Keldgate Manor Estates Limited

Keldgate Manor

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?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

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. The inspection was unannounced.

At the last inspection on 5 November 2013 we found that the provider had met the standards that we reviewed.

Keldgate Manor is a residential care home that is registered to provide accommodation for up to 35 older people, some of whom may have a dementia related condition. On the day of the inspection there were 28 people living at the home. Some double rooms were used as single rooms.

There was a registered manager in post as the time of this inspection and they had been in post since the home was first registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. There was a low staff turnover and therefore a consistent staff group. This meant that people were supported by staff who knew them well. Staff had been employed following robust recruitment and selection processes.

People's nutritional needs had been assessed and a system had been introduced to ensure that these were known by staff and met on a daily basis. People told us that they were satisfied with the meals provided by the home.

We observed good interactions between people who used the service and staff on the day of the inspection. People told us that staff were caring and this was supported by most of the relatives we spoke with, as well as health and social care professionals. People had been consulted about their end of life care and clear records were held.

We identified some areas of improvement that needed to be made by staff in respect of people's individual needs being met. Although we received some comments from relatives and health care professionals about the lack of social stimulation, we were told by the registered manager, care manager and staff that there was a range of activities available to people and we saw some of these taking place on the day of the inspection.

People's comments and complaints were responded to appropriately. Arrangements were in place to seek the feedback of people and their relatives about the service provided, both through surveys and the setting up of a home committee. People reported they were involved in making decisions about the service they received .

Staff received a range of training opportunities and told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

The home was well led and we found that the registered manager and care manager learned from incidents at the home and from good practice guidance.

Summary of findings

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.

The service provided safe care. We found that there were enough staff on duty and that agency staff were not used, so people were supported by a consistent staff group. Staff had been employed following robust recruitment policies and procedures and had induction training before they commenced work unaccompanied.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with understood how to protect the rights of people's who had limited capacity to make decisions for themselves. Staff also displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

Is the service effective?

Good

The home provided effective care.

A system had also been introduced to ensure that people's nutritional needs were assessed and met, and people told us that they were happy with the meals provided by the home.

We saw that people had access to a variety of health care professionals when they needed it. Most health care professionals said that staff asked for advice appropriately and followed their advice, and that this had led to people's health improving.

Staff had undertaken training on topics that provided them with the knowledge and skills they needed to support the people who lived at the home.

Is the service caring?

Good

Staff at the home were caring.

People who lived at the home and their relatives told us that staff were caring. Health and social care professionals said that they had seen positive relationships between people who lived at the home and staff.

People's wishes for their end of life care were recorded and there were clear records to identify when people had 'Do Not Attempt Resuscitation' (DNAR) notices in place.

Summary of findings

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with. People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Some health care professionals said that they had noticed staff did not always explain to people what support they were going to be providing for them.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for their care were recorded and these were known by staff. However, we saw one example of when a person's nutritional care plan had not been followed.

There was a complaints procedure in place and forms were readily available for people to complete should they wish to make a complaint. There was also a home's committee that consisted of people who lived at the home and relatives. This enabled people to share their views about the care provided at the home and about how the home was operated.

Is the service well-led?

Good

The home was well-led.

We saw that the registered manager and care manager promoted a positive culture and this was confirmed by the staff who we spoke with.

There were systems in place to enable managers and staff to keep up to date with good practice guidance, including 'champion' training and attending meetings organised by the local authority. The home had also taken action after they had read the recommendations of a serious case review that was reported in the national press.

There were quality audits in place to monitor that systems were being followed by staff and that the home and equipment were maintained to ensure the safety of the people who lived there.

Keldgate Manor

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

We visited this service on 10 July 2014. The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the home. We also spoke with nine health or social care professionals (including district nurses, community psychiatric nurses and the specialist falls team) who had involvement with people who used the service. In addition to this, we looked at the information the registered provider had submitted to the Commission in their provider information return (PIR).

On the first day of the inspection we spoke with three people who lived at the home, ten relatives, the home's administrator, the registered manager and the care manager. On the second day of the inspection we spoke with three members of staff plus the home's administrator, the registered manager and the care manager.

