Coast Care Homes Ltd

Whitecliff Care Home

Inspection report

Whitecliff
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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 was unannounced and took place on 14 and 15 December 2016.

Whitecliff Care Home provides accommodation for up to 28 people who have a dementia type illness. It is situated in St Leonards on Sea.

There are two managers in post who are going through the process to enable both of them to become registered. 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.

Staff were very attentive and people were at the heart of everything they did. Staff provided kind, considerate, compassionate care. Staff provided a range of activities and ensured people were engaged with these. Staff knew about the things that were important to people.

Relatives told us people were kept safe and free from harm. There were appropriate numbers of staff employed to meet people's needs and provide a flexible service.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and appropriately.

The staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Systems, processes and standard operating procedures around medicines were reliable and appropriate to keep people safe. Monitoring the safety of these systems were robust.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. The risk assessments we read included information about action to be taken to minimise the chance of harm occurring.

Staff knew the needs of the people they supported and provided a personalised service. Care plans were in

place detailing how people wished to be supported and families were involved in making decisions about their care.

People were supported to eat and drink. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required to meet people's needs.

Staff told us the managers were accessible and approachable. Staff and relatives felt able to speak with the managers and provided feedback on the service.

The managers and provider undertook spot checks to review the quality of the service provided and made the necessary improvements to the service.

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.

Assessments were undertaken of risks to people who used the service and staff. Plans were in place to manage these risks. There were processes for recording accidents and incidents.

People were being protected from abuse because staff understood the correct processes to be followed if abuse were suspected.

People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff. There were enough staff to meet people's needs.

People could expect to receive their medicines as they had been prescribed because safe systems were in place for the management of medicines.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

People were supported to eat and drink according to their plan of care.
Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required.

People's rights were respected, and the home was following the best interest's framework of the MCA. People's choices were supported.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

Is the service caring?

Good

The service was very caring.

Staff were highly motivated and inspired to offer care that was kind and compassionate. Staff provided a strong, visible person-centred culture, where people were at the heart of everything.

Staff were very attentive and we saw positive interactions between staff and people using the service. People responded well to staff.

People's equality and diversity needs were respected. Staff knew about the things that were important to people.

People's needs were met by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect.

Staff were respectful of people's privacy.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People benefitted from engaging in a range of activities.

Relatives felt the staff and manager were approachable and there were regular opportunities to feedback about the service.

Is the service well-led?

Good

The service was well-led.

Staff were supported by the managers. There was open communication within the staff team and staff felt comfortable discussing any concerns with the managers.

The managers and the provider checked the quality of the service provided and made sure people were happy with the service they received.

Whitecliff 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 15 December and was unannounced. It was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

People had communication difficulties associated with their dementia. We observed staff interacting and supporting people in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During our inspection we spoke with one visiting healthcare professional, four care staff and the two managers. After the inspection, we spoke with four relatives. We looked at the care records for three people. We also looked at records that related to how the home was managed, such as minutes of meetings, training records, five staff files, emergency procedures and a variety of audits.

Good

Is the service safe?

Our findings

The service was safe.

People benefited from a safe service where staff understood their safeguarding responsibilities. The provider had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Whistleblowing is a way in which staff can report concerns within their workplace. Staff were aware of the provider's safeguarding policy and told us that they knew how to recognise and report concerns they might have about people's safety. Staff said that if they had concerns then they would report them to one of the managers. If they were unavailable, they would contact external agencies such as the local authority safeguarding teams to ensure that action was taken to safeguard the person from harm. Staff said, "I'd report anything to either the team leaders or the managers" and "We know there are organisations outside the home for the protection of vulnerable people if necessary" and "If it wasn't sorted by management I'd go straight to the safeguarding people." All staff told us and records confirmed they had received training on safeguarding procedures. The managers understood when and how to make safeguarding referrals to the local authority.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. For example, analysis of the number of falls and the times these had occurred identified that a high number of falls were occurring between six and seven pm. Changes were made to the times staff had their breaks to ensure the additional staff were available between six and seven pm and the number of falls reduced.

