Beechcroft Residential Home

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Inspection report

Salop Drive
Oldbury
West Midlands
B68 9AG

Tel: 01214292993
Website: www.carltoncaregroup.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Our inspection was unannounced and took place on 20 June 2016. At our last inspection on 8 June 2015, although there was no direct impacts on people to determine a breach of regulation, we assessed two domains [domains are the different subject sections within the report], safe and well-led as 'requires improvement'. We re-looked at the issues that previously required improvement. We found that some issues had been addressed, but some still needed further improvement which included staffing levels. We also found some new issues including staff sickness management that also required improvement to prevent people being at risk of not receiving the care and support they needed.

The provider is registered to accommodate and deliver personal care to a maximum of 50 people. At the time of our inspection 47 people lived at the home. People who lived there were elderly and had needs associated with old age and dementia.

A manager was registered with us as is required by law and was present on the day. 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.

Staffing levels needed further consideration to ensure that they would consistently meet people's needs and keep them safe.

Most people and their relatives told us that the quality of service was good. Governance processes were in place but had not always been effective to ensure that staff sickness levels and other staff issues had been resolved.

Monitoring methods were used but they had not always checked that people's likes, dislikes and preferences were current.

People were generally given their regular medicines as they had been prescribed. However, protocols were not in place for medicines prescribed on as needed basis to ensure that people also received those medicines safely.

Recruitment processes ensured that most of the checks had been undertaken on staff to prevent people being placed at risk of harm or abuse. The provider had not always however, gained enough information to ensure that all staff were in full good health.

Staff knew how to keep people safe which prevented them being placed at risk of harm or abuse. Processes were in place to prevent people being placed at risk of sore skin and accidents.

Staff received induction training and support to ensure they did their job safely in the way that people preferred.

Staff were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager had met the requirements set out in the MCA and DoLS to ensure that people received care in line with their best interests and were not unlawfully restricted.

People were provided with drinks and meals that they generally enjoyed in sufficient quantities to prevent them from a risk of dehydration and malnutrition.

People's health was assessed to ensure that their health care needs were met by a varied range of external healthcare professionals.

People were cared for and supported by friendly, helpful and kind staff.

People were supported to retain their independence and undertake the tasks that they could do themselves.

People were glad that visiting times that were flexible and that their family and visitors and were made to feel welcome by the staff.

People made decisions about their care and support and they and their families were involved in how their care was planned and delivered.

Recreational activities were offered for people to participate in and enjoy but these needed to be further considered for all people's recreational needs to be met.

A complaints procedure was in place for people and their relatives to raise their concerns or complaints if they had a need to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's views on staffing levels were mixed so did not confirm that staff were always available when they were needed.

Medicine systems did not include the management of medicines prescribed on an as needed basis.

Recruitment processes did not always check or confirm that staff had good health.

People told us that they had not experienced abuse or maltreatment.

Is the service effective?

Good

The service was effective.

Staff received training and the support they needed to meet people's needs in a safe way and in the way they preferred.

People were supported to eat and drink what they liked in sufficient quantities to prevent them suffering from ill health.

Staff worked with external health care professionals to provide effective medical and nursing support.

Is the service caring?

Good

The service was caring.

People and their relatives told us that the staff were generally kind, caring and helpful.

People's dignity and privacy was maintained and their independence promoted.

People felt that staff supported them to maintain their appearance to maintain their self-esteem.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and their care plans were produced with them and their family.

Staff were responsive to people's preferences regarding their daily routines.

A complaints process was available for people and their relatives to access if they felt unhappy about anything.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Governance processes were in place but had not always been effective to ensure that staff sickness levels and other staff issues had been resolved.

Monitoring methods were used but they had not always been effective in checking that peoples likes, dislikes and preferences were current.

Methods to gain the views of people were in place and these were listened to and acted on by the registered manager.

The management of the service was open and inclusive.

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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.