We spent time observing the interaction between people, relatives and staff. We looked at all areas of the home, including bedrooms (with people's permission), office accommodation and the garden. We also spent time looking at records, which included the care records for three people who lived at the home, staff records and records relating to the management of the home.

Good

Is the service safe?

Our findings

Everyone who we spoke with said they felt safe living in the home. The provider had safeguarding policies and procedures in place and we saw examples of when these had been followed. For example, we saw safeguarding incidents had been correctly reported to the local authority. Staff had also undertaken training on safeguarding adults from abuse. The three staff who we spoke with confirmed that they had completed this training at the time of their induction to the home and then again as refresher training. On the day of the inspection we saw workbooks that had been provided by the local authority for all staff to enable them to complete further training on this topic.

The staff members who we spoke with were able to describe different types of abuse and the action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us that they would report any concerns to the registered manager or the care manager and that they were confident the issue would be dealt with professionally. They said they felt all staff within the team would do the same. This showed us that staff understood and had confidence in the procedures in place to keep people safe.

We found staffing numbers were based on meeting people's individual needs, such as their level of dependency and whether they needed the support of one or two staff for mobilising. On the day of the inspection we observed that staff were visible and were attentive to people's needs by providing help and support when they needed it, indicating there were enough staff. Staff also told us that they thought there were sufficient numbers of staff to meet the needs of people who lived at the home.

Some staff worked part time and this meant that there was usually someone available to work additional hours to cover staff absences. In addition to this, the registered manager and the care manager lived on the premises and were available to assist staff if needed. The home did not employ agency staff and this meant that people who lived at the home were always supported by people who they knew.

A relative told us that there had been a high turnover of staff. However, we checked this with the care manager and we were able to confirm that five staff had left the service during the previous twelve months.

We checked the recruitment records for a two new members of staff. We saw that two written references and a Disclosure and Barring Service (DBS) check had been obtained prior to the person commencing work. There was a record of the induction training they had completed when they were new in post. This included 'shadowing' experienced staff until they were confident about working unsupervised. We saw the records for a prospective staff member; two written references had been obtained but the DBS check had not been received. Because of this, they had not yet commenced work at the home. This indicated that the provider did not allow people to commence work until they had checked that they were suitable to work with vulnerable people.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. We found the registered manager and care manager had a good understanding of DoLS and were aware of the recent supreme court judgement and its implications on compliance with the law. The three staff we spoke with told us that they received training on dementia care and DoLS as part of their induction training. We saw that three staff had attended additional training on DoLS and six staff had completed training on the Mental Capacity Act 2005 (MCA). Staff said that this had helped them to understand how to assist people with limited capacity to make decisions.

The home had taken appropriate steps to ensure people's capacity was assessed where complex decisions needed to be made. For example, each person's care plan included a mental capacity assessment and a decision making matrix. We saw comments such as, "I like to make my own decisions. I do not like to be told what I should think" and "(the person) can make day to day decisions such as what to wear, eat, wash, bath and shower." Where it was considered that people lacked the capacity to make more complex decisions, best interest meetings had been arranged. These are meetings where people involved in a person's care meet to discuss decision making on a specific topic when the person does not have the capacity to make

Good

Is the service safe?

that decision themselves. A social care professional told us that the registered manager and the care manager had always asked for mental capacity assessments and best interest meetings when this was appropriate.

Care plans included suitable risk assessments that recorded how identified risks should be managed by staff. These had been updated on a regular basis to ensure that the information available to staff was correct. When people displayed particular behaviours that needed to be managed by staff in a specific way to ensure the person's safety or well-being, this information was recorded in their care plan. In addition to this, there was a 'flag up' board in the office where risk management plans were listed so that staff had regular reminders about how to manage people's specific behaviours. This information was not on view to visitors to the home.

At the last inspection we had checked the home's contingency plan. We were concerned that it included a reference to the use of candles. At this inspection we saw that the plan had been updated and included appropriate information. The registered manager was able to describe to us how they had used their business continuity plan during a recent emergency at the home.

Good

Is the service effective?

