JJ and S (Chippenham) Limited

Kenver House Limited

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 December 2016 and was unannounced. The previous inspection was carried out on 19 September 2013. We had no previous concerns prior to this inspection.

Kenver House provides accommodation and personal care for up to 30 people. At the time of our visit there were 28 people living at the home. The registered manager told us the home had two vacant beds. The home also provided day-care to people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the home is run.

Most people could not directly tell us about their care and support because of their cognitive impairment. We spent time at the home observing how people were cared for by staff. Throughout our inspection people were cared for and treated with dignity, respect and kindness.

The registered manager and staff understood their role and responsibilities to protect people from harm. Risks had been assessed and appropriate assessments were in place to reduce or eliminate the risk.

People were provided with safe care by adequate numbers of appropriately skilled staff being made available. Staff recruitment procedures were safe and the employment files contained all the relevant information to help ensure only the appropriate people were employed to work at the home.

People were given their medicines in the right amounts at the right times by senior staff who had been trained to carry out this task. All medicines were stored, administered and disposed of safely. The home had policies and procedures for dealing with medicines and these were adhered to.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received appropriate training, and had a good understanding of the Mental Capacity Act 2005 (MCA) and the DoLS.

Staff appeared to be caring and we observed positive caring relationships with staff and people living at the home. People told us they were happy with their care.

People had access to a range of healthcare professionals when they required specialist help. Care records showed advice had been sought from a range of health and social care professionals.

People had their nutritional needs assessed and monitored and were supported to enjoy a range of food and drink of their choice throughout the day.

Concerns and complaints were encouraged and responded to and people knew how to complain and share their experiences. People living at the home, relatives and staff were encouraged to provide feedback, as were professionals. Compliments were received in abundance and displayed on a notice board.

The home was well led and management promoted a positive culture that was open and transparent. The registered manager demonstrated good visible leadership and understood their responsibilities. Quality assurance practices were robust and records and data were collected and used to make improvements.

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 home was safe.

Staff were confident about recognising and reporting suspected or actual abuse.

Risks had been identified and measures had been developed to protect people from unnecessary harm. Staff understood how to manage risks and at the same time actively supported people to make choices.

Policies and procedures were in place to minimise the risks of infection.

There were sufficient numbers of staff on duty and prospective staff underwent a thorough recruitment checks to ensure they were suitable to work at the home.

Medicines were administered safely by appropriately trained staff and stored securely.

Is the service effective?

Good

The home was effective.

People received support from staff who had received training and knew how to meet people's needs.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered. The registered manager knew their responsibility under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to protect people.

People nutritional needs were met and tailored to their individual need.

People had access to healthcare services and had their healthcare needs met.

Is the service caring?

Good

The home was caring.

People were treated with kindness and compassion and had their privacy and dignity respected.

Staff understood people's needs and the things that were important to them. Independence was encouraged.

People said they were very happy with the care and support they received. The staff had a good understanding of people's care needs and knew people well.

Staff demonstrated a good understanding of people's likes and dislikes and their life history.

Is the service responsive?

Good

The home was responsive.

People's needs had been assessed and they were involved in making decisions about the care and support they received.

People had plans of care in place that detailed the care and support they needed. These were regularly reviewed.

People were provided with daily activities which they could participate in if they wished.

There was a formal complaints process in place and people knew what to do if they were concerned or worried about anything.

Is the service well-led?

Good

The home was well-led.

The home was well managed and staff were clear about their roles and responsibilities. Staff were supported by the registered manager.

Accidents and incidents were monitored by the registered manager to ensure any triggers or trends were identified.

People were regularly asked for their thoughts and comments on

the home. There were systems in place to monitor the quality of the care provided to people. Regular audits were carried out by the registered manager.	

Kenver House Limited

Detailed findings

Background to this inspection

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

This inspection was completed on 8 and 9 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector. The previous inspection was carried out on 19 September 2013.

Prior to our visit we asked for a Provider Information Return (PIR). The PIR is information given to us by the provider. The PIR also provides us with key information about the home, what the home does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. This included notifications we had received from the home. Services use notifications to tell us about important events relating to the regulated activities they provide.

We contacted six health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the home. We received a response back from two professionals and also spoke with one professional during the inspection visit.