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. For example, one person's care plan identified they needed support from two staff for short distances, and needed a wheelchair for longer distances. Risk assessments had been carried out in respect of falls, nutrition and skin care. Other risk assessments were in place to help ensure that people were cared for safely. One person's care plan identified the risks associated with a medical condition and described the symptoms staff should look for, why it happened, how to prevent the symptoms and what to do if the symptoms appeared. Where risk assessments identified any actions were needed, these were clearly described. For example, if people refused treatment such as skin checks, the action plans gave guidance about what staff should do. Staff knew about the assessments and protocols in place to protect people. Both the care plans and risk assessments we looked at had been reviewed regularly.

People were kept safe from the risk of emergencies in the home. Personal emergency plans guided staff what support individuals needed to evacuate the building, and explained how this support would change if people were in different areas of the home. Staff understood the arrangements in place to keep people safe in an emergency and knew where to access the information.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried

manner. Staff from this home and the sister home were able to work on either site if necessary, though there were core staff who stayed in each home. Agency staff were used where necessary; this usage had been around once a month. Where agency staff were used, they had received training in dementia care and had worked in the home previously. This meant people were supported by staff who had got to know them. Staff rotas showed that staff with a range of skills were available, such as carers, housekeeping and cooks.

Risks of abuse to people were minimised because there was a robust recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

There were safe medication administration systems in place and people received their medicines when required. People's medicines were administered by registered staff who had an annual medicines supervision to maintain their competency and ensure their practice was safe. No one was receiving covertly administered medicines and no one was self-medicating, though the providers medicines policy contained the process for staff to follow should this be necessary.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct. Some people were prescribed medicines on an 'as required' basis and these medicines were managed safely.

A master signature list was available; this ensured that in the event of an error the dispensing practitioner could be quickly identified from the MAR chart initials. Fridge and room temperatures had been recorded daily to ensure the optimal storage of medicines, such as those used for diabetes.

We observed that the premises were clean and odour free during our inspection. Staff were observed washing their hands before handling food and wore appropriate gloves and aprons. Disinfectant hand gel was available.

All visitors had to ring a doorbell and be invited in by a member of staff. Every visitor was asked to sign the visitor's book when they arrived. This meant people were able to have visitors but were kept safe by staff.

Good

Is the service effective?

Our findings

The service was effective.
People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff told us, and records confirmed that staff were up to date with the training the provider considered mandatory, which included understanding behaviours in dementia and manual handling. Staff said, "We're offered regular training", "We've just done all our mandatory training" and "Things change a lot so training needs are high, we do lots." Staff were able to access training courses provided by the local authority, which meant they benefitted from face to face training provided by trainers who had been recognised by the council as being of a good standard. Specialist training was also provided to staff, such as advanced dementia care and associated techniques and strategies to reduce anxieties. Staff said, "They [managers] would get us on training straight away if a new resident came in and we needed to be trained in something." The managers told us families were invited to attend dementia training with staff so "They understand what our staff do."

New staff were supported to complete an induction programme before working on their own. They told us, "We did training like infection control as well as in house training such as learning about the residents" and "It was very thorough". The managers told us, "No-one is able to pass induction till they've passed the Care Certificate" and "Staff also have one week home specific induction shadowing staff." The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people. New staff completed a three month probation which could be extended if necessary.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "I have no concerns; we can raise anything straight away". All staff told us they felt supported by the managers, and other staff. Comments included: "I'm never worried about raising anything" and "They [managers] handle everything really well". Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required.

People were always asked for their consent before staff assisted them with any tasks. Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Where people had made advanced decisions, these were respected. For example, one person had chosen to refuse certain medical treatments; this was clearly documented so that in the event they would need this treatment, their wishes would be respected. Relatives with lasting power of attorney told us, "I'm always asked for consent, for example for things like the annual flu jab or taking people out on trips" and "I'm involved in all decisions." Lasting power of attorney (LPA) is a way of giving someone you trust the legal

authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. Staff told us, "We know if people are able to make decisions or if they need help doing this, for example by using picture cards" and "We don't make decisions we know they can make"

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 Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were three people living in the home with DoLS in place at the time of the inspection, and other applications had been submitted.

