Trustees for The Roman Union of The Order of St Ursula

The Lourdes Community Nursing and Residential Care Home

Inspection report

The Ursuline Convent
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20 October 2016

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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 19 and 20 October 2016. It was an unannounced inspection.

The Lourdes Community Nursing and Residential Home is registered to provide nursing or personal care for up to 15 people. At the time of our inspection there were 15 people living in the home.

A registered manager was 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.

People felt safe and comfortable living at the home and there was a calm and welcoming atmosphere. Staff were compassionate in their interactions with people and had developed positive and caring relationships with them. Staff were gentle and supportive and spoke with people in a polite and considerate manner.

Staff understood their role in keeping people safe and reducing the risk of harm to people. Risks to people had been identified, assessed and actions had been taken to minimise them. Staff respected and promoted people's independence, while remaining aware of their safety. The provider had plans to ensure people were kept safe in the event of an emergency.

Medicines were managed safely and people received the medicines they required in the correct dosage at the prescribed times. People told us staff were responsive if they were in pain.

There were enough staff to keep people safe. Safe and effective recruitment practices were followed to ensure all staff were of good character and suitable for the roles they performed. Staff were provided with an induction, further training and relevant qualifications to support them in meeting people's needs.

Staff showed an understanding of the principles of the Mental Capacity Act 2005 in relation to people they supported. Before providing care, they sought consent from people and gave them time to respond. They respected people as individuals and supported them to make their own choices as far as possible.

People were offered a choice of foods and were supported to eat and drink according to their needs. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health and when their health needs changed.

People received personalised care and support. People's care plans were regularly reviewed so staff had a clear picture of the person's needs and of any changes in the support they required to maintain their health.

The environment of the home was responsive to people's beliefs and spiritual needs.

Staff were committed to providing a high standard of care and enjoyed working with the people who lived in the home. However, staff did not always feel supported because they did not have regular opportunities to talk about their work or any issues on a one to one basis with managers. Staff felt there was not a consistently open culture in the home and communication between them and the management team could be improved. A staff survey in 2016 had identified some of these issues, but no action had been taken address them.

There were effective internal quality assurance systems that monitored people's care. Where accidents or incidents had occurred, they had been appropriately documented and action taken to mitigate the risks of a re-occurrence to the person involved.

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.

People felt safe living at the home. Staff understood their role in keeping people safe and reducing the risk of harm to people. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. There were sufficient staff on duty to keep people safe within the home. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective.

Staff were provided with an induction, further training and relevant qualifications to support them in meeting people's needs effectively. Staff had an understanding of the Mental Capacity Act 2005 and worked within the principles of the legislation. There were arrangements in place to ensure that decisions were made in peoples' best interest. People enjoyed the meals provided and lunch time was a social part of the day.People received support from health care professionals to meet their health needs.

Is the service caring?

Good

The service was caring.

There was a calm and welcoming atmosphere in the home. Staff were compassionate and had developed positive and caring relationships with people. Staff listened to people and took time to get to know them as individuals. Staff respected people's privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care was delivered in line with their individual care plan. People received personalised care and support which was responsive to their needs. A handover of information between each shift helped to ensure staff knew

about any changes in people's needs or risks to their health. The environment of the home was responsive to people's beliefs and spiritual needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were happy with the way staff cared and supported them within the home. People were encouraged to share their opinions about the quality of the service to ensure improvements focused on their experiences. The provider's quality monitoring system included checking people received an effective, good quality service. However, there was not a consistently open culture in the management of the home. Staff did not always feel supported or that any concerns they raised were always responded to.

The Lourdes Community Nursing and Residential Care Home

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 was 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 19 and 20 October 2016. The first day of the inspection was unannounced and was conducted by one inspector and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care. On the second day a second inspector supported the inspection.

We reviewed information received about the service, for example, the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service. These are people who contract care and support services paid for by the local authority. They did not share any concerns about the service.

We spoke with five people who lived at the home and two visitors. We spoke with the registered manager, a member of the Board of Trustees, a member of the management committee and six staff including a nurse, care staff and ancillary staff. We also spoke with a visiting healthcare professional to the home.

