

Four Seasons (H2) Limited

# The Headington Care Home

## Inspection report

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## Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Requires Improvement ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

This inspection took place on 7 March 2017 and it was unannounced.

The Headington Care home is registered to provide accommodation for up to 60 older people living with dementia who require nursing or personal care. At the time of the inspection there were 59 people living at the service.

There was a registered manager in post. 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. The registered manager worked closely with the deputy manager.

At the last inspection on 27 January 2016, we asked the provider to take action to make improvements and ensure staff were deployed effectively during meal times, staff engaged with people meaningfully and offered person centred care and ensured people received meaningful activities and stimulation. At this inspection on 7 March 2017, we found these actions had been completed. However, we still have some concerns.

People had varied dining experiences. Some people were not always supported in a timely manner during meal times. Some staff prioritised other tasks to supporting people having meals.

People who were supported by the service felt safe. The staff had a clear understanding on how to safeguard people and protect their health and well-being. People received their medicine as prescribed. There were systems in place to manage safe administration and storage of medicines.

The Headington Care home had enough suitably qualified and experienced staff to meet people's needs. People told us they were attended to without unnecessary delay. The provider had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where risks to people had been identified, risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe.

Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they cared for.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005 and applied its

principles in their work. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

Staff treated people with kindness, compassion and respect and promoted people's independence and right to privacy. People received quality care that was personalised to meet their needs.

People were supported to maintain their health and were referred for specialist advice as required. Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People were actively involved with the local community. People were encouraged and supported to engage with services and events outside of the home. Staff supported and encouraged people to engage with a variety of activities and entertainments available within the home. Activities were structured to people's interests and people chose what activities they wanted to do. The environment was designed to enable people to move freely around the home.

Feedback was sought from people and their relatives and used to improve the care. The provider had systems to enable people to provide feedback on the care they received. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

Leadership within the service was open and transparent at all levels. The provider had effective quality assurance systems in place.

The registered manager informed us of all notifiable incidents. The registered manager had a clear plan to develop and further improve the home. Staff spoke positively about the management support and leadership they received from the registered manager.

## 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.

Risks to people were assessed and risk management plans were in place to manage the risks and keep people safe.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Medicines were stored and administered safely.

### Is the service effective?

Requires Improvement ●

The service was not always effective.

People were supported to have their nutritional needs met. However, the dining experience varied.

Staff had the knowledge and skills to meet people's needs. Staff received training and support to enable them to meet people's needs.

Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who were being deprived of their liberty were cared for in the least restrictive way.

People were supported to access healthcare support when needed.

### Is the service caring?

Good ●

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

Staff knew how to maintain confidentiality

### Is the service responsive?

Good ●

The service was responsive.

People received activities and stimulation which met their needs and preferences.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's views were sought and acted upon.

People knew how to make a complaint and were confident complaints would be dealt with effectively.

### Is the service well-led?

Good ●

The service was well led.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

# The Headington 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 7 March 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in dementia care and 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 the inspection we reviewed the information we held about the service and the service provider. The registered 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 notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We also obtained feedback from commissioners of the service.

We spoke with eight people and eight people's relatives. We looked at 10 people's care records including medicine administration records (MAR). During the inspection we spent time with people. Some of the people who used the service had communication and language difficulties and because of this we were unable to fully obtain each of their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the deputy manager and 10 staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

# Is the service safe?

## Our findings

People looked happy and appeared to feel safe living at The Headington Care home. One person told us, "I'm very happy and I feel safe". People's relatives told us they felt their family members were safe. They said; "I feel confident [person] is safe and cared for" and "Always feel that [person] is safe when I'm not visiting".

Risk assessments were in place to enable staff to support people safely. These protected people and supported them to maintain their freedom. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person's health deteriorated and they were nursed in bed. The person's pressure area risk assessment was reviewed and the person nursed on a pressure mattress. Another person had unprovoked challenging behaviour that could have potentially posed a risk to themselves and others. They had a comprehensive risk assessment in place which had been reviewed regularly and resulted in the provision of one to one care for this person.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. Staff told us, "If I have concerns I will report to the manager and safeguarding team" and "I would inform my manager and deputy manager immediately".

People benefited from staff who understood and were confident about using the whistleblowing procedure. There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. They told us, "Whistleblowing is about reporting poor care. I can whistle blow outside the organisation to safeguarding and CQC", "I would alert the safeguarding team" and "I can whistle blow in-house. We have a policy that we follow. If no one takes action, I will report to police, safeguarding and CQC".

