

Alexis Care Limited

Angela Court

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	Inspected but not rated
Is the service effective?	Inspected but not rated
Is the service caring?	Inspected but not rated
Is the service responsive?	Inspected but not rated
Is the service well-led?	Inspected but not rated

Summary of findings

Overall summary

This inspection took place on 11 October 2016 and was unannounced. Angela Court is registered to provide accommodation for 37 older people who require nursing and personal care. We are not able to award a rating following this inspection. This is because, the service was not fully operational and there were not enough people using the service to gather sufficient evidence to demonstrate the systems used were embedded.

On the day of our visit there were six people living at the service which included two people receiving respite support. The people at the service were having their nursing needs met by the local health authority community nursing team. This was because the provider had made the decision to only admit people with who required personal care and had not employed registered nurses.

Previously we carried out an unannounced comprehensive inspection of this service during December 2014 and January 2015. Angela Court was at the time of the inspection, subject to a whole home multiagency safeguarding investigation. As a result, Devon County Council and the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) gave notice to the provider. This meant the termination of the individual contracts for all people at the home for whom they had funding responsibility. The provider also made the decision to give notice to people who held a privately funded contract with them. This meant that from 5 February 2015 nobody was living at the home. During the inspection, we identified a number of serious concerns about the care, safety and welfare of people who lived at Angela Court. We found 16 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting all of the regulations.

The provider worked with the Care Quality Commission (CQC) and kept us informed about their plans to reopen and the measures they would put into place to keep people safe.

In June 2016 the provider started admitting new people into the service. The Provider has recently developed and had begun to implement best practice care delivery based on the household model of care pioneered in the USA by LaVrene Norton, Action Pact and Steve Shields. This has resulted in the environment being divided into smaller houses to support small group living. Groups are determined based on the stage of the dementia of the person living at the home. The provider had employed senior consultants and a director with experience and expertise in developing this model of care for people living with or without a dementia.

The service is required to have a registered manager. A registered manager is a person who has registered with CQC 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. A manager had been appointed and had submitted their application to CQC to become the registered manager at the service. The manager was very visible at the

service and undertook an active role. They were very committed to providing a good service for people in their care and demonstrated a strong supportive approach to staff.

The premises and equipment were managed to keep people safe. The provider had refurbished the main communal area of the home. The ground floor wing referred to as, the 'Otter suite' was nearing the end of its refurbishment. The Otter suite had eight bedrooms with six having ensuite facilities. Plans for the future development of the other areas of the home were under discussion.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had been developing skills and knowledge to meet people's needs. There were adequate staffing levels to meet people's needs.

People felt safe and staff had a good understanding of what constituted abuse and how to report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom. The manager was working with the local pharmacist to put in place systems to manage people's medicines on their behalf.

Care plans were personalised and recognised people's health, social and psychological needs. They contained detail regarding people's wishes, backgrounds and goals. People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

The manager and staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

People were supported to eat and drink enough and maintain a balanced diet. The manager had been working closely with people and staff to provide a social inclusive dining experience which included staff joining people for meals. They were also developing a menu with people at the service. Staff relationships with people were strong, caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate. Staff spoke confidently about people's specific needs and how they liked to be supported.

Staff supported people to follow their interests and take part in social activities. People had developed strong social groups within the home and the local community. The culture of the home was open, friendly and welcoming. The manager was taking the lead at the home and was working to delegate staff roles and responsibilities. The provider had a team of representatives who regularly visited the home to support the manager and staff. They used a range of quality monitoring systems to continually review and improve the service. There had been no complaints received. The manager was aware of the provider's complaints policy and was open to people's concerns and took action promptly to resolve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

The manager ensured staff levels were adequate to meet people's individual needs.

There were effective recruitment and selection processes in place.

Incidents and accidents had been analysed to see if there were patterns or themes which could be avoided or needed to be addressed.

People's medicines were being safely managed and systems were being put into place for people choosing to stay at the service as their home.

The premises and equipment were managed to keep people safe.

Inspected but not rated

Is the service effective?

The service was effective.

Staff received training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through contact with community health professionals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain a balanced diet.

Inspected but not rated

Is the service caring?

Inspected but not rated

The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Visitors were encouraged and always given a warm welcome.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

The service was responsive to people's needs.

Care plans were personalised and contain information about people's histories, wishes and social need. They reflected people's health needs and guided staff how to appropriately meet their needs.