Our findings

People and their relatives reported that the home provided effective care overall. One relative said "They couldn't be better" and another relative said, "I have nothing but praise (for the home)." Only one relative expressed concerns about the care provided by staff and we noted that these had already been dealt with via meetings with the local authority, the family and managers of the service. We saw the records that had been made following the meetings that had taken place. These included a record of the feedback that had been given to staff in respect of learning from these meetings and how the service would ensure that consistent care was provided.

Feedback from health professionals on the effectiveness of the care was positive. For example, one health care professional we spoke with said that staff were helpful and knowledgeable about people who lived at the home. Another told us, "Staff listen to advice and ask for advice appropriately." One health care professional explained how staff had followed their advice in respect of someone who had a potential pressure area. Staff had ensured the person has taken regular bed rest and the wound had almost healed.

Care plans included a form that recorded all contact with health care professionals. We saw that this included contact with GPs, district nurses, tissue viability nurses, speech and language therapists and the falls team. All entries had been dated and signed by staff, and included the reason for the contact and the outcome. Correspondence to and from health care professionals had been retained and we saw examples of when advice given about people's care had been incorporated into care plans.

The staff who we spoke with told us that communication between staff, and between staff and managers, was effective. They described how they used a 'catch up' book that recorded any incidents and any visits from health care professionals. They said that people's initials were used to protect confidentiality. This made sure that staff were aware of the latest information about each person who lived at the home.

The provider told us in the provider information return (PIR) that they had undertaken training on dementia care and they were aware that the environment of the home needed to be improved in respect of people living with dementia. This included having coloured uniforms for staff to aid identification and replacing patterned carpets with plain carpets to create less difficulties for people experiencing problems with their visual perception when they were walking around the premises. They had plans in place to action these improvements.

People's food and drink preferences were recorded in their care plans and any special dietary needs were also recorded. Nutrition had been recognised as an important area of care by the manager and a new system had been introduced to ensure that staff were aware of people's dietary needs. A nutritional assessment had been completed for each person who lived at the home. This resulted in their needs being categorised as red, amber or green depending on the level of support they required. These assessments and related documents had been placed in a coloured ring binder in a box of the same colour. This identified for staff the people living at the home who required additional support to ensure their dietary needs were met. All records relating to food and fluid intake were kept in this folder and we saw that records had been maintained consistently and thoroughly. When we spoke with staff they were able to explain this system to us and how it had helped them to ensure people's dietary needs were met.

The registered manager told us that a soft diet was prepared for some people and that each food item was presented separately. This ensured that people were able to enjoy the different flavours of their meal. A visitor told us that their relative had said that they enjoyed the meals provided at the home.

People were provided with a three course meal and there was a choice of main course and dessert. There was no menu on display and the registered manager agreed that they would start to display a menu again so that it was available for people who were able to access it and for people's relatives. However, we saw that staff explained the meal choices to people at mealtimes and provided alternatives when these were requested.

The provider had introduced a system that reminded staff about people's specific conditions or personality traits. These included dementia, a 'nervous disposition' or a mental health concern. For example, the symbol of a butterfly signified that the person had a diagnosis of dementia. In addition to this, there was a symbol to signify that a person had a 'Do Not Attempt Resuscitation' (DNAR)

Good

Is the service effective?

document in place. These symbols were very discreet and were only known to staff. This system helped to make sure that staff were aware of people's specific needs or personality traits but in a discreet way that protected their dignity.

We looked at training records to check whether staff had undertaken training on topics that would give them the knowledge and skills to care for people who lived at the home. We saw that staff completed induction training on the topics of person centred care, safeguarding adults from abuse, infection control, dementia, pressure area care, dying / death / bereavement and personal profiles. Some of this training was repeated as refresher training. Refresher training included the topics of moving and handling, infection control, empathy and understanding and equality and diversity. The manager told us that dementia and dying/death/bereavement were going to be added to this list.

There was a moving and handling 'champion' at the home who had undertaken training with the local authority. This person's role was to be aware of good practice in respect of moving and transferring people and in the use of hoists and slings, and to share this with their colleagues. The registered manager told us that no staff worked alone with people who needed assistance with moving and handling until they had completed this training.