Our inspection was unannounced and took place on 20 June 2016. The inspection team included one 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 asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Providers are required by law to notify us about events and incidents that occur; we refer to these as notifications. We looked at the notifications the provider had sent to us. We asked the local authority their views on the service provided. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We met and spoke with 15 of the people who lived there and five relatives. We spoke with eight staff [this included care staff, senior care staff and a domestic staff member], the registered manager, the provider and a visiting external healthcare professional. Not all of the people were able to fully communicate verbally with us so we spent time in communal areas and observed their interactions with staff and body language to determine their experience of living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us. We looked at three people's care records, eight people's medicine records, accident records and the systems the provider had in place to monitor the quality and safety of the service provided. We also looked at three staff recruitment records, the training matrix, provider feedback forms that had been recently completed by relatives and the people who lived at the home, and a report that had been produced

by an external agency following a visit they had made.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection of 8 May 2015 some people told us that they felt that there was adequate staff other people said that there were not. We raised this with the provider and the registered manager who told us that they would review staffing levels. As with our last inspection people, relatives and staff had mixed views about staffing levels. Some people felt that there were not enough staff. A person told us, "Sometimes we have to wait for staff to come to us". A relative said, "At times there are no staff present in the lounge and I worry that people may try and stand and fall". A staff member said, "If staff phone in sick then this sometimes causes a problem". Other people told us that there were enough staff to assist them 'promptly'. A person said, "There are staff when I need them". Another person told us, "I think there are enough staff". On the day we saw that staff were available to support people and at mealtimes to assist. We found that there had been a small increase of staffing hours and that some staff shift times had been changed to accommodate people's needs and safety. The registered manager confirmed that they had 30 vacant care staff hours. These were being covered mostly by the staff on their days off. They told us that they had recruited some new staff however, not all staff had stayed. They further told us and showed us evidence that they were continuing to recruit and some new staff had been appointed to improve the situation.

At our last inspection of 8 May 2015 we found that processes in place did not always ensure medicines were managed safely. This was in relation to the storage of some medicines and recording. We looked at the issues again and found that those particular issues had been addressed.

Staff told us and we saw certificates to confirm that staff had received medicine training. Staff told us and it was confirmed by the registered manager that medicine competency assessments were not carried out to ensure that staff transferred what they had learnt on training into everyday practice. Although we did not identify that medicines had not been given correctly we saw that there were medicines that had been prescribed on an 'as needed' basis but protocols were not in place to advise staff when the medicine should be given. A protocol for each medicine prescribed on an as needed basis may give people assurance that they would be given their medicines when they were needed, and not given, when they were not needed. The registered manager told us that they would address these issues.
People told us that they were happy that staff looked after their medicines for them. A person told us, "I would forget to take my tablets". Another person said, "They [the staff]never forget to give me my tablets". A third person said, "I like the staff to put my tablets in my hand". We indirectly observed a staff member giving people their medicines. We saw the staff member put the tablets in the person's hand and asked other people how they would like to take their tablets. We saw that they explained to the person that they were giving them their tablets and what they were for. We saw that people agreed to take their medicines. This showed that staff supported people to take their medicines and in the way that they preferred.

We found that recruitment systems were in place. We checked three staff recruitment records and saw that pre-employment checks had been carried out. These included the obtaining of references and checks with the Disclosure and Barring Service (DBS). The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concerns. However, we found that there was no health declaration completed for one staff member. For a second staff member

who declared on their application that they had a health condition there was no risk assessment to confirm that they would be safe to work. This meant that the provider had not obtained or explored all staff information about staff health conditions to enable them to make a judgement about their suitability.

People we spoke with told us that they had not experienced any poor treatment. This was confirmed by the relatives we spoke with. A person told us, "Never had a situation of being shouted at or staff being rough". Another person said, "I have only been treated with kindness nothing bad" A relative said, "No I am not aware of any kind of abuse here". We noticed that people were happy and relaxed when they were in the company of staff. Training records confirmed that staff had received training in safeguarding people and abuse prevention. We saw policies and procedures for safeguarding adults and contact numbers for the local safeguarding authority for staff to make referrals to or obtain advice from. Staff spoken with knew how to recognise signs of abuse and how to report their concerns. A staff member said, "Oh I would not tolerate any bad practice I would report any concerns straight away. The manager would deal with it". A relative highlighted that sometime in the past they were not happy with the way a staff member had spoken to a person. They told us, "This was addressed quickly to our satisfaction". This confirmed that the provider had systems in place in order to protect people who lived there from abuse.