We looked at a range of records about people's care including three care files. We looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the registered manager and the provider made to assure themselves people received a quality service. We looked at personnel files for three members of staff to check that safe recruitment procedures were followed, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe and comfortable there. One person told us, "I feel safe. People are kind and you know they will always help you when you need help." Another person told us they felt safe because they knew the home was secure and explained, "Yes definitely I feel safe. People have to say who they want to see before they can get into the home."

Staff members we spoke with understood their role in keeping people safe and reducing the risk of harm to people. Staff knew to report concerns about people's safety to the nurse on duty or the registered manager. They also told us they would escalate their concerns externally, for example to us, if they felt appropriate action had not been taken. Throughout our visit, we saw people were at ease with staff. This demonstrated they felt relaxed and confident with the staff at the home.

There were enough staff on duty with the right competencies and experience to meet people's health and welfare needs. There was a nurse on duty 24 hours a day and four care staff in the morning and three in the afternoon. The registered manager, who was also a registered nurse, worked four days a week. The provider also employed catering staff and ancillary staff who were responsible for doing laundry and keeping the home clean and in good repair. This meant care staff only had caring responsibilities. The registered manager told us if they identified an increase in people's needs they would increase staffing levels. They explained, "In the past we had a person who was quite distressed ……if I need extra staff for a one to one, we will do that."

On the day of our visit, there were only three care staff on duty in the morning because one member of staff was unwell. Whilst care staff told us they felt rushed, we saw they were able to provide all the necessary care and support people required to maintain their health.

Staff told us the provider had recently had to rely on agency staff to support permanent staff. This was confirmed by one person who told us, "The carers are amazing because they are short staffed. One night they had an agency night nurse and an agency carer which is hard for them." We raised this with the registered manager who explained the use of agency staff was mainly due to staff sickness and holidays. There was a vacancy for one member of care staff which was currently being recruited to.

The provider's recruitment process ensured risks to people's safety were minimised. Records showed the registered manager checked staff's suitability before they started working at the home. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS helps providers to make safe recruitment decisions by providing information about a person's criminal record and whether they are banned from working with people who use health and social care services. We saw some DBS checks for existing staff had been completed several years ago. The registered manager told us they were considering renewing DBS checks to ensure they had the most up to date information on all staff who worked at the home. The registered manager made sure nurses maintained their professional status by checking their registration (PIN) numbers were current.

Risks to people had been identified, assessed and actions had been taken to minimise them. Assessments were in place to help prevent people falling or developing pressure areas. This information was recorded in each person's care records and instructed staff on how to manage and minimise risks. Risk assessments were reviewed and updated regularly with any changes to the level of risk. This was to ensure staff provided people with consistent and safe care. For example, all three people we pathway tracked had been assessed using a recognised assessment tool as being at high risk of skin breakdown. The appropriate equipment was in place to ensure the risks were minimised and staff had a good understanding of how it worked. For example, staff knew how to alter the pressure in air mattresses dependant on the person's weight.

Staff respected and promoted people's independence, while remaining aware of their safety. For example, one person was able to move freely around the home using a walking frame. Staff were aware that this presented some risks, but understood the importance to the person of being able to maintain their independence. A member of staff told us, "Every half an hour we have to check where [person] is. She is at risk of falling and her eyesight is bad. She uses a walking frame and we keep reminding her to use it."

The provider's policy for managing risk included risk assessments of the premises and equipment. For example, there was a risk assessment for the lift being out of action and people being limited to using the stairs to move around the home.

We checked the administration of medicines to see if they were managed safely. We found medicines had been stored safely and in line with manufacturer's guidance. Arrangements were in place to obtain, administer and record people's medicines. Medicines were available and Medicine Administration Records (MARs) had been signed to confirm administration, or a reason documented to explain why a medicine had not been given.

We observed one of the nurses giving people their medicines. The nurse wore a red tabard that clearly indicated they were completing a medicine round and should not be disturbed. The nurse followed best practice and procedures to ensure medicines were given to the correct person and in the dosage prescribed.