Activities were based on people's interests, past histories and promoting people's strengths. The provider had developed strong links with the local community and was working to develop these further.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Inspected but not rated

Is the service well-led?

The service was well led.

The manager was in day to day control at the service and was a positive role model to staff. Staff spoke positively about communication and how the manager worked well with them.

The provider's visions and values centred around the people they supported.

People's views and suggestions were taken into account to improve the service.

A number of effective methods were used to assess the quality and safety of the service people received.

Inspected but not rated

Angela Court

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.

Angela Court is registered to provide accommodation for 37 older people who require nursing and personal care. This inspection took place on 11 October 2016 and was unannounced. Two adult social care inspectors completed the inspection.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which we received in August 2016. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

We met all of the people who lived at the service and received feedback from five of them who were able to tell us about their experiences. During the inspection we used different methods to help us understand people's experiences. These methods included informal observation throughout the inspection. We also spoke with a visitor to ask their views about the service.

We spoke and sought feedback from six staff, including the manager, a senior care worker, a care worker, the maintenance person and two of the provider's representatives who are referred to as, the Clinical Director and Dementia Practitioner.

We reviewed information about people's care and how the service was managed. These included two people's care records on the provider's computer system and one person's care folder and two people's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits, and minutes of team meetings. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from one of them.

Is the service safe?

Our findings

People said they felt safe and supported by staff. One person commented, "Safe as houses." Another commented, "I feel safe here."

Management of medicines were safely managed. Prior to our inspection people had been receiving respite support at the service and had brought their medicines into the service. Staff had worked with people to ensure they had their medicines as prescribed. Medicine administration records (MAR) were well completed with no missed signatures to demonstrate administration. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines were kept safely in locked medicine cupboards in people's rooms. Two people were self-administering their medicines. Risk assessments had been completed to assess the risk. Systems were in place to undertake checks to ensure medicines had been taken safely.

The manager had been working with the local pharmacist to put in systems for people who had chosen to stay at the service. These included safe appropriate arrangements were in place when obtaining medicines. The manager was implementing a formal medicine audit system as more people had started to need their medicines managed.

The environment was safe for people who used the service, visitors and staff. The manager said they had an on-going programme of redecoration underway to improve the environment of the home. Currently, just one area of the home was being used by people living there. This was the 'Otter suite' and were completing two ensuite facilities for the last two rooms before they were occupied. They confirmed there were discussions planned with the provider and their representatives regarding the redevelopment of the other parts of the service. The provider employed a full time maintenance person who oversaw maintenance at the service. They undertook regular checks and maintenance of equipment. External contractors undertook regular servicing and testing of moving and handling equipment, fire and electrical equipment. Fire drills were carried out weekly in accordance with fire regulations. Staff recorded required repairs and faulty equipment in a maintenance file and these were dealt with and signed as completed by the maintenance person. A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service.

The area of the home which was in use was clean without any odours present and had a pleasant homely atmosphere. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The laundry room had been reorganised and clean laundry was stored in a separate cupboard. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional risk, pressure damage and falls risk.

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission (CQC).

The manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis.

Accidents and incidents were reported and appropriate action taken. They were reviewed by the manager to identify ways to reduce risks as much as possible.

There were effective recruitment and selection processes in place to ensure fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken and any employment gaps had been explored. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

The manager was actively recruiting to develop her staff team for the future and more people moving into the service. The provider had recorded in the home's brochure, 'The recruitment process is based on values and beliefs method of selection...We select the right person for the right house based on our assessment of their strengths and abilities.' The manager was following this vision to find suitable staff for the home. The staff and manager undertook additional shifts when necessary. Arrangements had been made with a local care agency for consistent agency staff to be used to ensure adequate staffing levels were maintained.

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff had time to meet people's individual needs. People and staff said they felt there were adequate staff levels to meet their needs. On the day of our visit there was a team leader supported by two care staff, a housekeeper, a maintenance person, a gardener and the manager. At night people were supported by a waking night care worker and a sleep in care worker who was available if required. The model used by the service was that staff undertook roles to support people, so care staff also undertook the laundry and the cooking.

Is the service effective?

Our findings

People's needs were met by staff who had the right competencies, knowledge and qualifications. One person said, ""They (staff) know what they are doing."

