Prime Life Limited

Byron House

Inspection report

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Date of inspection visit:
01 December 2016
06 December 2016

Date of publication:
06 February 2017

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

We inspected Byron House on 1 and 6 December 2016. This was an unannounced inspection. The service provides care and support for up to 23 people. When we undertook our inspection there were 22 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of mental health needs or because they were experiencing difficulties coping with everyday tasks.

There was a manager in post, who had been interviewed by CQC for the registered manager's post and was waiting for her certificate to arrive. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was no one subject to such an authorisation.

We found that people's health care needs were assessed and care was planned and delivered in a consistent way through the use of their care plans. People were involved in the planning of their care. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans were put in place to minimise risk in order to keep people safe.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

People were treated with kindness and respect. Staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. Meals could be taken in dining rooms, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. There were menus on display so people could remind themselves of the choices they had made.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. On-going training was available for all staff.

People had been consulted about the development of the home and quality checks had been completed to ensure the home could meet people's requirements. This included environmental checks both in and outside the building and there was a maintenance plan in place. There was an analysis of quality checks and lessons learnt were passed on to staff.

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.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse. Risk assessments were up to date and staff ensured people were protected from harm.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. Menus were on display, so people could be reminded of their choices.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff. Staff respected people's needs to maintain as much independence as possible.

Staff ensured people's privacy and dignity was maintained at all times.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them. The care plans fully explored the needs of people and how other agencies could help them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Good

The service was well-led.

An analysis of audits was undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The views of visitors and other health and social care professionals were sought on a regular basis.

Byron House

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 1 and 6 December 2016 and was unannounced. The inspection was undertaken by an inspector.

Before the inspection, the provider had 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 reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals before and during the site visit.

During our inspection, we spoke with six people who lived at the service, three members of the care staff, a member of the domestic staff, a cook, the manager and an area manager. We also observed how care and support was provided to people.

We looked at four people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the manager had completed about the services provided.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. They said this was because there were always staff available to attend to their needs and they felt their belongings were safe. One person said, "It's the best place yet for me, it's warm and secure. I feel safe." Another person told us, "I sleep alright at night here, because I feel safe."

We observed staff handling situations where people's behaviour was disturbing to others. Staff were calm, talked with each person and offered alternatives to how they would like to spend their time. People told us staff dealt well with those situations and they felt safe. One person said, "I don't' like it when anyone starts shouting, but staff calm everyone down." Staff told us they dealt with each situation quickly so people would not be alarmed and would feel safe.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the manager would take the right action to safeguard people. This ensured people could be safe living in the home

People told us there were sufficient staff to meet their needs. One person said, "If I need them staff are here, day and night." Another person said, "Sometimes I like staff to come with me when I go out and there is never any problems finding a member of staff."

Staff told us that the staffing levels were good and there were sufficient staff to enable them to meet people's needs. One staff member said, "Staffing levels in the home are fine. [Named staff member] does a lot of the accompanying to appointments and sometimes the manager goes." Another staff member told us, "Staff go out with people all the time, but we make sure there is a core number of staff in the building to meet other people's needs."

The area manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These were reviewed on a monthly basis by the manager and head office staff. The manager discussed the staffing needs for some people with complex needs with commissioners of services. This was because those people may require more input by staff on a one to one basis at certain times of the day. We saw in the care plans when those discussions had taken place. There was a contingency plan in place for short term staff absences such as sickness and holidays. Staff told us they were happy to pick up extra shifts as they felt it was important that people knew the staff on duty.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. There was an analysis to show themes and trends, which would help to identify specific safeguarding concerns. Staff told us that changes in care needs were discussed at staff meetings, reviews of people's care needs and daily shift handovers, which they said was effective.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely. This was to ensure each person was capable of being as independent as possible. Where people had chosen to smoke assessments had been completed by staff to ensure people were safe to do this independently or if they needed help on where they could smoke on the premises. Also how important it was to ensure what they were smoking had been extinguished correctly. We observed staff reminding people of this and checking items had been extinguished. There were receptacles around to extinguish smoking items, but people could not smoke within the premises.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would become anxious when hearing the alarm and those who may need assistance with walking. A plan identified to staff what they should do if utilities such as gas and electricity failed. Staff were aware of how to access this document. The fire risk assessment had been reviewed in October 2016. Staff were required to complete daily fire checks to ensure all fire fighting equipment was in place, lights worked and fire doors were maintained. We saw the checklist the staff completed, which was up to date.