During our visit we met and spoke with three people living in the home and four relatives. We spent time with the registered manager, deputy manager, an activities coordinator, admin staff and spoke with five staff. We looked at three people's care records, together with other records relating to their care and the running of the home. This included employment records for three members of staff, policies and procedures, audits and quality assurance reports.

Good

Is the service safe?

Our findings

People were safe from the risk of abuse and neglect because staff understood how to raise concerns and were confident to do so. Staff understood the signs of abuse and knew what actions they would take to protect people from harm. Staff had access to procedures relating to safeguarding and understood their responsibilities in reporting concerns to ensure the registered manager or senior staff took appropriate action. Comments from staff included, "If I was concerned abuse may be taking place I would report this", "Any allegations would be taken seriously and all concerns would be reported and documented".

Staff said they could 'whistle blow' to external agencies including the local authority safeguarding team if their concerns of abuse were not fully addressed. Staff were aware of the whistleblowing policy and contact details were available about who to contact to report any concerns they had about poor care practice. Information was displayed within the home from the Local authority detailing how to report abuse.

Visitors to the home were required to sign the 'visitor's book' kept outside the main office. Visitors recorded their name, the time they arrived and left the home. Due to the needs of people who lived at the home a keypad system was installed on the front door. Staff advised people they had a visitor and sought their permission before they allowed the visitor to see the person.

Staff spoke with us about specific risks relating to people's health and well-being and how to respond to these. These included risks associated with weight loss, behaviours which may challenge and falls. During the inspection we heard the registered manager appropriately reported concerns to the local frailty team as they were concerned about the number of falls some people had. They also reported concerns to the local authority safeguarding team. People's records provided staff with detailed information about these risks and the action staff should take to reduce these. An example being sensory equipment was used for some people who had been assessed for this. This involved a sensor fitted to the floor next to the person's bed and also a sensor alarm fitted to the bedroom door. Sensors were connected to the home's call bell system and alerted staff that a person maybe in need of assistance. This was important where people were unable to use the call bell system.

The home was clean, odourless and free from clutter. Policies and procedures were in place to minimise the risks of infection. All staff had been trained in the prevention and control of infection. The registered manager had been identified as the home infection control lead. Hand washing facilities and suitable personal protective equipment, such as disposable gloves were freely available in designated areas within the home. People's clothing and other items which were contaminated with bodily fluids were laundered separately. The laundry room was due to be refurbished early 2017 to make the dirty area and clean area bigger with an extra washing machine and dryer installed. These arrangements helped minimise the risks of cross infection within the home.

People were engaged in different activities including going out into the community with staff. Assessments had been undertaken of the risks relating to people's individual needs. An example being one person liked to go out for walks daily by themselves to the local church. Another example was the registered manager

and staff organised short breaks away for people to Weston Super Mare and Blackpool. The risks had been assessed and a plan put in place to manage these risks. This had been recorded so all staff were aware of how to support each person. This showed people were assisted to take part in activities which promoted their independence, with risks to the person minimised.

Staffing levels were reviewed regularly by the registered manager to ensure people were safe. The registered manager told us staffing levels were based upon the amount of support people required. An example being staffing levels would be increased if people were funded for one to one support or to provide assistance to people with planned outings and holidays. During the inspection we observed nurse call bells were responded to promptly by staff. This indicated there were sufficient numbers of staff on duty in order to meet the needs of people living in the home. When we spoke with relatives, they told us they had never witnessed their relative having to wait long for assistance. Staff were on hand to provide support with people's care needs when required. One professional commented on how staffing at the home was consistent and that the turnover of staff seemed low.

Rotas confirmed staffing levels were maintained at all times. At the time of our inspection there were no vacant staff posts. Records confirmed sickness, training and annual leave were covered by permanent care staff as overtime and by agency staff. Staff we spoke with told us "We have a good team here and support each other covering the rota", "We have good support from both managers who are hands on and willing to help out", "We have enough staff here and we all help out picking up extra shifts".

We looked at staff recruitment records and spoke with staff about their recruitment. We found that recruitment practices were safe and the relevant checks were completed before staff worked in the service. A minimum of two references had been requested and checked. Disclosure and Barring Service checks had been completed and evidence of people's identification and medical fitness had also been obtained. The registered manager told us over the next year they planned to renew DBS checks for those staff who had been employed for over three years. A DBS check allows employers to check whether the staff had any convictions which may prevent them working with vulnerable people.