The provider had ensured all staff had received training when they started at the service. The manager had delivered some training including manual handling. Staff had also undertaken training at the provider's head office and on-line training. Training undertaken included medicines, pressure sore prevention, safeguarding vulnerable adults, moving and handling, person-centred care, dementia in care, health and safety, food safety, Infection control, first aid and conflict resolution. Staff were positive about the training they had received. Staff comments included, "Training is good, especially what we did at head office. It was good as it related to the job we are doing here and makes us more confident to do our job."

Staff had undergone an induction which included three days of training. New care workers worked alongside a more experienced care worker until the manager was satisfied they had the skills to work alone. Care staff said they felt the induction had given them the skills to carry out their roles and responsibilities effectively. The manager said they would be implementing the Care Certificate which had been introduced in April 2015 as national training in best practice for care workers who had not worked in care before.

The manager recognised the importance of staff supervisions and met with care workers to undertake supervisions. One care worker said, "I have monthly supervisions...I raise issues happily... (the manager) listens and acts."

People's consent for day to day care and treatment was sought. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were. Staff had undertaken training in MCA 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's liberty was restricted as little as possible for their safety and well-being. For example, a careful assessment was undertaken whenever the use of bedrails was considered for the person's safety.

The manager confirmed that no DoLS applications had been submitted to the local authority. This was because people could come and go from the service as they chose and their liberties were not restricted.

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP, and care plans showed appointments with an optician and/or chiropodist were in the process of being arranged. Where any health concerns were identified, staff at the home sought advice appropriately. Health professionals said staff were helpful and followed their guidance and they had no concerns about the service and had confidence in the staff to make referrals promptly.

People and records confirmed the staff monitored people's health and care needs, and acted on issues identified. For example, where one person had been taken unwell the GP had been called and their guidance had been followed.

People were supported to eat and drink enough and maintain a balanced diet. We observed a lunch time meal with all people using the dining room. They were joined by staff and there was a happy atmosphere with lots of chatter. Staff had asked people their meal preferences during the morning. Staff were attentive to people's needs and responded quickly to requests. People were very complimentary about the food, comments included, "The food is lovely, plenty of it. We choose our supper"; "The food is very nice" and "We enjoy our ice cream."

Staff were knowledgeable about different people's dietary needs and who required a special diet. For example, sugar free. Staff had gathered information about people's dietary requirements, meal sizes, likes and dislikes when they first arrived at the home.

Care plans guided care workers to observe people who might have difficulties swallowing. They were advised if they had any concerns to contact the speech and language therapist (SALT) for an assessment. At the time of the inspection, nobody had required an assessment.

People had their weight monitored regularly to ensure they were not at risk of weight loss. When people first came to the home they were weighed weekly until the staff were happy they maintained their weight and then went to monthly monitoring.

Is the service caring?

Our findings

Staff were kind, caring and friendly towards people and were seen positively interacting with them, chatting, laughing and joking. People's comments included, "They are wonderful every one of them. I wouldn't have come back if it wasn't good here": "Cannot fault the care." and "All of the staff are wonderful, so kind." One person said, "(The manager and maintenance person) fall over backwards for you. I am very fond of them more like friends."

Staff were considerate and caring in their manner with people and knew people's needs well. Staff used friendly and supportive care practices when assisting people in their daily lives. We observed a care worker support a person who had a hearing impairment. They took time with the person and wrote down questions and gave the person time to respond.

Staff treated people with dignity and respect when helping them with daily living tasks. Staff maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, covered people and gained consent before providing care. One care worker said, "I make sure people are safe and protect their wellbeing. I give them choices and respect their dignity and privacy. I like to greet them (people) politely." Another said, "I always ask them if they are happy for me to do things. I always close the door...ask them discreetly if they need to use the toilet."

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. The atmosphere at the home was calm, peaceful and homely. During breakfast a care worker supported a person in the dining room. They were prompting the person and supporting them as required in a discreet and unrushed manner.

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in, where they spent their day and the clothes they wore. Staff said they knew people's preferred routines such as who liked to get up early, who enjoyed a chat and who required reassurance and emotional support. One care worker said, "I make sure everyone is safe and happy and has the choice to do what they want. I don't want to take away their independence." Another said, "It is important for people to have choice. We encourage independence. I ask them if they are ready to get up, or want a cup of tea or their breakfast. I always ask what they want."

People's relatives and friends were able to visit when they liked. A relative said they were made to feel welcome when they visited the home. A person said that their visitors were always offered refreshments and called in at all different times. They said, "It isn't any different than being at my own home, they pop in it is wonderful."