We were invited into four people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us how they had chosen bed linen and paint. They said staff had helped them to display pictures and other ornaments, which they had purchased or brought from their previous home.

The main entrance to the home was through a reception area where people either rang a bell to summon staff to enter or who had authorised access. Staff told us that people could have access if they had been assessed as being capable of retaining that information and this was recorded in their care plans. Some people had keys to their bedrooms. One person told us, "I like to lock my door. It's a personal thing." Another person told us, "I can come and go when I like. I know the code to get in, but I don't give it to anyone else." Staff were observed giving entry to visitors and asking them to sign a visitor's book, which is used in the event of a fire to check who was in the building. We were asked for our identification badge before gaining entry.

There were areas of the home which needed a little more refurbishment. This included some work in the gardens, repainting of some communal areas and replacement of some furniture. The area manager told us had recently identified the garden area as a priority and the manager was waiting until the weather improved to complete the work. There was a property audit schedule in place and this home was due to have theirs reviewed by the end of December 2016. We were provided with a list of purchases which had been in made in recent months, which included re-decoration in the library, five bedrooms repainted, replacement flooring in some areas and replacement patio furniture.

We saw that recruitment checks were carried out prior to people being employed at the service. The provider asked for two references, proof of identification and undertook checks with the Disclosure and Barring Service (DBS) to ensure that people did not have any past convictions that would present them as a risk to people living at the service.

People told us they received their medicines and understood why they had been prescribed them. One

person said, "I like to come for mine." They went on to tell us what a doctor had prescribed for them. Another person told us they did not like taking medicines, but staff had explained why they needed certain medicines to keep them healthy. They said, "I understand now so do take the tablets." Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in a locked area. Records about people's medicines were accurately completed. A separate register was kept for those medicines which were required to be recorded in a separate book and there was accurate recording by staff. Staff told us that medicines arrived from the local pharmacy supplier in good time for them to check the supplies and store away.

We observed medicines being administered first thing in the morning, at lunchtime and at various times during the day. Appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Most people preferred to come to the office to receive their medicines and there was a small sofa outside the office, which people used as a waiting area. Staff who administered medicines had received training and their competence was tested as part of the yearly appraisal process. Reference material was available in the storage areas.

Good

Is the service effective?

Our findings

None of the staff we spoke with had been newly recruited. They told us that the induction programme at the time of their recruitment had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The manager told us that all new staff were now registered for the new Care Certificate. This would give everyone a base line of information and training and ensure all staff had received a common induction process.

We saw that there was a training system in place which head office staff kept a track of for each location on the provider's portfolio. This system was flexible and enabled the provider to identify units each year that they felt would be most appropriate to the needs of staff at the time. This would highlight where more training and development would be needed. There was also regular training around issues such as food safety, diversity and equality and health and safety. The training planner showed that training for staff was mostly up to date, with only minimal gaps. Where staff had failed to attend training courses or where updates were required these were highlighted on the planner and sessions booked. The planner gave a percentage score of how many staff had attended each course. This gave the manager an indication of the success rate and popularity of some courses, which were not mandatory. Staff told us they thoroughly enjoyed all the training courses and felt the courses had benefitted the way they worked with people. Staff were encouraged to take on specific roles within the home and cascade their knowledge to other staff. These included infection control, nutrition, diabetes and continence care. Staff told us they used those people to pass ideas through and to help maintain standards within the home.

Care staff received supervision, according to the records. The area manager stated they were a little behind at this point in the year as there had been a change of manager, but this was now being addressed. Staff told us the supervision sessions were useful as they could voice their own opinions and also receive a review of how they were performing. The supervision sessions also tested staff members' competence after training sessions to see what they had absorbed from the courses.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. We found that the provider had followed the requirement in the DoLS. No applications had recently been submitted to the local authority.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. Staff gave us a good resume of what the MCA and DoLS would mean for the people they looked after.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times when it had been necessary to hold best interest meetings with people and assessments completed to test their mental capacity and ability.

People told us that they liked the food and the variety. One person said, "Very good meals." Another person told us, "All the meals are there for you. It's different every day and we have plenty of drinks." People told us the meals were freshly cooked each day and they had seen deliveries of fresh food such as meat, vegetables and fruit. One person said, "Sometimes I ask staff to keep sandwiches for me for later on, which they keep in the fridge." People said they were never hungry and also enjoyed take-away food such as pizza, Chinese and Indian take-aways.

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and if they needed assistance. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. This ensured people received what they liked and what they needed to remain healthy.