People we spoke with told us they received their medicines on time and staff were responsive if they were in pain. One person told us, "The nurse keeps asking me every day if I have any pain and whether I need any pain relief." Where people did have medicine 'as required' for pain relief, the nurse ensured the appropriate amount of time elapsed between dosages to minimise the risk of people exceeding safe dose limits within 24 hours.

One person was able to take their own medicines and had given written consent to do this. There was a risk assessment and management plan in place to support the person to do this safely. Another person was given their medicines covertly. This is when medicines are disguised in food or drink. A best interests meeting had been held with the registered manager and appropriate healthcare professional to ensure it was in the person's best interests.

The provider had procedures and policies in place to ensure the safety of the environment and minimise the impact of unexpected events happening at the home. This was to ensure people were kept safe and received continuity of care. Safety checks were completed for gas, electricity, equipment and fire safety. The provider had an emergency folder which contained contact numbers of suppliers to be contacted in the event of an interruption to services to the home. This included electrical power failure, loss of heating or a gas or water leakage. People who lived in the home had an up to date personal evacuation plan (PEEP) to instruct staff and the emergency services about what support they would need if the building needed to be

evacuated.

Good

Is the service effective?

Our findings

People felt staff had the skills, knowledge and understanding to provide them with effective care. One person told us, "The nurses are very aware and notice what needs to be done. They are wonderful. I couldn't speak highly enough of the nurses. They take a lot of time and trouble and the carers are amazing." Another person told us, "They are very competent."

Staff were provided with an induction, further training and relevant qualifications to support them in meeting people's needs. The provider's induction programme for new staff involved them 'shadowing' and working with more experienced staff prior to them working alone. The 'shadowing' period provided an opportunity for senior staff to check the competency of new staff. All new staff had a probationary period of six months and were confirmed in post when they had been assessed as competent.

Staff felt the training they received provided them with the skills to meet people's needs effectively and safely. One staff member told us, "We do mandatory training like manual handling. I have got infection control on Friday and I have just done fire safety training." Another staff member said, "The training is always ongoing and you are encouraged to do it. There is no problem with the training, that is really encouraged." The registered manager explained that external healthcare professionals were invited into the home if there was a specific medical need. For example, staff had received advice from healthcare professionals about the effects of macular degeneration (a condition affecting sight) and how to support people living with dementia.

Training records indicated that some training the provider considered to be essential was slightly overdue and training in safeguarding people had not been recorded. However, during our visit we did not identify any concerns and observed staff followed good practice. For example, staff complied with good infection control practice. Care staff washed their hands after supporting people and when coming out of people's rooms. Dirty linen and waste was disposed of correctly and sharps were placed in yellow bins within the treatment rooms. Staff understood their role in safeguarding people from harm.

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. We checked whether the service was working within the principles of the MCA.

Where a need had been identified, people's ability to make decisions had been assessed. For example, some people had bed rails attached to their beds to keep them safe. Assessments had been completed to check whether those people had the capacity to consent to the use of bedrails. Where a person had been identified as not having capacity to consent, there was evidence of a decision being made in the person's best interests to prevent injury. This was signed by an appropriate healthcare professional and registered manager.

Staff showed an understanding of the principles of the MCA in relation to people they supported. Before providing care, they sought consent from people and gave them time to respond. For example, the nurse ensured people were happy to take their medicines and had clearly given consent before their medicine was given. A member of staff told us, "If they don't want assistance, they don't want it. They have choice."

Staff described how they assumed a person had capacity and respected their choices. They told us about the importance of treating each person as an individual. A member of care staff explained this meant they would give a person information relevant to the decision and if the person was still unable to communicate a preference, they would do what they thought was best for the person, unless the person declined. The staff member told us, "You make sure they can understand what you are saying, you explain it and show them. When you get to know people you know their likes and dislikes and you would help them to make a decision. It does help when you know them."

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). The registered manager had identified two people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority which had been granted. One of the DoLS had conditions attached to the authorisation. The conditions had been complied with, although one person raised a concern that they had only received an invitation to a required 'best interests' meeting through a third party. The registered manager and a representative from the provider assured us they understood their legal obligations to comply in totality with all conditions attached to a DoLS authorisation.

We identified one person who had been assessed as not having a capacity to make their own decisions in relation to their care and treatment. The registered manager told us they would review this person's care plan immediately to identify if there were any restrictions on their liberty that required a DoLS application to be submitted.