Families where possible, were involved in person centred planning and "best interest" meetings. A "best interest" meeting is a multidisciplinary meeting where a decision about care and treatment is taken for an individual, who has been assessed as lacking capacity to make the decision for themselves. The managers explained how they will arrange a best interest meeting for one person when the results of hospital tests are known, so the best decision can be made for the person.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. A GP had been consulted for one person who was underweight; the GP's advice was being followed and the family were kept informed. Relatives said, "My relative is always well-fed" and "They seem to enjoy their meals."

People were able to choose where they ate lunch. Some people chose to eat in the main dining room and others in the lounges. The food served looked appetizing and was appropriately presented. People used plate guards and specialist equipment where necessary to enable them to remain independent. We observed three people being assisted to eat their meals; all assistance was provided appropriately with staff sitting alongside the person and focusing on that person. Staff provided encouragement to people who were not eating. People were able to make choices about what they ate. One person didn't want either of the main choices available, so they were able to have an alternative instead.

Kitchen records had information about nutritional care for the people who used the service. Four week rolling menus showed a variety of foods were available which covered required nutritional needs. The home had been awarded five stars in a food hygiene inspection in September 2016.

Food and fluid charts showed that people's intake of nutrients was being recorded where required. People's weights were recorded on a monthly basis unless otherwise stipulated. The manager explained that should anyone be observed losing weight, they would be referred to a G.P. who in turn would refer to a dietician. Other reasons for weight loss would also be investigated if necessary. Some people who used the service required pureed foods; we saw that these were provided as required.

People's care records showed relevant health and social care professionals were involved with people's

care. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Care plans were in place to meet people's needs in these areas and were regularly reviewed. The service followed the advice of healthcare professionals. A visiting healthcare professional told us the manager had listened to them and was clear they could manage all the steps they had discussed. They told us they were happy the staff could provide end of life care with support from hospice services and were very pleased with the outcome of their discussion. They said, "It was very much about what was best for the patient, backed up by good care plans and documents."

Good

Is the service caring?

Our findings

The service was very caring.

People using the service were not able to give us feedback directly about the care that they received, however we made observations and were able to speak with relatives after our inspection. Staff were highly motivated and inspired to offer care that was kind and compassionate and displayed determination and creativity to overcome obstacles to achieving this. For example, when one person was hospitalised staff visited them in hospital to provide personal care, so the person could be supported by staff they knew. One relative we spoke with told us, "My relative was shying away from everything when she went in there, then I saw her dancing at the Christmas party and enjoying it!" Another relative said, "My relative comes on in leaps and bounds when she's there." Staff told us, "We're passionate about what we do" and "We're very person-centred, we're not clinical and there's a sense of happiness".

From our observations, we could see the service had a strong, visible person centred culture where people were at the heart of everything. Staff and management were fully committed to this approach and found ways to make it a reality for each person using the service. For example, we saw that where some people had some behaviours that challenged others, the constant interaction between staff and people together with the range of activities for people to engage in meant there were few opportunities for people to exhibit these behaviours. One relative told us, "I've seen residents being difficult, it's amazing how they deal with it, and staff are so patient."

Staff relationships with people were strong, caring and supportive; people were relaxed in the presence of staff and appeared to be very happy. Staff were very attentive and had a kind and caring approach towards people. Relatives told us, "I've seen staff in tears when a resident has passed on, you can see the residents mean a lot to them." Throughout the inspection, people were freely able to walk around the home and visit the office. The managers got people to help them with simple tasks and took time to entertain people. One person told a manager, "You're wonderful." Staff told us, "Staff provide very good care", "We're one big family" and "You can't work with people and not be like family." Our observations in the main lounge area was that the room was buzzing, people were smiling and animated as they were engaged in the variety of activities going on. Staff treated people like family and gave them appropriate hugs and kisses, which was greatly appreciated by the people concerned.

There was a commitment to working in partnership with people in, which meant people felt consulted, empowered, listened to and valued. People were always offered choices about what they wanted to do and where they wanted to be. Our observations were that people were engaged in activities they enjoyed and where they declined to participate they were offered alternatives. People were given the information and explanations they needed, at the time they need them. Staff told us how they gave people choices, such as showing them the options available. Relatives told us, "It's really good, they're always doing things to keep residents stimulated" and "There's always something going on, residents have a better social life than I do!"

