schools visited the home to perform concerts.

People told us they enjoyed activities in the home. People's comments included; "Yes I have enough to do during the day, I'm never bored. They sometimes have activities, like singalongs and where we're encouraged to take part. Some of them do join in but I tend not to", "I like the entertainment, especially when there's a good singer there. My Mother had a beautiful voice. I used to have a good voice but not now. I don't sing a long, I croak", "I love the entertainment when there is something going on. They do a lot of singing here" and "I love music anytime".

During our visit we observed a seated fitness activity. Many people joined in the activity which was a lively and jovial event clearly enjoyed by those taking part. We also saw the conservatory was full of plants potted by people ready to be planted in the garden. Staff had helped people prepare the plants. The member of staff responsible for organising activities spoke with us about their work in the home. They said, "I use information in care plans to try to match activities with people's previous hobbies and interests. I also talk to the families to see what people like, plus I know what works. Gardening, visiting singers and BBQs are their favourites so we do lots of that".

People's and their family's opinions were sought through regular surveys. The surveys asked people questions about all aspects of the service, care and staff. We saw the results of the last survey which were very positive. People and families could also post comments about the service on the provider's website. Where concerns had been raised the service took action to address them. For example, some families had questioned afternoon staffing levels. The registered manager investigated the concerns as a result changed the staff rota to provide an extra member of staff in the afternoon. Families had also requested a monthly email update relating to people's care. We saw this was now in place.

The services complaints policy was displayed at the entrance to the home and was given to people and their families when they joined the service. The policy also contained details of how to complain. Records showed the service had not received any complaints. The registered manager told us, "We tend to deal with any issues long before a formal complaint needs to be raised. I keep a 'niggles' book to record any concerns or comments brought up". The niggles book was maintained and contained queries and questions raised by people and their families, almost all of which were related to the laundry and were of a minor nature.

People told us they knew how to complain and were confident action would be taken. One person said, "I've never needed to complain but I would know how to, yes. I believe that they'd listen to it and act on it". Another person said "I've never needed to complain but would know what to do if I wanted to make a complaint. No need though. I'm sure they would act quickly if I did complain to them".

Requires Improvement

Is the service well-led?

Our findings

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care and results were analysed resulting in identified actions to improve the service. For example, one audit identified a faulty hoist. The engineer was contacted and the hoist was serviced. We saw the hoist was now operational. The registered manager also held 'clinical governance' meetings with the GP. Hospital admissions, deaths, safeguarding and incidents were reviewed and actions from these meetings were identified to improve the service. For example, following a meeting in February 2016 a medicines review was undertaken for all people at the home and, where appropriate, the GP updated people's medicine.

However, medicine audits did not identify our concerns relating medicine stocks. Whilst the registered manager was aware the management of medicines required a review and some action had been taken these actions did not address our identified concerns. The registered manager did take immediate action once we raised our concerns and by the second day of our inspection a full review had been undertaken and a new audit system put in place. This included spot checks and audits of all medicines along with revised paperwork and medicine records. Although actions were taken we have asked the manager to provide us with details of how these improvements will be sustained.

People clearly knew the registered manager who was visible around the home throughout our visit. We saw them engaging with people who greeted her warmly with genuine affection. The registered manager knew people and called them by their preferred name. People told us the service was well managed. One person said, "[registered manager] does come round quite often. She always pops her head around the door to find out how I am. Yes, I believe that this place is very well managed by [registered manager]". One person's relative said, "Yes, I think this place is very well managed and well led".

Staff told us the registered manager was supportive and approachable. Comments included; "I think she is lovely. Really understanding and I can go to her with anything. She is helping me with my diploma (national qualification) in care", "She is very caring, understanding and supportive. She's also a good listener. The best manager I have worked with" and "I like her very much, very supportive and I think we work in a similar way. She has been very supportive to me".

The registered manager led by example. The registered manager supported people individually throughout the day and greeted relatives and visitors in a warm and welcoming fashion. Their example gave staff clear leadership and we saw this enthusiastic, person centred approach repeated by staff throughout our visit.

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced.

The registered manager told us their vision was, "To make this a safe and caring home. I want to pay attention to detail and give our people what they want, for this to really be their home". Staff echoed these

sentiments. One staff member said, "This is a home in the real sense of the word, not a work place".

Accidents and incidents were recorded and investigated. The registered manager analysed information from the investigations to improve the service. For example, one person had fallen but they were uninjured. The incident was investigated and the person's care plan reviewed to ensure they were safe and the person was referred to the GP. It was identified the person had contracted an infection. The person's medicine was then reviewed and they were closely monitored. Records showed all falls were monitored to look for patterns and trends and were regularly discussed with the care home support service.

The registered manager shared learning with staff through briefings, handovers and staff meetings. For example, at one staff meeting an issue was raised relating to a person's skin condition. As a result the district nurse was contacted and provided specialist training for staff in relation to this person's skin condition. We asked staff about how learning was shared. One staff member said, "We have meetings, briefings and face to face conversations where we all share information. Very useful and I think I am well informed".

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.