People told us they could choice their meal the day before, but were always asked on the day if they still would like their choice. Menus were on display in the dining rooms. We saw that staff ensured people were well hydrated during the day. People were offered hot and cold drinks regularly by staff. Staff took meals to people who preferred to eat in their rooms. They ensured each person had all the utensils and condiments they required. We observed the lunchtime meal. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and encouraging them to eat and drink. Staff did not hurry people.

People told us staff obtained the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as flu vaccinations. Staff had recorded when people had seen the optician and chiropodist. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance. This was affirmed by the health and social care professionals we spoke with before and during our visit.

We heard staff speaking with people about hospital appointments and home visits and asking whether they would like relatives or staff to accompany them. People told us they had appropriate and timely access to health care. One person said, "If I need to see a doctor I need one straight away and staff help me do that." Another person said, "I like to see my community nurse regularly and they will come here as I don't like the clinics."

People told us staff treated them with dignity and respect at all times. One person said, "They respect when I want to get up and go to bed." Another person told us, "I don't need a lot of help, just the bathing, but staff

make sure we are not disturbed and respect when I want to have a bath."

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment.

Good

Is the service caring?

Our findings

People told us they liked the staff and felt well cared for by them. They spoke to us about instances where they felt staff had been particularly kind to them when they were anxious, distressed about a family situation and worried about where they would live in the long term. One person said, "It's peaceful living here. I've lived here a long time now and love it." Another person told us, "Staff offer to communicate with me if I want it, which sometimes I don't. They respect that."

People were given choices throughout the day if they wanted to remain in their bedrooms or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with other people, and some with staff. There was a lot of animated conversations between people and staff, including lots of laughter.

Staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, someone asked the same question continually. Staff responded with the same answer and diverted the person away from the topic and the person became more settled. We saw staff took time to respond and engage with people who spoke to them.

Staff ensured that the dignity of people using the service was protected. For example, when someone came out of the toilet area with their clothes in disarray. Staff went quickly to the person and reminded them about their clothing before they entered a communal area where people were sitting. Staff reminded people to shut bathroom and bedrooms doors when they were changing their clothes. They informed people that others may not wish to see them in a state of undress. People respected what staff said on all occasions.

The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. Some people choose to go out for most of the day and as the weather was cold staff reminded them to wrap up warmly. One person said, "I've never been so well looked after. They are like mother hens. I love it."

We observed staff helping a couple of people who appeared withdrawn. They engaged with them throughout the day, ensuring they had everything they required and when asked to leave them alone did so. Staff continually went back to those communal areas throughout the day to check each person was well. Staff explained some people were not used to living in a communal setting so they observed them to ensure they did not have any underlying needs which required to be addressed, rather than a settling in time.

Some people preferred to stay in their bedrooms for most of the day. Staff respected their wishes and we saw them returning to bedroom areas to enquire whether people required help or company. We observed staff in people's bedrooms helping them to arrange photographs, helping with a puzzle book and reading the headlines from newspapers. Staff spoke at a level people understood; using local sayings which people

appeared to enjoy hearing and generally having banter with people.

We saw signatures in the visitors' book of when people had arrived at the home and saw some people visiting. Staff told us some families visited on a regular basis, but that some people choose to go home to parents and other relatives on a frequent basis. This ensured people could still have contact with their own families. People told us staff would telephone their family members when they wanted to speak with them and encouraged and helped them to send card for birthdays and Christmas.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our visit.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Good

Is the service responsive?

Our findings

In the care plans we looked at the placement criteria for people was recorded. It was clear why they were at the home and if the setting was appropriate to their needs. There was a risk history for people leading up to their placements at this home. The care plans took into consideration the needs of each person prior to admission and the notes showed the communication between other services and health and social care professionals prior to an offer of accommodation was made by this home.

People told us they knew about their care plans and had contributed to them. The wording in the care plans showed the care plans were written with people and their views being recorded. Staff told us care plans were to be updated every couple of months. There was evidence this took place in the care plans we reviewed.

The people we spoke with gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. People told us staff responded quickly when they used their call bell, day and night.

In the care plans there was clear information on plans for people's health and well-being over a period of time. For example, where people had physical needs, such as mobility problems which were affecting their mental health. In one care plan we saw where a person's medical condition was causing difficulties for them to walk. Other health professionals had been involved to ensure they had the correct mobility aids and also doctors had been involved in assessing the person's mood swings as their mobility decreased. In another care plan we saw there had been a decline in a person's memory function. There had been a formal assessment of their needs and staff were considering a referral to a memory clinic. Where people's physical health had started to decline due to problems of old age a reassessment of their needs had taken place. Staff had assisted the person in visiting other care homes to see if they would like to move in the future. The person spoke to us about this and told us how supporting staff were, but they would make their own decisions, which staff respected.