We saw that an audit had been circulated to staff to ascertain if they were happy with the training provided by the home. This asked, "Are we getting your training right?" The three care workers who we spoke with told us that they felt they received sufficient training to provide them with the skills and knowledge they needed to carry out their role.

Good

Is the service caring?

Our findings

All of the people and their relatives who we spoke with told us that staff were caring. One relative told us, "I definitely would not have left my relative here for six years (if the staff were not caring); the carers are marvellous" and "This type of home suits us; it is more like a house than a hospital." We found the registered manager and the care manager to be caring people who were dedicated to providing good care.

The feedback we received from health and social care professionals was mostly positive. One health care professional told us that they had witnessed positive caring relationships between people who lived at the home and staff. Another told us, "The care given is sometimes very good and the relationship visible between the staff and some individuals is extremely good." A third health care professional told us staff kept them updated about the well-being of people who used the service. A social care professional said, "Families have always been happy with the service and several have made the same comments over the years i.e. how much they feel the staff do care rather than it just being a job." However, one health care professional said they had sometimes needed to give advice to staff about meeting people's personal hygiene needs, as they felt that some people had not been provided with optimum care. On the day of the inspection we saw that everyone who lived at the home looked clean, well dressed and well groomed.

The three staff who we spoke with displayed an understanding of people's preferences and wishes for care and we saw that this information was recorded in care plans. For example, one care plan recorded, "We love (the person's) independence. They just smile when things go wrong and become happy when you hold their hand" and another said, "I like a smiling cheerful face." The training records showed that staff had undertaken training on Empathy and Understanding and that they had completed a self assessment following the training to measure their own skills in this area.

We saw that care plans included information about people's wishes for their end of life care. We saw that some people had 'Do Not Attempt Resuscitation' (DNAR) documents in place and that care plans clearly recorded when they had a DNAR notice in place. We noted that the home had a 'champion' for palliative care. This person had undertaken specific training on end of life care and had responsibility for sharing their learning with other staff. If someone in a shared room was receiving end of life care, there were empty bedrooms available so that they could be transferred to a private room. We saw the people could visit the home at any time so family and friends would be able to be with people if they wished to do so at the end of their life.

There were six shared bedrooms at the home but the registered manager told us that only one was currently being used by two people. She said that the people were happy sharing the room as they liked to know that they were not alone. We looked in the room and saw that there were two screens stored in the room so that they could be used to promote privacy and dignity. Health care professionals told us that staff always considered the privacy and dignity of the people who lived at the home. On the day of the inspection we observed that staff assisted people with personal care in a sensitive and respectful manner.

We saw that people's family and friends visited the home throughout the day and that they were always made welcome by staff. We noted that information about advocacy services was available to people who lived at the home and their relatives. Although none of the people who lived at the home had used advocacy services, the information was available to them if they wished to access independent advice.

On the day of the inspection we saw that staff asked people about their food and drink choices, whether they wanted to take part in activities and where they wanted to spend the day. People's views and wishes had also been recorded in their care plan. One care plan recorded, "(The person) will make whatever decision they feel will be right for them at the time." When people did not have the capacity to make decisions about their care, their chosen representative had been consulted or best interest meetings had been arranged.

A health care professional told us that they had witnessed staff providing meals for family members when they had visited, especially people's husbands or wives, so that they could enjoy a meal together. This felt that this had helped people who were new to the home to settle in and also helped people to maintain contact with family and friends.

Good

Is the service caring?

Care plans included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. This helped staff to understand the person and therefore provide more individualised support. In one care plan we saw a record advising staff to accept a person's actions even though these did not promote good hygiene. This person had dementia and did not realise how much support they required. The care plan advised staff how to discreetly take action to reduce the risk of harm for this person.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. One health care professional explained how staff had followed their advice in respect of someone who had a potential pressure area. Staff had ensured the person has taken regular bed rest and the wound had almost healed. However, another health care professional told us that staff had not followed their advice in the past, or had not been aware of the advice due to poor communication at the home. They said that when the advice had been repeated it had been followed. In addition to this, one health care professional told us that they had noticed staff did not always explain to people what support they were going to be providing and that support was not always centred around the person. This may have resulted in people not receiving the care they needed.