The service continually reflected on their practice finding ways to improve the care and support people

received. Throughout the inspection, there were several instances when staff fed their observations back to the managers, and different things were suggested. Staff told us, "Some of our residents can't communicate and their body language isn't clear" and "We're here to make sure they're laughing, not sitting in chairs in a circle." A manager said, "Nothing is more important than the happiness of our residents."

People's equality and diversity needs were respected. Staff knew about the things that were important to people, such as being able to walk around barefoot for spiritual reasons. People's personal history was recorded in their care plans as well as their religious and sexual preferences. One person's care plan identified they took great comfort from friends that only they could see; staff we spoke with were aware of this.

People's privacy was respected and all personal care was provided in private. Staff w said that their understanding of showing respect for people's privacy and dignity included making sure people were covered when receiving personal care and knocking on people's doors before entering. The managers explained how they completed spot checks to ensure people received personal care in line with their needs and wishes, such as checking they had the toiletries they needed and had been given choices. Relatives told us if staff saw someone needed assistance they did so in a discreet way and preserved their dignity. All staff had completed privacy and dignity training as part of their induction. People were able to meet their visitors in private rooms if they wished.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. People's documents were stored in the office or in a locked cupboard. The office was always occupied by members of staff, but if required could be locked. By doing this people's private information was protected from being seen by unauthorised parties.

Good

Is the service responsive?

Our findings

The service was responsive.

People's needs were assessed before they began to use the service and reviewed regularly thereafter. Relatives said, "We're kept informed about any changes." People's assessments considered all aspects of their individual circumstances including their dietary, social, personal care and health needs and considered their life histories, personal interests and preferences. Staff knew how people wanted their care to be provided, what was important to them and how to meet people's individual needs. People received personalised care that met their needs.

Care plans were person centred and clearly identified the particular ways of providing support that were unique to that person. One person's care plan identified patterns of confusion the person might experience, and described how the person might become more anxious if they were encouraged to rest before they felt ready to do so. Another care plan identified the beliefs and values the person held, such as strong family values and hard work. From our discussions with staff, it was clear they were knowledgeable about the people they were supporting.

The care records seen had been reviewed on a regular basis. This ensured the care planned was appropriate to meet people's needs as they changed. People or their relatives were involved in developing their care, support and treatment plans. A manager told us, "We can send care plans electronically to families who live abroad for them to review." We saw other professionals had been involved in a timely way when required, to ensure the health and well-being of people. Staff we spoke with told us they used care plans to inform their practice. Profiles within care records showed a good understanding of individual's care needs and treatment. The information also showed staff monitored people's health and checked their needs were met.

There were behaviour plans in place for some people. These identified how staff could and should respond to any behaviour which they found challenging. This may include aggression to staff or others, distress and agitation. There were specific plans that identified trigger points for people's challenging behaviour. These plans described how best to manage their reactions and behaviours, for the benefit of all people in the home. We asked staff about this and they were able to demonstrate an understanding of distraction techniques. Staff showed an understanding of how to respond to behaviours which may cause harm to the individual or others. One person could be tearful and display behaviours which challenge others; staff said, "We identify triggers and distract them." Where people demonstrated behaviours that might challenge others, staff and the managers responded in such a way that any tensions were immediately diffused. Staff consistently demonstrated kindness and compassion and people responded positively to them.

People were able to take part in a range of activities according to their interests. One manager said, "We're really big on activities, if they're not baking they're singing or doing something!" The information on the activity board showed the planned activities for the day, which included baking and making decorations for the Christmas party. Staff told us, "Our activities are brilliant, there's such a good range" and "If people have

a busy morning we try to have a quieter afternoon." People were able to access the garden freely and were also able to take part in activities in the sister home. People's care plans showed the type of in house entertainment people enjoyed as well as outings, visitor's and one to one sessions.