We checked the records and money held in safe keeping for two people and found that this balanced correctly. We found that only a small number of staff had access to the money to help keep it safe. We saw that records of transactions were signed by two staff and that the money was checked regularly ensure that it was correct. This meant that if an error occurred the staff should be able to determine when it occurred.

A person said, "I do feel safe here". Another person commented, "I am safe the staff help me to walk so that I do not fall". A relative said, "Absolutely they [person's name] are safe". We observed safe procedures for lifting and hoisting a person. We also saw that staff supported people with walking difficulties to walk and sit down safely. They reminded people of what to do to stay safe that included putting their hands on the chair arms and ensuring they were over the chair before they sat down. Staff told us about people's risks and what they had to know about to prevent injury. We saw records to confirm that risk assessments were undertaken to prevent the risk of accidents and injury to the people who lived there. These included risk assessments and care plans for people who were at risk of sore skin. We saw that equipment was used to prevent sore skin including mattresses, cushions and leg protectors. We identified that although some people had skin conditions no person had a pressure sore. An external health professional said, "The staff calls us quickly if they are concerned about a person's skin". This highlighted that instructions from risk assessments and care plans had been followed by staff.

Good

Is the service effective?

Our findings

Overall people we spoke with told us that they felt that the service was good. A person said, "I am content here". Another person told us, "I think it is good here". A relative said, "The service is fairly good". Staff we spoke with confirmed that people's needs were met and they were kept safe".

A staff member told us, "I have not been here long. I am doing my induction training". Staff told us that induction training involved looking at policies and procedures, being introduced to people and 'shadowing'. Shadowing is when staff work alongside experienced staff to get familiar with and learn their job role. Staff files we saw demonstrated that induction processes were in place. The provider had information about the 'Care Certificate' and told us that staff who needed to undertake this training had the opportunity to work towards this. The Care Certificate is an identified set of standards that care staff should adhere to when carrying out their work. However, the registered manager also told us and staff files that we looked at highlighted that most staff newly employed had already completed a recognised qualification in health and social care which meant that they did not always need to complete the Care Certificate.

A person told us, "They [the staff] are trained to do their jobs". Another person said, "It must be a hard job but I think the staff do well". A relative said, "I think the staff have the right knowledge". A staff member told us, "We have a fair amount of training. I asked for some more medicine training and am doing that now which is good. I can do my job". Staff we spoke with confirmed that they had received the training they needed. Staff training records confirmed that staff had received the mandatory training for their role which would ensure they could safely meet people's individual needs.

A staff member told us, "I do feel supported. We can go to the manager at any time". Staff told us that they felt supported by managers and their peers all of the time. Another staff member told us, "We have supervision sessions". Records that we looked at confirmed this. We saw where problems had been identified these were discussed with staff to assist them in their professional development. Staff told us that staff handovers were held to ensure that staff were communicated with about people's current needs and had the opportunity to raise issues and views. The registered manager confirmed this.

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. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A person told us, "I feel free to walk and do what I want". Another person said, "The staff explain what they are going to do. They [staff] always ask me for consent first". We heard staff explaining to people what they were going to do before using the hoist and giving them their tablets and asked people if they were happy for them to do this. This showed that people were given the opportunity to refuse the care if they wanted to.

Staff and relatives we spoke with confirmed that where a person lacked mental capacity they involved appropriate family members, advocates, or health/social care professionals to ensure that decisions that needed to be made were in the person's best interest. The registered manager had applied to the local authority regarding DoLS issues where they deemed it was needed. This confirmed that the provider was aware of what they should do to prevent people having their right to freedom and movement unlawfully restricted.