We saw that one person's nutritional assessment recorded that they should be provided with small portions at meal times and that they should be encouraged to eat. We observed the lunchtime meal and saw that this person was not provided with small portions and there was no real attempt to persuade this person to eat their meal. We were concerned that staff were not following the guidance in this person's nutritional plan.

During the lunchtime period we observed that a domestic assistant cleaned the lounge, using a vacuum cleaner and aerosols/air fresheners. Some people were eating their meal in the lounge and this did not promote their safety or their dignity, and did not provide a pleasant meal time experience. We discussed this with the care manager who explained that the lounge was cleaned at lunchtime as most people had moved into the dining room. They said that they would ensure rooms were only cleaned when people were not using them.

Some health care professionals mentioned concerns about the conservatory at the home; this is used as a lounge and a dining room. They said that the rooms were very hot in the summer and that this posed a risk of over-heating and dehydration. This issue was also raised by a relative. In response to this, the manager had obtained thermometers from the Clinical Commissioning Group (CCG) to monitor room temperatures but we did not see any evidence on the day of the inspection that these were being checked and recorded. However, no-one who lived at the home and no relatives identified this as a concern on the day of our visit and we saw that people were encouraged to drink fluids throughout the day.

A health care professional we spoke with told us they thought there were enough staff to enable good care and a range of activities to take place, which helped people to achieve good outcomes. A social care professional told us, "I feel the staff work well with other professionals and have always taken the time with family members during and after meetings to discuss things like dementia and other health issues to help families to understand." They said that they had seen the care manager deal with some quite emotional situations "In a really nice way with easy to understand explanations."

One of the care workers had responsibility for arranging activities and had time allowed for this during their working day. Staff told us that a pianist visited the home every Monday and that people who lived at the home enjoyed a 'sing along' session. On the day of the inspection we saw that an activity took place in the morning and in the afternoon. However, we noted the quiz that took place in the morning was not suitable for the people who lived at the home. We discussed this with the registered manager and they told us that some of the people who lived at the home enjoyed a more challenging quiz but acknowledged that the quiz did not suit everyone. They told us that they had a variety of quizzes to suit the needs of different people and they would ensure these were used appropriately.

Although we had seen activities taking place at the home and records evidenced that these took place on a regular basis, a relative told us that there was little social stimulation for people. They said, "The staff do not communicate enough with the residents and there is a lack of stimulation. The gardens are not used enough for the residents to get fresh air." The lack of social stimulation was also raised by two health care professionals. We discussed this with staff and they told us that they did encourage people to use the garden but most people preferred to sit in the conservatory and look out at the garden.

The registered manager and care manager told us that they had previously had a poor response to residents meetings and they decided to introduce a home committee to try to obtain the views of people who lived at the home and relatives. We saw that these meetings took place each month and that two people who lived at the home, two

Requires Improvement

Is the service responsive?

relatives and the registered manager had attended the most recent meeting. We spoke with the chair of the committee on the day of the inspection and they gave positive feedback about care at the home and how the committee had been involved in decisions made by managers. For example, the chair of the committee told us that they now sat on employment interview panels to represent relatives and people who lived at the home. The committee had decided to reduce the monthly surveys to quarterly surveys and had received good feedback about food provision at the home. They had asked the chef to produce comment sheets so that continual feedback could be sought.

The provider told us in the PIR that they had received two complaints in the previous twelve months. We saw that the complaints procedure was displayed in the home, along with a form ready for people to fill in to make it easier for them to pass their complaint to the registered manager or care manager. A relative explained to us how they had used the complaints system at the home and said that they had, "Come to some sort of agreement." We checked the records held in respect of this complaint and saw that there was a comprehensive record of all actions taken, including information about everyone who had been consulted and the decisions made.

The three members of staff who we spoke with told us that they would support people who lived at the home to make a complaint. If an incident had occurred and the person did not wish to make a complaint, staff said that they would still pass on this information to the registered manager or care manager if they felt that it needed to be addressed.