People were able to have a varied choice of meals and were involved in making decisions about the meals provided. Everyone we spoke with was complimentary about the quality of the food. One person told us, "It is excellent. It is good and extremely well cooked and they go to great trouble to heat it up." Another person described the food as "smashing". One of the kitchen staff told us, "The budget is very high here for food. We changed the menu three months ago but it does need tweaking as there are a few things that people aren't keen on. They do get asked at their residents' meetings what they would like."

The meal at lunch time was a social part of the day when people from the wider Lourdes community came to the home and sat down to eat with the people living there. Tables were laid with cutlery, serviettes and flowers. Salt and pepper and sauces were available and vegetables were brought to the table in covered dishes. This meant people could help themselves which promoted their independence. People who needed help were assisted by others who were more able. Meals looked nicely presented and there was plenty of food available for people who wanted second helpings.

Whilst most people ate in the dining room, some people ate in their bedrooms because they were cared for in bed. Staff provided support when people needed assistance with eating and supported people at a pace that was suitable to people's individual needs. Drinks were available and staff ensured they were in reach of those people who could manage themselves.

People were assessed to meet their individual needs and to ensure they received a healthy and balanced diet. A member of kitchen staff told us that information about people's dietary needs was maintained in the

kitchen. They told us that meals were fortified with extra calories to support people in maintaining their weight but was unable to tell us if anybody was actually at risk of malnutrition. When asked they responded, "I'm not told that."

People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included the GP and community nursing services, and dieticians. We spoke with a visiting healthcare professional to the home. They told us that staff in the home were very co-operative and told us, "I have never had any problem with the care that the Sisters receive. I think they are well cared for." They told us that communication was good within the home and stated, "I always feel welcome and the staff are always willing to give you a hand."

Good

Is the service caring?

Our findings

Staff were compassionate in their interactions with people and had developed positive and caring relationships with them. People felt comfortable and relaxed with staff and described them as 'wonderful'. One person told us, "They are so friendly, they make you feel at home…..I felt when I came here I had come home. Everybody was so kind." Another said, "They (staff) are very nice. You couldn't fault them, they are lovely people."

There was a calm and welcoming atmosphere in the home and a friendly and caring rapport between staff, the people who lived there and their visitors. All staff, including non-care staff, greeted people by name as they moved around the home and took time to engage positively with them.

Staff spoke with people in a polite and considerate manner. Staff demonstrated they valued people by sharing discussions with them about things that were important to them. Staff took time to listen to people and showed genuine interest in what they spoke about. Staff listened to people's views and responded thoughtfully and respectfully. At lunch time staff spoke with people about the meal and people often smiled in response to the conversation.

The mannerisms of staff in both speech and touch were gentle and supportive. Staff engaged with people in a meaningful way which was not just task led. They took time with people and worked with them at a pace that suited the individual. Staff quietly supported people to be as independent as possible and do as much for themselves as they were able to. We saw staff encouraging people who could walk with a walking frame to do so, which maintained their independence and kept them safe.

Staff had taken time to get to know people. They understood that in order to provide good care they needed to know who the person was and respect what was important to them. When talking about people, staff referred to them by their religious names and appeared to know a great deal about their religious and occupational history within the Order and their individual preferences. One member of staff explained, "We know our residents really well, what their preferences are and how they want to have their care. What is nice is meeting people at this stage of their lives and learning what they did. You have to meet all their needs, their physical, emotional and spiritual – the whole person."

Staff responded to people quickly and respected their wishes. They gave people choices about where they wanted to be and what they wanted to do. One person told us, "They (staff) couldn't be more obliging."

Staff were kind and courteous and respected people's privacy. People received personal care in the privacy of their bedrooms. Bedrooms were personalised to reflect people's individual tastes, preferences and interests and contained items and pictures that were important to them. When entering people's rooms, staff always knocked on the door and waited for a response before going in.

Staff told us they always endeavoured to provide care in a way that promoted people's dignity. A staff member explained, "It is very important. We always make sure people are covered and explain everything

we are going to do." One person told us, "They never rush you even when they give you a bath. You can take your time and lay in the bath." People were smartly dressed and attention had been paid to the appearance of people who required support with personal care.