People were supported by sufficient numbers of staff. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. Staff told us, "We generally have enough staff" and "Staffing is enough but we struggle when staff go off sick". The home used a dependency assessment tool at the beginning of care provision to assess the staffing ratio required. The dependency assessment was also completed whenever people's needs changed.

The Headington Care home followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working

with vulnerable people.

People received their medicine as prescribed and the home had safe medicine administration systems in place. The provider had a medicine policy in place which guided staff on how to give medicines safely. We observed staff administered medicines to people in line with their prescriptions. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. Staff had completed medicines training. One member of staff told us, "We have medicine training updates every six months".

Equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. Staff were aware of the providers infection control policies and adhered to them.



## Is the service effective?

### Our findings

At our last inspection On 27 January 2016 we found staff were not always deployed effectively during meal times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection on 7 March 2017 we found some improvements had been made and staff were deployed effectively during meal times. However, we found some concerns.

During lunch time we observed people having meals in all four dining rooms. The dining experience was varied and there were inconsistent practices. Where people needed assistance with their food, the support differed from dining room to dining room. For example, on the Meadows dining room, lunch was served at 12:30. One person did not receive their first meal course for nearly an hour after sitting down despite others on the table being assisted to eat their main course as well as pudding. However, staff reassured the person and apologised for the late lunch. On the Blue dining room lunch started 12:30. One person was not served lunch until 13:10. This person required assistance therefore was left eating their main meal when everyone else had finished. One staff spent more time washing up dishes when their time could have been used to support and interact with people. On the Red dining room, one person supported during lunch was given food too quickly and in far too large portions not allowing them time to digest their food.

On the Famous dining room, people had a good dining experience. The atmosphere was pleasant. There was conversation and chattering throughout the dining room. People chose where they wanted to sit and did not wait long for food to be served. People were shown meal choices. People were supported to have meals in a dignified way by attentive staff. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace. We saw staff asked people if they wanted more and this was provided as needed. We saw people supported with meals in their rooms having the same pleasant dining experience.

These inconsistent practices resulted in some people not enjoying the dining experience. Although there were generally enough staff overall to help people during meal times, staff prioritised other things rather than support people to have their meal.

We discussed these findings with the registered manager who showed us evidence they had reviewed meal times staff deployment and introduced dining experience audits which had identified these shortfalls. This had resulted in the introduction of protected meal times to allow all staff including nurses to support people during meal times. The registered manager told us this was work in progress.

People told us they enjoyed the food. One person said, "I like breakfast and it always makes me feel full". Another person commented, "I like the food. I choose from the plates what I want to eat". One person's relative told us, "[Person] is very fussy with food but they always give [person] something else if they don't like what's on the menu".

People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. The home contacted GP's, dieticians, speech and language therapists (SALT) as well as care home support if they had concerns

over people's nutritional needs. Records showed people's weight was maintained. Drinks and snacks were available to people throughout the day.

New staff were supported to complete an induction programme before working on their own. This included training for their role and shadowing an experienced member of staff. One member of staff told us, "My induction lasted for five days, I really enjoyed it". Staff we spoke with told us they felt supported. One staff member told us, "I feel very supported".

Staff told us they had the training they needed and were supported to refresh their mandatory training. Staff completed training which included safeguarding, infection control, manual handling and fire safety. Staff were supported to attend specific training courses to ensure they had the skills to meet people's needs. Staff said, "They [provider] have taught me things that I didn't know" and "I requested training in catheterisation and it was provided". We viewed staff training records which confirmed staff received training on a range of subjects.

People were supported by staff who had regular 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. They said, "My deputy manager carry's out my supervision, if I am doing something wrong then she helps me to improve my practice" and "We have supervisions every three months and we discuss updates and how to improve care". Staff were also supported to develop and reflect on practice through annual appraisals.

People were supported to access health professionals when needed. People's care plans showed people had been referred to GP and district nurses when needed. Records showed and people told us they were supported to access on going health care. People had 'hospital passports' to allow information sharing when they were admitted to hospital. This was a prepared document which had all the necessary information ready for any person going into hospital including past medical history and any medicines the person was taking.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Staff knocked on people's doors and sought verbal consent whenever they offered care interventions. Staff told us they sought permission and explained care to be given. For example, where people were supported with personal care. One member of staff said, "We knock and wait for permission to enter people's rooms".