There was a suggestion box situated in the hall and this gave people another opportunity to make comments or suggestions about the care provided by the home, anonymously if they wished to do so. A social care professional told us, "Families have always been happy with the service."

Good

Is the service well-led?

Our findings

The service was well-led and managers promoted a positive culture. There was a registered manager in post who was supported by a care manager. One health care professional told us, "I have had a close relationship with the managerial staff and have felt very much that they have taken on any advice and/or changes with great interest and care." A social care professional told us, "The staff are always helpful and management will go out of their way to do that little bit extra for the service user. They will arrange things like transport when someone has respite care or attend to people's personal preferences. On the whole, no problems with the home."

We received feedback from a team of health care professionals and they stated that managers appreciated their regular discussions; they said that staff were aware of when it was appropriate to contact them to make referrals and to seek advice. They told us that they had built up a good relationship with care workers and managers, who were approachable if they needed to express any concerns. They said that staff had required extra support to deal with the complex needs of some people and their families, but were happy to ask for this support.

We spoke with a visitor whose relative had just moved into the home. The relative was concerned about some aspects of the person's behaviour since moving into the home. We observed the 'open door' policy that the care manager had told us about. The relative went straight to the office to ask about this person and the care manager told them that they were eating and drinking fine and they were keeping an eye on them. The relative told us that they had been reassured by this conversation.

The registered manager and care manager told us that they had decided to introduce a home committee to try to obtain the views of people who lived at the home and relatives. This was because they were experiencing poor responses to surveys that they had distributed to people who lived at the home and relatives. We saw that these meetings took place each month and that two people who lived at the home, two relatives and the registered manager had attended the most recent meeting. These meetings were minuted and the minutes were displayed on the home's notice board so that they were also available to people who did not attend the meetings.

Surveys were sent to relatives and professionals several times a year and we saw the records of the surveys distributed during 2014. The registered manager told us that they struggled to get responses. For example, surveys had been sent out to relatives asking them for suggestions about how to improve the environment and they only received one reply. We discussed the frequency of surveys and how relatives might respond if they received less surveys to complete. A reduction in the frequency of surveys had also been suggested by the home's committee and the registered manager had agreed to this.

We looked at the records of staff meetings and noted that several copies of the minutes had been printed so that staff could have their own copy. Staff were required to sign a document to evidence that they had read the minutes. The records showed that meetings were held on a regular basis and that staff were invited to make suggestions and express concerns. The three staff who we spoke with confirmed that meetings were an opportunity for them to ask questions, make suggestions and express concerns, and that a positive culture was promoted by the registered manager and the care manager.

We saw that staff also had regular supervision meetings with a manager and that these meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff. Staff had annual appraisals and we saw that a notice was circulated to staff following the appraisal period giving them feedback about the positive and negative comments and issues that had been raised, and how these were going to be addressed. This evidenced that there was an open culture at the home.

Quality audits were undertaken to check that the systems in place at the home were being followed by staff. These included audits on the new system introduced to monitor people's nutritional needs, an infection control audit, the monitoring of daily care plan records and a medication audit. All of the audits identified any areas for improvement and the actions needed.

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed monthly, and again annually. This was so any patterns or areas requiring improvement could be identified. Information had been recorded in respect of a medication error. This had been recorded under the heading "Lessons learnt" and stated

Good

Is the service well-led?

"When changing supplier of chemist the transition period can create risks. Ensure photographs are done as the first priority." This showed that staff had learnt from previous incidents or concerns at the home.

We spoke with the registered manager about the key challenges to achieving excellence and they told us that they kept up to date with good practice guidance by attending regular meetings that were organised by the local authority. They had appointed 'champions' to give staff responsibility for their particular areas of interest, such as moving and handling, palliative care and dignity. The care manager told us that they had also held a staff meeting in response to a serious case review that had been reported in the national press. The recommendations of the serious case review had led them to introduce more streamlined documentation.

We checked a sample of maintenance certificates and these evidenced that the premises and equipment had been maintained in a safe condition. There was a fire risk assessment in place and there was a current safety certificate in place for the fire alarm system. In-house checks were carried out each week to ensure that the fire alarm system and emergency lighting were in full working order.