People's medicines were stored and administered safely. Medicines were stored securely following current guidelines for the storage of medicines. There was a dedicated room for storing people's medicines. The room was clean and well organised. A fridge was available to store medicines which required lower storage temperatures. Daily temperatures of the room and fridge were taken and recorded to ensure both the room and fridge remained at a safe temperature. The medicines room was locked when not in use and during the medicines administration round was locked when unattended. Each person had a medication administration record (MAR) detailing each item of prescribed medication and the time they should be given. Staff completed the MARs appropriately. There were safe systems in place for the receipt and disposal of medicines. A local pharmacist recent visit to the home showed current guidelines and legislation in managing people's medicines was followed.

Good

Is the service effective?

Our findings

We asked people at the home and their relatives if they found the care provided at Kenver House to be effective. We received positive feedback which confirmed people spoken with were of the opinion their care needs were met by the home. Comments included, "The staff understand my relatives needs and offer myself support as I sometimes find visiting difficult, "The staff seem to know X very well and know how to support them".

Staff received comprehensive support to carry out their role. Staff we spoke with said they had regular supervision, handover meetings and attended staff meetings. This gave them an opportunity to discuss their roles and any issues as well as identifying any training needs. During our inspection we looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. The staff files we looked at showed each member of staff had received supervision and had attended regular staff meetings. Records confirmed staff had received an annual appraisal to discuss their ongoing training and development.

People were supported by staff that had received a comprehensive induction. Records showed the induction process included meeting people, familiarisation with people's needs, understanding risks and care plans and learning the homes policies and procedures. Staff said they had spent time shadowing experienced staff before they worked unsupervised.

Training was planned and was appropriate to staff roles and responsibilities. Staff we met said they received ongoing training. We viewed the training records for the staff team which confirmed staff received training on a range of subjects. Training completed by staff included, safeguarding food hygiene, first aid, dementia care, nutrition, manual handling, infection control, health and safety and fire safety. Records confirmed staff had successfully undertaken an NVQ or Diploma in Health and Social Care level 2 or above. The registered manager had recognised some relatives had found it difficult to understand the effects of their loved ones living with dementia. They supported relatives through difficult times and provided insight into dementia care. Relatives were offered the opportunity to attend dementia care training funded by the home. The registered manager held relatives meeting throughout the year. At one of the meetings held the registered manager had invited professionals along to discuss dementia care. They gave information to relatives about supporting people with dementia and how people should be cared for.

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). At the time of our inspection two people's applications had been

authorised by the local authority. Other people's application forms were awaiting assessment by the local authority or were awaiting a decision to be made. These were submitted as some people could not freely leave the home on their own, also because people required 24 hour supervision, treatment and support from staff. The DoLS provide a legal framework and allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

People were supported by staff who had good knowledge and understanding of the MCA. The registered manager and staff we spoke with had a good level of insight about their duties under the MCA and how to support people with decision making. Staff took the opportunity to show us MCA pocket cards which they carried around on them. These had been made by the registered manager. This gave staff clear information and helped them understand the principles of the MCA.

People were involved in making decisions about their care and provided consent where possible. Records showed that the principles of the Mental Capacity Act 2005 (MCA) had been considered when determining a person's ability to consent to decisions about their care. People's care records contained clear information about whether people had the capacity to make their own decisions. Assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed. Staff said they always asked people's consent before providing any care and continued to talk to people while delivering care so people understood what was happening. Care records contained clear information which showed consent was sought from people. An example being documented in care records were "X consented to personal care" and "X consented to have a shower".

Care records evidenced referrals had been made promptly to a range of health professionals when people's needs had changed or they had become unwell. These included doctors, district nurses, care home liaison team, frailty team, opticians and dentists. The registered manager said the local doctor surgery visited the home each week to provide an in house surgery. Outside of the weekly visits, the GP would visit as and when required. Each person had yearly wellbeing check which was very well organised in advance to allow other professionals the time to plan and attend. Professionals who attended included doctors, district nurse, community psychiatric nurse and pharmacist. This was coordinated in house at the home as a multi-disciplinary approach with each person being seen by the range of professionals with follow up action recorded.

We observed pressure reliving equipment such as pressure cushions was available for people to use. The registered manager advised people they currently looked after did not have any open wounds or pressure sores. The district nurse team were not providing any treatment for wound care at the time of the inspection.