Good

Is the service responsive?

Our findings

People felt that staff were responsive to their individual needs and provided care in a way they preferred. One person told us, "Everything is arranged for your comfort and wellbeing."

People received personalised care and support. Before people started to live at the home an initial assessment was completed which included some of their likes and dislikes. Once at the home, care plans were formulated which informed staff how to meet people's identified needs in a way they preferred. People's changing needs were kept under review and monitored in their care plans. Care plans were regularly reviewed so care staff had a clear picture of the person's needs and of any changes in the support they required to maintain their health.

Staff told us communication between staff was good and that information about any changes in people's needs or risks to their health was shared during a handover between shifts. The handover involved both nurses and care staff which demonstrated a valuing of all staff and their contribution to the care people received. One member of care staff confirmed, "We always have handover. Communication is very important." The handover helped to ensure people's needs were met in a responsive manner and gave staff confidence when supporting people.

The environment of the home was responsive to people's beliefs and spiritual needs. People attended a daily service in the chapel which could be transmitted to the bedrooms of those people who were cared for in bed.

The layout of the home enabled people to have choices about where they wished to spend their time. During our visit we saw some people liked to socialise and spend time together in the communal lounge. The lounge was comfortable and well-furnished and provided a pleasant place for people to be together. People were asked what programmes they would like to watch on the television. Daily newspapers were available for people in the lounge and visitors to the home joined people there for tea and coffee. Other people preferred to spend time in their bedroom reading, listening to the radio or watching television. One person had a computer in their room for their personal use.

The registered manager explained that the religious culture of the people who lived in the home meant that having time for solitude, prayer and relaxation was important to them. There was no activities coordinator in the home, but we were told that some group activities were offered and trips outside the home had recently been introduced. For example, the day before our visit some people had enjoyed a visit to a local museum. On the day of our visit the planned activity was doing crosswords. However, this was not undertaken during the time we were there. When asked about the activity, two people told us, "That often does not get done until the evening." One person told us they sometimes found it difficult to find things to occupy their time and another said, "There is not as much to do as there used to be." We discussed this with the registered manager. They agreed to look at the individual needs of people to provide more opportunities for one to one engagement in hobbies and interests that were important to them.

Information about how to make a complaint was displayed on the notice board in the communal area and people told us they would feel comfortable raising any concerns. One person told us, "I would speak to the manager because she is very nice. I haven't got any worries." Another said, "I would go to the head one (registered manager) or the nurse who was on duty that day." One person told us they did not know who they would speak to but said, "I would go and ask someone." Staff told us they would support people if they wished to make a complaint. One staff member said, "I would reassure them and ask if they minded if I went to speak to the nurse in charge and take it from there."

There was a system and procedure in place to record and respond to any concerns or complaints about the service. The registered manager told us no formal complaints had been received by the service in the 12 months prior to our visit. However, we were aware of some concerns that had not been raised formally. All expressions of dissatisfaction or concern should be recorded so the provider can assure themselves they have been dealt with satisfactorily and to monitor any trends to prevent a reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

People were happy with the way staff cared and supported them within the home. One person told us, "It really is lovely here….I never want to go away from here." Another said, "I couldn't fault them." A visitor to the home told us, "[Registered manager] has a wonderful team. They are as generous as a team could possibly be and competent."

Staff were committed to providing a high standard of care and enjoyed working with the people who lived in the home. Comments included: "I really like working here", "It is a very nice place to work with excellent care. All our residents are very well looked after" and "The care here is really good." One member of staff told us, "I did one night here as agency and was so impressed by the care I asked if there was a vacancy. The night nurse knew so much about the residents. I also can't praise the carers (staff) enough. They always cover shifts for each other when they can. I would have my parents here without a shadow of a doubt."

There was a management structure in place. There was a Board of Trustees comprising six Sisters from the Order, together with a management committee which had been established three years ago. The management committee consisted of two volunteers, one of whom had a background in finance and project management and the other had a clinical background. The role of the management committee was to advise and guide the Board of Trustees and to support staff. A member of the committee explained, "We are not taking over from the Board but sitting beside them." One of their first tasks was to appoint a property surveyor to survey the premises which were in need of repair. The surveyor had set a timetable for prioritising remedial work and the second phase of the work had just been completed at the time of our visit.