A person said, "I love my food and we have choices every meal time". Another person told us, "I like the food. I eat a lot". Meeting minutes that we looked at confirmed that people were asked their views about the meals provided. We heard staff asking people at breakfast what they would like to eat. We saw that hot and cold options were available and staff confirmed that this was the case every day. Before lunch we heard staff again telling people what the meal options were and ask them what they would prefer. We observed that people enjoyed their meals. However, one person told us that they were regularly offered a food item that they did not like. We spoke with the registered manager about this. The registered manager told us that they would ask staff to review all people's food likes and dislike at the end of the month when care plan reviews would be undertaken to resolve this.

We saw that people came to the dining room mid-morning as they had chosen to get up later. Two people had their breakfast in their bedrooms as they preferred this. We observed that some people did not want to sit at a table so were supported to sit in a chair with a small table to eat their meal. They told us that were happy with this. This showed that mealtimes experiences were flexible in order to meet people's preferences.

A person told us, "The staff always offer us plenty of drinks". During the day we saw that staff offered people a range of hot and cold drinks and that two choices of squash we made available at all times in the lounges. We saw that special cups were available to assist people to drink easily. A staff member told us that a number of people required a thickening agent in their drinks to prevent them choking and we saw that this was used. Staff were also able to tell us how they prevented people choking. A staff member said, "Pureed and soft meals are made available and we always make sure that we supervise at mealtimes". During meal times we saw that staff were available to give assistance to people who needed this. We observed that a person started to cough when they were eating. A staff member noticed this and immediately went to assess the situation. Records highlighted and staff confirmed that if a person was at risk of weight loss a referral was made to the dietician. This showed that staff were aware of people's risks concerning the consumption of food and drinks and took action to reduce these.

A person who lived at the home told us, "I get my eyes and feet looked after". A relative told us, "I think that [person's name] has the doctor when needed". Other people and their relatives told us that people were offered access to routine checks of their eyes, teeth and feet. The staff we spoke with and records that we looked at highlighted that staff worked closely with a wider multi-disciplinary team of healthcare professionals to provide assessment and treatment to people. This included specialist health care teams and speech and language therapists. A visiting healthcare professional told us, "We [the healthcare team] come in here at least twice a week". The staff refer to us when needed and follow our instructions". This ensured that the people who lived there received the health care support that they required to promote good health.

Good

Is the service caring?

Our findings

One person told us that they were spoken to once in a way they did not like by a staff member. However, they told us that the situation was remedied by the registered manager and that they had not experienced this again. Other people and their relatives told us that the staff were kind and caring. A person said, "The girls [staff] are really good". Another person told us, "The staff are smashing". A relative said, "The staff are friendly and kind". One person told us that they had a 'sweet tooth' and always asked a particular staff member for sweets. They told us that they tapped the staff member's pocket when they wanted one. The staff member showed us that they kept a tube of mints in their pocket especially for the person. This demonstrated the staff member had a caring, generous nature. We saw that staff spoke with people and showed an interest in what they were saying. We observed that staff interactions with people were kind, friendly and caring. We also saw that staff supported people at a pace that suited them. We heard a staff member say to one person, "Are you ready, take your time". Staff we spoke with told us that their colleagues [other staff] were caring towards the people who lived at the home.

A person said, "It is a happy home". A relative told us, "The home has a nice relaxed atmosphere". The provider promoted a homely atmosphere. The home felt warm and welcoming. People and their relatives confirmed that they felt that the home was welcoming and friendly.

A person told us, "I do spend time alone when I want to". Staff confirmed that people could spend time on their own in their bedrooms if that was their choice. We saw that in addition to the two main lounges there was a small lounge and other seating areas for people to spend their time if they wanted to. A person said, "The staff cover me up". Staff we spoke with described how they promoted dignity and privacy in every day practice. Other people and their relatives also told us how staff promoted people's privacy and dignity. Records confirmed people's preferred name and we heard staff using that name to respect their wishes. However, a relative told us that they felt that staff could take better care to ensure their family members 'mid-riff' was not exposed when they were transferred to a chair. We spoke with the registered manager about this who told us that they would ensure that this was addressed.