The registered manager told us some people were at risk of malnutrition. These people's intake of food or fluid was being monitored. Food and fluid charts were in place these had been completed accurately. People's care plans recorded information about their nutritional intake and the support they needed to maintain good health. Records confirmed people's weight gain or loss was monitored so any health problems were identified and people's nutritional needs met. Special diets were provided to people who required them and people were referred to a dietician when needed. This showed people at an increased risk of malnutrition were provided with food choices which supported their health and well-being.

We observed the lunch time meal on both days. The food looked appetising and was nicely presented. People were able to choose from two options and if they disliked second option the chef prepared another

meal of the person's choice. People could also choose to sit in one of several places to eat so people were able to enjoy their meal with a small group of people or could eat in the lounge if they preferred. Suitable adapted crockery and cutlery were available to people where needed. The daily menu was on display on a board within the dining area. Menus choices were balanced with a choice of fresh meat, fish and fruit and vegetables. We observed a variety of drinks and snacks were available for people throughout the day.

People's bedrooms were in good decorative order and had been personalised to people's individual taste. The registered manager said they wanted to create a homely environment for people to help people settle. People were encouraged to bring items of furniture to the home to help personalise their bedroom and to make people feel at home. An example being one person had their own fridge, lamp, wardrobe and chest of draws. Another person had brought in a selection of dolls and a highchair as this was appropriate to their needs. This helped to create a familiar, safe space for people. One visiting professional felt that some rooms were in need of "updating" with "investment of furniture". However during our visit it was clear bedrooms had been furnished to people's acquired taste which created a homely environment. The registered manager told us when rooms become vacant they would look to redecorate if required.

Good

Is the service caring?

Our findings

Most people could not directly tell us about their care and support because of their cognitive impairment. However three people made the following comments when asked about the care they received from staff, "I am looked after well", "I am happy here and have no troubles", "The staff are caring". We spoke with relatives regarding the care and support their family member received. Comments we received included, "We visit twice and week and are always made to feel welcome. We are pleased with the care X receives. They are very well looked after here", "The care is very good here and X is looked after very well by caring staff", "I visit here regularly and see people being looked after and treated very well".

We received the following comments from professionals, "Staff appear to be caring and support clients' needs", "The staff seem very caring of the residents".

We spent time at the home observing how people were cared for by staff. Throughout our inspection people were cared for and treated with dignity, respect and kindness. The atmosphere at the home was joyful and people seemed at ease with staff. We sat and observed lunch both days in the lounge and dining room. We observed staff asking people where they wanted to sit and what they wanted to eat and drink. We noted there were five staff around at all times to support people. Some people chose to wear a clothes protector which was discreetly offered to people in a dignified manner. Where people required extra support or prompting to eat and drink this was provided with respect and dignity.

Staff we spoke with told us how they supported people through bereavement by showing empathy and respect. They told us about how they supported one person to attend the funeral of a person who lived at the home. We were told they were close friends and described how this had affected the person. The staff offered comfort and support to the person and gave them time to grieve.

People could move freely around the home and could choose where to spend their time. The home was spacious and allowed people to spend time in various areas. For example, some people were sat in the 1950's room and we observed this was regularly used by people and their families. Other people were sat in the lounge, TV room, dining room and conservatory. In the afternoon they preferred to spend time in the main lounge and dining room as the activities coordinator provided afternoon activities. People appeared relaxed and comfortable in the company of staff. One visiting professional felt that one of the lounges was 'over crowded', however during our visits we found this room was very popular with people and they seemed to enjoy the homely environment it created. There were various lounges in the home which was quieter and less busy.

Staff respected people's privacy and dignity. An example being when on two occasions we observed staff knocked on people's doors and sought permission before they entered people's rooms. Staff were able to tell us what actions they undertook to make sure people's privacy and dignity were maintained. This included keeping people's doors closed whilst they received care, talking them through what personal care they were providing throughout.

People were cared for by staff who valued them and demonstrated they were proud of working at the home. One member of staff described how they enjoyed seeing people happy by taking them on holidays and outings. Another member of staff told us, "We wanted to create a family type environment where people are made to feel at home. For this reason I really enjoy coming to work".

People were encouraged and supported to care for the home's pets which included a bird avery and one rabbit. The registered manager said in the summer particularly people living in the home liked to spend time in the garden watching the birds and listening to them sing. People also handled the rabbit and gained a sense of comfort from this.