When a person had been admitted as an emergency due to their decline at home staff soon recognised one of the person's prime needs was around their religious observances. There was nowhere locally this could take place. Staff therefore found another home the person could move to which satisfied their need and was still within reach of the person's family visiting.

Where there had been incidents where people's challenging behaviour could be harmful to them or others, staff had analysed the causes of people's behaviour. For example, when a person had been drinking alcohol heavily when out on a community visit. This meant staff had the means of knowing the triggers which could result in a person's behaviour and would therefore be able to prevent them and others being harmed.

People told us that staff would contact other health and social care professionals if they needed them. There was evidence in the care plans that staff had arranged visits and sought advice from a number of health and social care professionals, as well as family and friends. In the care plans there were recordings of

joint agency working to ensure people could access all the resources they required. This could result in people receiving the appropriate care to meet their needs.

Where people could access the local community this was in their care plans. Where people liked to go, when they liked to go and if they required an escort were all recorded in the care plans. What was termed a "grab sheet" was in each care plan, which recorded the vital information about each person to be given to other agencies should people go missing.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use to remind staff of tasks to complete each day.

We were informed that all staff helped with social, religious and cultural activities with people. This ensured that social activities could take place seven days a week as staff were always available. Staff told us activities were arranged through consultation meetings with people. A programme was on display for December 2016 of local events and we saw the advertised activities taking place. The photograph album and photographs on display showed a number of different activities which had taken place over a period of time. The activities records showed a number of events people had taken part in including, a film night, board games and a birthday party. Some people told us they preferred their own company and were happy to watch the television, read in the library or look at a daily newspaper. One person said, "I have a very big room and I don't like to go out, but I keep myself occupied. I have a routine each day."

Links with the local community had been encouraged. Some people told us they enjoyed walks on the local beach. Others visited local public houses, went out for lunch and visited local shops. Some people told us about visits away from the area to visit exhibitions such as The Deep in Hull and to Horncastle market. People were looking forward to Christmas and told us about the arrangements they had asked staff to make for parties in the home and away with their own families.

The provider had a system for managing complaints and this was available in the entrance of the service for people to access. We reviewed the complaints information and there had been one formal complaint recorded since our last visit. This complaint had been dealt with appropriately. People told us they would be happy to make concerns known to staff and felt confident they would address any issues promptly and in confidence.

Good

Is the service well-led?

Our findings

There was a manager in post who was awaiting their certificate from CQC which would state they were now registered. People told us they could express their views to the manager and staff and felt their opinions were valued in the running of the home. One person said, "The new manager is lovely. I could talk to her all day." Another person said, "I've no problems discussing my views and feel the manager and staff respect who I am."

Systems for auditing and monitoring the service were in place and these were kept up to date. The internal infection control audit for October 2016 showed a 100% compliance on all issues, including staff training. Other audits included an analysis of falls and incidents to show trends and themes, how staff were showing dignity and respect to people by maintaining the environment and giving personal care to people and evaluating care plans. A selection of care plans were usually checked each month, but the manager informed us she was currently going through everyone as she was new and wanted to ensure each one reflected accurately people's needs.

The provider held monthly meetings with people to gather their views about the running of the service and the notes from the meetings showed that much of the discussion was around activities, meals and personal allowances. The manager was looking at different ways of gaining people's views as this method did not include many people as some people became anxious in meetings. The last questionnaire sent to people had been in April 2016. The results showed the actions around such as new furniture being purchased, a garden fete being organised and menus being altered had taken place. We saw that people's post was either put on their placements at meal times or taken to people's rooms.

Staff told us they felt supported and could influence change and could voice an opinion at the regular staff meetings. We saw the minutes of staff meetings for June 2016 and October 2016. A variety of topics had been covered including, infection control, medicines, staff rotas and security. Staff had been given opportunity to voice their opinions and given answers to queries. Staff told us whatever they asked of senior staff they always received an answer and were not left wondering what an outcome could be for them and people who used the service. Details of an audit in March 2016 showed what actions the provider was taking around developing the business, future training and maintaining the baseline services already in place. Staff told us they had been consulted about those proposals.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.