The provider followed the Mental Capacity Act 2005(MCA) code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. The 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. The registered manager and staff were knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected. For example, one person lacked capacity to understand the importance of taking medicines. One member of staff told us, "Some residents sometimes lack the capacity to comprehend the consequences of refusing to take medicines. In these circumstances, we might act in their best interests, but we always have to explain, follow procedure, fill out a form and get the pharmacist and GP involved".

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

Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider followed the requirements in the Deprivation of Liberty Safeguards (DoLS). Applications under the DoLS had been authorised and the provider complied with the conditions applied to the authorisation. People who had DoLS in place were being supported in the least restrictive way. Staff had been trained and understood the requirements of the MCA and the specific requirements of the DoLS.

The Headington Care home was suitable for people who lived with dementia. People could move around freely in the communal areas of the building and gardens. There were several sitting rooms, the music room and garden areas, which gave people a choice of where to spend their time. Most of the home's areas were decorated in a way that followed guidance for helping people with dementia to be stimulated and orientated. The registered manager told us their plans for development were, "To improve the environment adaptation of the home and make it even more dementia friendly".

## Is the service caring?

### Our findings

People looked content with the care they received. People's relatives told us, "[Person] is treated very well, always", "Best care that can be expected" and "The care is excellent. All staff are extremely kind".

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated respect and dignity. We observed many caring interactions between staff and the people they were supporting during our inspection. For example, staff offered care to people in the lounge discreetly and took them to their rooms. Staff used distraction techniques to support people in distress. The atmosphere in the home was calm and pleasant. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. There was chatting and appropriate use of humour throughout the day.

Staff told us they enjoyed working at the service. They said, "I have been here a long time and I love working with people living with dementia" and "We are like a big family here".

Staff knew people's individual communication skills, abilities and preferences. Care plans contained information and guidance on how best to communicate with people who had limitations to their communication. For example, one person's care record stated, 'Observe for body language and gestures when communicating. Allow time for a response'. We saw staff following this guidance and communicating effectively with this person.

People were treated with dignity and respect. Staff took time to ensure people understood what was going to happen and explained what they were doing whenever they supported people. For example, we observed one person being supported with a transfer using a walking aid. Throughout the task staff explained to the person what they were doing and how they were going to support the person. Staff then made sure the person was comfortable before moving on. For example staff asked the person if they "would like a cup of tea". The person accepted this offer and staff went away and came back with a cup of tea.

People received care in private. Staff told us, "We cover residents during personal care", "We always close windows, curtains and doors to ensure privacy" and "We knock on people's doors and explain what we are about to do". People's relatives told us their family members were treated with respect. They said, "Staff here are really caring and respect the residents" and "They give [person] all the dignity they deserve".

People were supported to remain independent. One staff member described how they had recently supported a person to maintain their independence in carryout personal care tasks for themselves. The staff member told us, "It's important people stay independent, people have been independent all their lives. It shouldn't stop here". Other staff comments included; "We allow time during tasks for people to do the few things they can" and "We let residents wash their faces and hands and only help where they struggle".

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to staff. Staff comments included; "We only give out information when necessary" and "We do not discuss

residents in public".

People's advanced wishes were respected. Staff told us they involved people and relatives in decisions about end of life care and this was recorded in their care plans. For example, one person had an advance care plan, end of life care plan (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Staff understood the importance of keeping people as comfortable as possible as they approached the end of their life. They told us how they would maintain people's dignity and comfort and involve specialist nurses in the persons care. One member of staff said, "We ensure they are comfortable and follow the end of life care plan".

# Is the service responsive?

## Our findings

At our inspection on 27 January 2016, we found people did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection on 7 March 2017 we found improvements had been made.

People had a range of activities they could be involved in which included group and one to one activities. The provider employed an activities coordinator who was passionate about their role. They told us they linked activities to people's interests and hobbies. The provider used a 'Pool activity level' tool. This was framework for providing activity-based care for people with cognitive impairments, including dementia. This tool is recommended for daily living skills training and activity planning by the National Institute for Clinical Excellence Clinical Guidelines for Dementia (NICE).

Staff understood the importance of involving people in appropriate activities which were stimulating and helped people to feel involved. Records showed there were one to one activities such as walking, jigsaws, reminiscence and creative arts and crafts as well as group activities including music therapy and board games and tea parties. On the day of our inspection we observed excellent staff engagement as well as a cake baking session which was well attended. People were actively involved and staff were at hand to support people who needed help.