Staff showed concern for people's well-being in a caring way. We spent time in the lounge after lunch and observed the care and support provided to people. One person had become distressed and begun shouting out for help. The staff recognised they needed reassurance and comfort. The staff sat with the person talking about their baby (doll) which diffused their feelings of anxiety. When the staff member went away we observed the person sat cuddling their baby. Another person carried around teddy bears and had become upset when their visitor had left. The staff went to find the person's teddy bears and gave this to the person who smiled and hugged them.

People were given support when making decisions about their preferences for end of life care. Arrangements were in place to ensure people, those who mattered to them and appropriate professionals contributed to their plan of care. The registered manager told us this ensured the staff were aware of people's wishes, so people had their dignity, comfort and respect at the end of their life. The staff told us they received support from their local GP surgery during these times.

Good

Is the service responsive?

Our findings

Throughout our inspection we observed people being cared for and supported in accordance with their individual wishes. Staff we spoke to appeared knowledgeable of people's care needs. Relatives commented, "The staff have got to know them now and that makes me feel reassured", "I know my relative is being looked after very well. The staff will call me if they have any problems".

The registered manager carried out pre-admission assessments to ensure they could meet the needs of people. Prospective people looking to move to the home also visited for day assessment followed by a trial period. The home then assessed people's identified needs and developed a care package to ensure they could meet their needs. We looked at the pre-admission records and found these looked at people's preferences regarding the care they wanted to receive, medical needs, health care needs and diagnosis. The home offered people respite care and day-care however this was offered only if a place was available.

People were protected against the risk of social isolation. The home monitored people's health and wellbeing including their emotional presentation. Records showed people whose presentation had changed were discussed during care plan reviews and daily handovers. Each person had a daily running report log and separate physiological report log. Staff recorded information about people emotional wellbeing. Staff were observed spending time talking to people to ensure they were well and if they had any concerns. A keyworker system was in place which meant people spent time with their allocated keyworker and their emotional issues were addressed and support given.

Input from other professionals was sought and given a high priority. Advice had been sought from a range of health and social care professionals and plans were put into place as a result. The home had referred a number of people to the local frailty team for advice regarding falls management. The registered manager had referred some people to continuing health care due to changes in care needs. This was to look at possible funding for one to one care.

People were involved in planning and reviewing their care through monthly reviews with staff. Records we looked at and discussions with staff showed the home took account of people's changing needs. One example was in relation to people's emotional wellbeing where the home worked with people and the community care home liaison team. People were assessed by professionals and strategies were recommended which enabled people to have the support they required.

People were offered a range of activities and an array of photographs of outing, holidays and activities were displayed on noticeboards within the home. During the first day of the inspection a singer was entertaining people in the lounge singing Christmas songs. We heard lots of laughter and people were singing and clapping their hands. For those people who preferred a quieter environment we observed staff assist people to sit in other lounge areas which seemed relaxing and calm. The home employed an activities coordinator and we observed them engaging people in activities. Activities included art and craft sessions, quizzes, bingo, reminiscence sessions, dancing and one to one activities.

The registered manager and staff regularly arranged trips out for people. An example being the day before our inspection visit, 29 people from the home visited the local school and watched a carol concert. Another example was the home took small groups of people to the pantomime and to the cinema. The registered manager organised holidays for some people supported by staff. Holidays were often to Weston super mare and Blackpool. This was organised so only small groups of people went at one time with staff. The registered manager had held holiday planning meetings with people, staff and relatives. One visiting professional said "Lovely wall of photos of Kenver holidays – They are the only home we know of as a team that actively support residents to go on holiday".

We looked at how complaints were managed. A copy of the complaints procedure was displayed on the noticeboard in the reception area and stated that all formal complaints would be acknowledged, investigated and responded to. The procedure did not contain the methods in which people should make their complaint. For example people could complain in in writing or verbally. The procedure did not contain the correct information as it advised people they could take their complaint to the CQC. It did not explain to people if they were unhappy with the way their complaint was investigated they could refer their complaint to the Local Government Ombudsman. The contact information for the Local Government Ombudsman was also missing. The Local Government Ombudsman (LGO) looks at complaints about councils, organisations and adult social care providers (such as care homes and home care providers). We shared our findings with the registered manager who was very responsive in putting this right. During the inspection they updated the home's complaints procedure with the correct information.