However, during our visit we found there was not a consistently open culture in the management of the home. Staff felt the registered manager needed to have a more visible presence and be more available to both people and staff. A typical comment from the staff we spoke with was, "[Registered manager's] door is closed a lot of the time. They don't seem to be available to the residents or the staff on occasions." When asked about the visibility of the registered manager, one person responded, "We don't see a lot of her when she is here. She is in her office a lot of the time."

Care staff told us they felt supported by their colleagues and the nurses, but not always by the management team. Care staff had an annual appraisal of their work practice and development needs, but did not have any other supervision or formal opportunities to talk about any issues or concerns. This meant staff had to speak to the registered manager on an 'ad hoc' and informal basis and could not always be confident their concerns had been dealt with. One staff member told us, "You can speak to [registered manager] about something that is important and I don't know if it is always dealt with…..if that happens it makes you feel awkward to go the next time." When asked how a lack of formal supervision impacted on them, one staff member responded, "It is frustrating because sometimes you want to say things." We shared this with the registered manager who agreed to offer regular opportunities for staff to speak with her on a one to one basis.

Nurses received clinical supervision from a member of the management committee. However, we were told this person had not completed their revalidation as a nurse and no longer had their registration. This meant they may not have the most up to date information about current best practice. The registered manager told us they would take action to ensure staff received appropriate clinical support.

Staff told us that communication between staff and members of the management team needed to be improved. One staff member told us, "I think communication between management and staff is quite poor. I think things we should know are not being told and some people know and some don't. It has been raised on quite a few occasions about communication but over time you just think that is the way it is." We saw a letter from the head of the Board of Trustees on 12 August 2016 which informed staff there were some potential changes in the management of the home. Staff had been given no further information which we were told had caused them some anxiety and concern. Subsequently, we were informed that a letter had been sent to staff on the second day of our visit inviting them to a meeting to discuss the planned management changes.

Staff were given the opportunity to share their views and concerns at regular staff meetings. Records showed that staff meetings were an opportunity for the registered manager to share information about best practice and responsibilities. For example, at the August meeting there had been a discussion about who had a DoLS in place and the good practice in the use of hoist slings. The meetings included an opportunity for staff to raise any topics of concern they wished to discuss although one staff member told us, "Some issues we raise will not always be dealt with."

Earlier in the year staff had been asked to complete a satisfaction survey about their role in the home. Out of 16 responses, 10 staff members had indicated they were undecided or disagreed that the provider 'cared about me as a person' and eight were undecided or disagreed that they were 'encouraged to feel free to say what I think'. These responses supported the feedback we received, but no action had been taken at the time of our inspection visit.

People were asked for their views about the service, to make sure care was focused on their individual needs and preferences. People were invited to attend regular meetings where they were asked their views about the home. At the meeting in May 2016 we saw people had been asked for their ideas about what they wanted included on the menus. We saw several of their suggestions had been included in the menus we looked at. At the meeting in February 2016 people had been asked for their choices for a new carpet in one of the communal areas. At a subsequent meeting people indicated they were happy with their choice. However, some people did not always feel listened to. They felt information they had shared had not always been taken into account or appropriately responded to by the management within the home.

There were effective internal quality assurance systems that monitored people's care. We saw records of audits and checks which monitored safety and the quality of care people received. These checks included care planning, medication and infection control. A full health and safety check had been completed by an external organisation who we were told would return in the future to check that any identified actions had been completed.

Where accidents or incidents had occurred, they had been appropriately documented and action taken to mitigate the risks of a re-occurrence to the person involved. For example, one person had been referred to the falls clinic after they had fallen a couple of times and equipment had been introduced to keep them safe.

The registered manager told us they understood their legal responsibility for submitting statutory notifications to us, such as safeguarding referrals or incidents that affected the service. This is so we are

aware of information about the service that affects the safety of people using it, to enable us to monitor changes or concerns effectively. The notifications had been submitted to us as required.