A person said, "I like to have my hair done". Other people also told us that they were happy that they had access to a hairdresser so that they could have their hair cut or styled. We saw that a well-equipped hair dressing salon was provided and found that a hairdresser visited the home weekly. We saw that people looked well groomed. Their hair was tidy and male people were shaven. We saw that some people wore jewellery. We heard staff complimenting people on their appearance to boost their self-esteem. A staff member said to a person, "You look really lovely". The person was pleased and smiled. People told us that they selected their own clothes. A person told us, "I get out what [clothes] I want to put on". A relative told us that they helped their family member to select clothing for the next day that they wanted to wear. We saw that people wore clothing that was appropriate for their age, gender and the weather. This showed that staff knew people's individual choices concerning their appearance and had supported them to achieve this.

A person told us, "I like to do what I can". Another person said, "The staff help me but only do the things that I cannot". This highlighted that staff knew it was important that people's independence was maintained.

People we spoke with told us that they could have visitors at any time and they were glad of that because it was important to them. A person told us, "I am so glad that my daughter can visit me when I want". A relative said, "I can visit when I want to". All staff we spoke with confirmed that visiting times were very flexible.

We saw that information was available giving contact details for independent advocate services. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. The registered manager and staff told us that people would be assisted to access an advocate if they required it to help them make decisions about their care and support.

Good

Is the service responsive?

Our findings

A relative said, "Before they [person's name] came to live here the staff asked me a lot of questions so that they knew what was needed". The registered manager told us and records that we looked at confirmed that prior to people moving into the home an assessment of need was carried out with the person and/or their relative. This was to identify people's individual needs, personal preferences, and risks, to make sure that their needs could be met and that they would be safe. We saw that a letter was held on the people's files that confirmed that following their assessment the staff would be able to meet their needs.

A person told us, "The staff know what I need and look after me well". A relative said, "I feel I am included in their care and am mostly kept up-to-date with any changes". Another relative told us, "They [person's name] needs have changed and a reassessment is being carried out. I am involved". Records that we looked at and staff we spoke with confirmed that people's needs were reviewed regularly or where required reviewed by the local authority and other health or social care professionals. Although people could not recall seeing their 'care plans' we saw that their care plans had been signed or dated by them or their relative to confirm that they agreed with the content.

A person told us, "The church people came in before and I liked that". Records that we saw highlighted that people had been asked about their personal religious needs. The registered manager told us that the church representatives that used to visit the home no longer did. They told us that they had taken time and effort to identify and negotiate with local clergy to provide a new service. They provided us with documentary evidence to confirm this.

We had mixed views from people about the activities that were provided. A person told us, "There could be more for men to do". Other people told us, "There are things for us to do that I enjoy" and, "We have singers come in they are good". A relative told us, "They [person's name] go out sometimes and I think that is good for them". An activities co-ordinator was employed who told us about the activities provided. They told us that different external providers came to provide exercise and singing sessions. They told us that they offered seasonal events at Christmas and Easter. We saw a newspaper clipping that showed that a party was recently held for one person to celebrate their 104 birthday. The registered manager told us that they had sat with people to watch the current football tournament and that people had enjoyed that. During the morning we saw that the activities co-ordinator offered a number of people photograph albums to look at. These were about past events and activities. We saw that staff engaged with people talking about the photos. We found that people were offered weekly trips to local places including Stourport and Ironbridge. However, one person said, "I am not going again as we do not get off the mini bus so it is a waste of time". The registered manager told us that this was correct. We discussed the situation as this could mean that people during the time out may not be able to access a toilet if they needed to. The registered manager agreed that the outing events needed further consideration. Minutes that we looked at highlighted that people were asked if activity provision was meeting their needs. We also found that the registered manager at the request of some people had introduced a weekly event where an alcoholic drink and crisps were offered to those people who wanted this. This demonstrated that the provider offered a range of activities for people to enjoy but some aspects needed further exploration and consideration.