Within the last 12 months the home had received two formal complaints and these had been investigated by the registered manager with an outcome achieved. Both of the complaints were about different issues. The registered manager said they would use information from any complaints to review their practice. Most people were not able to tell us about the action they would take if they were unhappy. We spoke with staff about how they would tell if people were unhappy. Staff told us they would notice any changes in the person's behaviour which may indicate they were unhappy.

Good

Is the service well-led?

Our findings

We received positive feedback about the leadership in the home. Staff told us management were supportive, approachable, responsive and regularly seen working alongside staff to provide support and care. The registered manager said, "I have an open door policy and the staff know they can come and ask for help", "My priority is the residents as they come first", "I like to know my residents are happy and cared for and like to lead by example". We observed people knew the managers in the home and had a friendly relationship with them. Both the registered manager and deputy managers had a good knowledge about people's needs. People spoke very highly of the registered manager and both deputy managers. There was mutual respect between all staff, and a strong sense of teamwork.

We received the following comments from professionals, "X (the registered manager) shows care and compassion for her residents, and her staff, who in turn support X", "The home seems well managed and the manager is very approachable".

The home had a positive culture which was person-centred, inclusive and empowering. There was an open and friendly culture combined with a dedication to providing the best possible care to people. Staff at all levels were approachable, knowledgeable, professional, keen to talk about their work and committed to the on-going development of the home. People appeared at ease with staff and staff told us they enjoyed working at the home.

The registered manager had clear visions and values.. They told us the main aim of the service was to continue to offer a high standard of personalised care to people. The registered manager spoke passionately about the service. They told us their focus for the next 12 months was to sign up all staff as dignity champions to promote dignity. They also planned to refurbish areas of the building which included turning one bathroom and toilet into a wet room. They were also plans in place to replace some flooring around the home and to paint the front of the home.

Information was communicated to staff through staff meetings, memos and during handovers. Staff told us they were kept up to date with developments within the home. The registered manager told us they recognised staff achievements through holding a yearly awards system. Staff were in the process of voting for the unsung hero award and employee of the year. These awards were held internally within the home and the winner was to be announced at the homes new year party. Staff told us the award system made them feel valued and gave them recognition for the work they carried out. This demonstrated a positive culture in which staff achievements were recognised.

People's views about the care they received were sought and acted on. The last quality assurance survey was completed in July 2016. This involved 28 questionnaires being sent out to relatives. Positive comments were received about the home and their overall satisfaction. Comments included "Staff are always friendly and approachable", "Very happy as a family we know X is being taken care of". Questionnaires were also sent out separately to professionals and staff during different times of the year and the results had been collated into performance graphs. The registered manager shared the overall results with the staff, relatives

and the people living at the home.

The registered manager said the provider (owner) visited the home weekly, sometimes twice weekly. They said they felt supported by the provider who was always available on the end of the phone day and night. The provider supervised the registered manager and completed audits of the home to check on the quality of the service given to people. During the inspection we had the opportunity to meet with them. They spoke very enthusiastically of the registered manager and gave praise to them at how well they managed the home. The registered manager said often when the provider visited they would bring cakes into the home for everybody. The registered manager kept up to date with current practice and guidance by attending external conferences where best practice information was shared amongst other homes locally. They also attended local authority training courses.

There were systems in place to regularly assess and monitor the quality of the home. This was to help ensure high quality care was delivered. Quality assurance measures included checks of the medication systems, care plans, training and supervision, infection control and health and safety. These systems identified any shortfalls with improvements being made. The registered manager visited the home unannounced at times which included late nights and early hours in the morning to monitor the quality of the care provided to people. They also regularly checked people's bedrooms for cleanliness and hazards to ensure they were maintained at expected standards. This meant people were protected against receiving inappropriate and unsafe care and support.

Systems were in place to monitor accidents and incidents within the home. Accidents and incidents at the home were recorded appropriately and reported to the registered manager or senior member of staff on duty. Any injuries to people were recorded on body maps with a completed accident form. For each time a person had fallen this was reported to the person's GP, relatives and the local frailty team. Accident and incident records were reviewed and analysed by the registered manager monthly to help identify any trends and potential situations which could result in further harm to people. This meant people were protected against receiving inappropriate and unsafe care and support.

The registered manager appropriately notified the CQC of incidents and events which occurred within the home which they were legally obliged to inform us about. This showed us the registered manager had an understanding of their role and responsibilities. This enabled us to decide if the home had acted appropriately to ensure people were protected against the risk of inappropriate and unsafe care.