Is the service responsive?

Our findings

The service was responsive to people's needs because people's care and support was well planned and delivered in a way the person wished. The manager recorded in their Provider Information Return (PIR) regarding how they were responsive to people's needs: 'Care and support plans are seen as an integral element to providing good care, we ensure that they are thorough and detail each individual's choices and preferences. As an individual's needs change we identify this promptly and we regularly review with the involvement of the individual... We ensure that members of the team are constantly reviewing the condition of those living at Angela Court and make the necessary referrals to healthcare professions whenever required.' This was evident during our inspection.

The manager had completed a comprehensive pre admission assessment for all of the people coming into the home. They met with them and their families where appropriate to ascertain their needs, views and wishes and to assess whether the service could meet their needs. The provider's representative also reviewed people's pre admission information to agree if the service could meet people's assessed needs. We were told this was so the responsibility was shared.

One relative said how they had been so grateful for the support they had received from the manager and staff at a time when their relative needed to find a place of safety. They said, "I couldn't ask for anybody to be more understanding and sympathetic to us as a family. They listened and gave us time."

The information from the pre admission assessment was used to develop comprehensive care plans. Care plans were recorded on the provider's computerised system which recorded people's care records and assessments. All care workers could access people's information using a unique identification access code. Care workers could record tasks completed and relevant information about people. For example checks undertaken, care and support given. There were also care folders for each person with paper records of key documents which had been gathered during the admission process.

Care plans identified people's medical history and health needs and guided staff how to support people safely. For example guiding staff regarding someone's foot care, skin integrity, mobility, night needs and recreation and activities requirements.

Care records included personal information and identified the relevant people involved in people's care, such as their GP. The records contained information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary. Care workers were advised about people, what they wanted to be called, important people in their lives, backgrounds, skills and interests, likes and dislikes. This meant that when care workers were assisting people they knew their choices, likes and dislikes and provided appropriate care and support.

Relevant assessments were completed and up to date. Risk assessments included an assessment of nutritional needs, mobility and skin integrity. These were reviewed monthly or as people's needs changed and care plans amended if required. People and their families were given the opportunity to be involved in

reviewing their care plans. Staff had completed consent and treatment paperwork regarding personal care and support, photographs and to share information.

Care workers said they found the care plans helpful and were able to refer to them at times when they recognised changes in people. One care worker said, "I like the new care plans they reflect what the resident needs."

People were supported to take part in social activities. The atmosphere at the home was welcoming with people living there appearing 'at home'. The main communal area had been refurbished and was comfortable with a dining area, television area and lounge so people could have private times if they chose. The manager said that people had formed a social group and liked eating together. This was evident at the lunchtime meal where two people held hands and were comfortable with each other. Mealtimes were a family affair with people and staff eating together. People were happy and content. People helped themselves to what was on offer, for example lamb, corned beef hash and vegetables. There were three choices of pudding offered. One person had a hearing impairment. Staff wrote down the choices for them to choose. One person told us how they had recently made everyone spaghetti bolognese and fish cakes. One care worker said, "It is better here now. We eat with people, not separately. It's more of a family... a home."

Before people came into the home they were consulted about their rooms and offered a choice of decoration. They were able to bring personal items in to make their rooms feel homely and familiar. These included photographs, soft toys and ornaments.

People were able to follow their interests and hobbies. The manager said they tried to match people with care staff with similar interests. They gave an example of a person that enjoyed gardening. They had been introduced to the gardener and undertook small tasks in the garden. The gardener also joined people for lunch which gave them and people the opportunity to chat about what they were doing in the grounds.

On the day of our visit a visit from the donkey sanctuary had been arranged. People were thrilled to see the donkey and were happily chatting about the experience. One person said, "The donkey came in my bedroom this morning." Where the visit caused one person to become upset due to past memories, staff took the person to one side and spent time with them reassuring them and gave them time to discuss their memories.

People were supported to access their local community and keep in contact with friends and family. A lunch club had been held at the home on the last Wednesday of each month. People, families and visitors from the home and the outside community could have lunch at the home together. The manager said they had arranged for an entertainer for the next lunch club. They confirmed people really enjoyed these sessions. In the designated room for the lunch club people had made bunting for a cream tea which had been held at the home. The manager said the friends of Angela Court were planning a firework evening.

Staff supported people to maintain their independence. One person said, "We go out. I like walking around the garden." The manager said one person had not been able to go shopping before coming into the home. They had planned with the person to accompany them on a shopping trip.