The managers sent questionnaires to families, staff and other stakeholders when they began their new roles in October 2016. As only six surveys from relatives had been returned at the time of the inspection, the surveys had not been analysed. Comments from relatives included, "Can't be improved, excellent care for all", "Staff are definitely approachable" and "Nothing springs to mind to improve the home." One relative told us they were able to make suggestions, and would be listened to. Comments from the staff survey included, "I've yet to find anything negative", "Great attitude from colleagues and management" and "Most staff are happy in their role and with the support from management". One member of staff recognised the changes that had been made after making it known they were unhappy. The managers planned on sending questionnaires out every six months, and said they would be responding individually to people if any concerns were raised.

We saw that people who used the service and their families had been made aware of the complaints procedures. Complaints were analysed to identify patterns and trends. There had not been any complaints since the new managers had taken over, and previous complaints had been resolved in line with the provider's policy.

Good

Is the service well-led?

Our findings

The service was well-led.

The home had not notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities. Providers are required to inform us of any abuse or allegations of abuse, such as when a person may be hit by another. Two people had been hit by other people between January 2016 and July 2016. Although families, GP's and other interested parties had been informed, the manager at that time had not notified the Care Quality Commission. We discussed this with the current managers, who assured us they would ensure all future notifications would be submitted in line with their responsibilities.

The service had a positive culture that was person-centred, open, inclusive and empowering. It had a well-developed understanding of equality, diversity and human rights and put these into practice. The managers had developed the staff team to consistently display appropriate values and behaviours towards people. The managers regularly worked alongside staff which gave them an insight into the positive culture the managers had developed. Staff told us, "We're a good team, I like the team and we're supported", "There have been changes; the spirit of the home has come back again" and "The managers are very supportive; they're always happy to come and help whenever we need them."

One person told us, "[Name} (manager) is my best friend, she's a lovely girl." Staff told us staff morale was improving and they were able to nominate staff for an employee of the month award. The recipient was awarded a certificate which entitled them to have half a day off but be paid for the full day, with the managers covering the person's shift. They also received tokens of appreciation such as a lunch bag, notebook and pen. Two other awards, a day carer of the year and a night carer of the year were also available. The managers said, "Staff morale has improved. The care was clinical before but the home has come alive now" and "Staff now cover for each other, they don't call in sick and they're willing to take on new roles." Staff told us, "They're good managers, they do a good job" and "The managers are very supportive, they handle everything really well; good managers".

The managers had a clear vision for the home. Staff told us, "They try to make sure we're a good home, for the residents to feel at home and be involved in activities rather than sitting in a chair all day" and "They have high expectations, we're a big family and it's all about the residents; there's not one minute of the day we're not thinking about them". Their vision and values were communicated to staff through staff meetings and formal one to one supervisions, as well as working alongside staff. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff told us their morale had been improved since the new managers had taken up their roles.

Minutes of staff meetings showed staff had been provided with information about new changes, team leaders' responsibilities and medicines training. Staff told us, "We have regular meetings but can still talk to the managers whenever we want." Other meetings had also been held, such as cooks and kitchen assistant

meetings and housekeeping meetings. This meant staff had been provided with information to help them through the changes brought about by the change in managers. The managers told us they planned to hold four main staff meeting each year, and other meetings would also take place.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. Where shortfalls in the service had been identified action had been taken to improve practice. For example, audits of the kitchen areas led to the kitchen being deep cleaned and new filters being put into the cooker hood. Other action plans showed staff files had been updated and additional training had been booked. As part of the inspection, all the folders and documentation that were requested were produced quickly and contained the information that we expected. This meant that the provider was keeping and storing records effectively.

In addition to the above, there were also a number of general environment and maintenance checks being carried out weekly and monthly. These included the call bells, sensor mats and furniture as well as safety checks on the fire alarm system and emergency lighting. There were up to date certificates covering the gas and electrical installations, portable electrical appliances, any lifting equipment such as hoists and the lift.

All accidents and incidents which occurred in the home were recorded and analysed. For example, there were a total of eight falls in November 2016 and these had been scrutinised to see if there were any patterns or trends, such as a particular time of day or place in the home. The analysis included looking at the individual, such as whether their footwear needed to be changed. People were referred to healthcare professionals for further assessment where necessary. People's care plans and risk assessments were updated as people's needs changed.