A person said, "I have not needed to complain. A relative said, "I know how to complain and I have raised an issue before and this was addressed. Another relative told us, "There was an issue and the staff became to know about this. It was the staff that realised that the manager needed to know about the issue. I am really glad that they dealt with the issue and it was resolved. Staff told us what they would do if someone complained to them. This included trying to deal with the complaint and reporting it. We saw that a complaints procedure was available on display for people to read and access. The complaints procedure highlighted what people should do if they were not satisfied with any part of the service they received. It gave the contact details for the local authority and other agencies they could approach for support to make a complaint. We looked at the complaints log and saw that there was a record of the one complaint that had been received, how it had been dealt with and that the complainant had been happy with the outcome. This showed that the provider had a system in place for people and their relatives to access if they were not satisfied with any part of the service they received.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection of 8 May 2015 we identified that quality monitoring processes were not adequate. We identified that there were some environmental hazards that could place people at risk of injury and that an on-going refurbishment plan was not in place. This inspection we found that the environmental issues had been addressed, and that although a refurbishment plan had not been produced, issues that needed attention were included in the provider's monthly visit to the home report. However, we found that further improvement was needed regarding some monitoring and governance to ensure that people received a quality service.

Governance processes were in place but had not always been effective to ensure that staff sickness levels and other staff issues had been resolved. A staff member told us, "Sickness causes a problem here especially at weekends. It can be the same staff who phone in sick regularly. This makes us short and people then can have to wait". We were told by the registered manager that some staff were taking more sick time frequently and that some staff did not always work as they should. They told us that this had an impact on the service provided. We saw that sickness monitoring processes were in place and that staff sickness rates were an agenda item in staff meetings and the provider's monthly visit to the home report. However, the registered manager told us that action could not be taken until staff members had taken a certain number of sick days. This meant that the sickness situation and the impact on people as a result, could continue We also found that where situations arose a one to one meeting with the staff member had been held to engender improvement. However, the registered manager told us that some staff did not always work as they should. This meant that the methods used to lead the staff were not always working and that people could be at potential risk of not receiving a quality service.

Monitoring methods were used but they had not always been effective in checking that people's likes, dislikes and preferences were current. The provider carried out an audit of the home once a month and produced a report of their findings. The registered manager undertook audits of medicine systems and analysed accidents and falls to prevent these occurring. However, although people had been asked about their wishes and preferences governance processes did not check the monthly reviews undertaken by staff to determine if people's wishes and preferences had changed. Subjects for checking could include if people still wanted to vote, that people always liked the meals offered, or their satisfaction with the frequency of baths and showers that were offered. This would give people greater assurance that their needs and preferences would be met.

Generally people and their relatives told us that the service was of a good standard. A person told us, "I think it is organised". The provider had a leadership structure that staff understood. There was a registered manager in post who was supported by two deputy managers who worked on a 'job share' basis. This meant that their joint hours equated to one full time post. Relatives we spoke with and people who lived at the home knew who the registered manager was and felt comfortable to approach them if they had any issues. On the day we observed that the registered manager was visible within the home. We saw that people were familiar with the registered manager. This highlighted that the registered manager was available for people and relatives to speak with if they had a need.

Conditions of registration had been met as the provider informed us of all events and incidents that they are

required to notify us of. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider completed and returned their PIR to us. Providers are required to display their current inspection rating. We saw that the provider's rating was available via links on their web site and on display in the home. This confirmed that the provider had met those legal requirements.

People told us that they completed provider feedback forms and that meetings were held for people to voice their views and opinions. We saw that the majority of the feedback indicated people's and relatives satisfaction with the service. We found that the registered manager had listened to what people and relatives had told them and had taken some action. Feedback forms had highlighted that some people and relatives did not know of the complaints procedure. To resolve this a large print copy had been displayed by the visitor signing in book and the process had also been raised in meetings held. People had asked for an afternoon where alcoholic beverages could be offered and this had been actioned. Minutes of meetings held for the people who lived there confirmed that people were asked and consulted with about changes being considered this included the possible change of the use of dining rooms and lounges.

We saw that a written policy was available to staff regarding whistle blowing and what staff should do if an incident occurred. Staff we spoke with knew of the whistle blowing policy told us that they would follow this if they ever had concerns about or witnessed bad practice.