People who were unable to leave their rooms were protected from the risk of social isolation. We saw staff regularly visiting people who remained in their rooms and took time to chat to the people and offer food and drinks.

The registered manager assessed people's needs before they came to live at The Headington Care home. Information was sought from people, their relatives and other professionals involved in their care. This information from the assessment informed the plan of care.

Care plans were personalised and contained detailed daily routines specific to each person. The provider used an 'My choice, my community' document which captured people's life histories including past work and social life enabling staff to provide person centred care whilst respecting people's preferences. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to go to bed. People and relatives confirmed they were involved in planning their care. One person's relative told us, "We are well involved in [person's] care planning. We had a review with other professionals a few months ago".

Staff considered details of what was important to each person and used this information to engage with people and ensure they received care in their preferred way. Staff told us and records confirmed the provider had a keyworker system in place. A keyworker is a staff member responsible for overseeing the care a person receives and liaised with families and professionals involved in a person's life. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through

consistency.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, one person's medicine was making them sleepy. Staff discussed with the family and the person's medicines were reduced by their GP. Staff updated the person's care plan to reflect the changes and daily records showed staff followed the advice of monitoring's the person's behaviour. We saw this person was more alert and involved with what was going on around them.

People were supported to maintain links with the local community and volunteers were used to encourage people to build relationships through public events such as tea parties, sports days and summer fetes.

People's views and feedback was sought through regular family meetings, electronic feedback board as well as through quality assurance surveys. Records of family meetings showed that some of the discussions were around what changes people wanted, people's opinions were sought and action was taken to respond to issues raised. For example, in the last survey, people had requested more activities and these had been provided. People's relatives told us they attended the resident and relatives meeting. They said, "We attend most meetings and we can make suggestions" and "The relatives meetings are good. We get a lot of updates through them". People and their relatives also received newsletters with updates of changes and planned activities within the service.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People's relatives commented that the registered manager was always available to address most issues. One person said, "The manager is very good and responds immediately".

We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

## Is the service well-led?

### Our findings

The home was led by the registered manager who was supported by a deputy manager. The registered manager had been in post for 10 year. They demonstrated strong leadership skills and had a clear vision to improve the quality of the service. There was a clear leadership structure which aided in the smooth running of the service.

The Headington Care home had a positive culture that was honest, open, inclusive and empowering. During our visit, management and staff gave us unlimited access to records and documents. They were keen to demonstrate their caring practices and relationships with people. Staff told us they felt the service was transparent and honest. One member of staff commented, "We can discuss things openly with the management team and know they will address it. We learn from that". The registered manager told us their biggest challenge had been to ensure staff ownership and keeping up standards. They told us, "This was important to make sure we do not lose staff". The registered manager also told us, the home had managed to maintain good relationships with the community, healthcare professionals and commissioners despite their last CQC requires improvement report.

Staff were complimentary of the registered manager, the support they received and the way the service was managed. They told us, "Manager is very supportive and approachable", "Manager is strict but very good, professional and caring" and "Manager and clinical manager always very supportive. We can approach them any time". The registered manager had an open door policy, was seen around the home on inspection day and had a good rapport with people and staff. She had a hands-on approach and knew people and their relatives individually. The provider facilitated a staff 'Rock award' which was voted by people their relatives. This award scheme allowed the home to acknowledge and celebrate staff contribution and drive improvement in care provision.

People and their relatives knew the registered manager and told us the service was well managed. Comments included, "It [home] appears to be well managed" and "Manager is always reachable any time of the day". People's relatives complimented on the registered manager's availability and ability to respond to concerns swiftly.

We received complimentary feedback from health and social care professionals. They spoke highly about their relationship with the registered manager and staff. They commented on how well staff communicated with them in a timely manner.

The provider had quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including catering, medicine safety, quality of life and care plans. Quality assurance systems were operated effectively and used to drive improvement in the service. For example, a medicines audit had identified missing records for as and when needed medicines and action had been taken to ensure that record keeping in this area had improved. The registered manager undertook 'daily walkabouts' to interact and observe staff care provision. The provider undertook routine monthly quality visits to monitor the quality of care.



Staff commented positively on communication within the team. Team meetings were regularly held where staff could raise concerns and discuss issues. The meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff discussed shortfalls identified in a records audit and agreed on a plan to address it. Staff told us, "We have team meetings often and use communication books for information sharing", "We do handovers at end of every shift" and "We have good team work and always at hand to help each other". The registered manager also facilitated daily heads of department meetings to ensure every department was up to date with changes.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. The registered manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.