The provider had a complaints procedure which made people aware of how they could make a complaint. People were given a copy when they came to the home and the procedure was on the wall in the main entrance to keep people and visitors informed. People said they would feel happy to raise a concern and knew how to. Comments included, "I can raise concerns they are always happy to sort them out" and "I have not had any reason to moan, they look after me brilliantly."

There had been no formal complaints received at the service since the service had started taking admissions in June 2016. The manager was very active within the service and spoke with people daily. They took any minor concerns seriously and took immediate action to ensure people were happy and satisfied with the outcome. They knew about the provider's complaints procedure and the actions they would need to take in the event of a complaint.

Is the service well-led?

Our findings

Everyone spoke positively about the manager and said they were supportive, caring and kind. Comments included, "Wonderful lady"; I sit with (manager) and have discussions about what is happening, she always listens" and "Very approachable and caring. I think of her as a friend."

The manager was in day to day control at the service and undertook duties as required and guided staff. They were working with a new team of care staff to develop the new, 'house model' implemented by the provider. They were still undertaking a lot of tasks themselves but was starting to delegate responsibilities to staff.

The provider was implementing a best practice model to provide care and support to people within different areas depending on people's needs. The provider recorded in the brochure about the home, 'The model is about creating smaller communities or families within a home and breaking away from institutional approaches to care. This results in better quality of life for the person receiving the service and their family.' They were developing the 'Otter suite' on the ground floor with this model in place. The manager said they had meetings planned to discuss the development of the rest of the home.

The manager was supported by representatives of the provider who regularly undertook visits to the home and were able to be contacted at any time. These included a catering manager who undertook checks on the catering and environmental issues associated with the safe running of the kitchen facilities. The manager said the provider's representatives were very supportive and were also available at the end of the phone to support her.

A range of quality monitoring systems were in use which were used to continually review and improve the service. The provider's Clinical Director and Dementia Practitioner undertook regular audits and reviews of all aspects of the service. These audits included the environment, care plans and people's clinical needs. They produced an action plan which was regularly updated to ensure actions which had been identified had been carried out. For example following an audit of a sample of people's care plans an action plan was developed. The plan was given to the manager and senior staff. These actions were reviewed and followed up.

The manager was available for staff to contact if required. In the event they were away the provider's representatives had an on call system where they were contactable at all times. This meant the manager and staff had someone they could contact if they needed guidance or support.

People's views and suggestions were taken into account to improve the service. The manager recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided. The manager spoke with people daily and asked their views. They said that as more people came into the service they would hold 'residents and family' meetings.

In the main entrance there was also an opportunity for people to record their views. There were four

different leaflets clearly labelled, 'outstanding, thanks, okay and poor' with large faces which depicted a relevant expression. The provider had kept us informed of the positive comments people had given. These included, 'Made him feel so welcome. We were able to go away and leave him knowing he was in safe hands' and 'The loving kindness and care shown by the staff was outstanding'.

Staff were consulted and involved in decision making about the service. The manager had held one staff meeting in September 2016 since they had reopened. A meeting had been scheduled on the day of our visit which was cancelled because of our visit. The manager said "I plan to have monthly meetings until staff feel secure and safe so they can bring up any points formally." At the meeting held staff were able to put forward their ideas and these were listened to and put into place. For example, the need for menu choices forms and a daily tasks sheet of tasks which needed to be completed. Staff confirmed they had regular discussions with the manager and management team. They were kept up to date with things affecting the home via team meetings and conversations on an on-going basis. We observed a handover which occurred at each shift change. The handover was very thorough. Information was handed over clearly; care workers were made aware of how people had been overnight, any health professional visits required and medicine required. One care worker said, "We always pass on information and are updated when we come back after being off for a few days. We are kept informed and are able to say how we feel."

The service worked with other health and social care professionals in line with people's specific needs. Staff commented that communication between them and the other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP's and district nurses. During our visit people were being visited by a GP and district nurse which had been organised by the staff. Health professionals told us that the management at the home were very approachable.

There were accident and incident reporting systems in place at the service. All accidents and incidents are recorded on the provider's computer system. This meant that as well as the manager the management team were alerted regarding accidents and incidents. They would look with the manager to see if there were any patterns in regards to location or themes. Where they identified any concerns or reoccurrence they would take action.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as when a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested and worked in line with their registration.