Care Quality Commission

Fairburn Chase Health Care Limited

Fairburn Chase

Inspection report

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Ratings

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

Overall summary

The inspection of Fairburn Chase took place on 3 November 2015 and was unannounced. We previously inspected the service on 17 March 2015 and, at that time we found the registered

provider was not meeting the regulations relating to management of medicines and supporting

staff. We asked the registered provider to make improvements. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations.

On this visit we checked to see if improvements had been made.

Fairburn Chase is a nursing home currently providing care for up to a maximum of 73 people over the age of 18. The home comprised of four units, Cygnet, Teal, Kingfisher and Athena, providing care and support for people with lifelong physical disabilities and acquired brain injuries. On the day of our inspection 43 people were being supported in three of the four units. Athena unit was currently empty, the registered manager explained the focus of this unit, when it opened, would be around enablement. This is about helping people become more

Summary of findings

independent and improve their quality of life. It focuses on helping individuals learn or relearn how to do everyday tasks for themselves rather than someone else doing the tasks for them.

The service had a registered manager in place. 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.

People told us they felt safe and staff we spoke with were able to describe various forms of abuse and the action they would take if they were concerned about a person's safety.

Recruitment of staff was thorough however, staff we spoke with said staff sickness impacted upon staffing levels.

Medicines were stored and administered safely, however, we could not evidence that all staff who had a responsibility for administering people's medicines had received relevant training.

Staff received induction and training when they commenced employment but refresher training for staff was not up to date. We saw evidence people received regular supervision.

Where people living at the home had their liberty restricted, for example, the use of coded door locks within the home, an authorisation was being obtained to ensure this was lawful and their rights were protected. Staff were able to tell us about the decisions people were able to make and where people may have needed extra support.

People were offered a choice of meals and drinks were available for people.

People told us staff were caring and kind. During the inspection we saw staff interacted with people in a friendly but appropriate manner.

The home employed life skills staff to support people to access a range of activities provided for people who lived at the home.

Care and support records were person centred and provided details which enabled staff to support people in line with the individual's personal preferences. Care plans were reviewed on a regular basis.

Complaints and concerns were logged and responded to.

The home had an experienced registered manager and clinical nurse manager in position. There was a system in place to monitor the performance of the home and where shortfalls were identified, an action plan was implemented.

Staff, people who lived at the home and/or their representatives attended meetings and were provided with feedback forms to enable them to give their opinion about the quality of care and support people received.

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?
The service was not always safe.

People told us they felt safe.

Staff told us staff sickness impacted upon staffing levels.

We could not clearly evidence medicines were administered by staff who were trained to do so.

Requires improvement

Is the service effective?
The service was not always effective.

Staff refresher training was not up to date.

The registered manager had begun to submit DoLs applications to the local authority.

People's nutrition and hydration needs were met.

Requires improvement

Is the service caring?
The service was caring.

We observed staff to be kind and caring.

Staff we spoke with understood the importance of maintaining people's privacy and dignity.

Good

Is the service responsive?
The service was responsive.

There was a range of activities provided for people who lived at the home.

Care and support plans were person centred and detailed.

There was a complaints system in place.

Good

Is the service well-led?
The service was well led.

There was an experienced registered manager in post.

The registered provider had a system in place to monitor the quality of service people received.

People who used the service, their representatives and staff were asked for their views about their care and support.

Good

Fairburn Chase

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 3 November 2015 and was unannounced. The inspection team consisted of four adult social care inspectors and a specialist advisor.

Prior to the inspection we reviewed all the information we held about the service. We also spoke with the continuing healthcare team and local authority. At the time of the inspection a Provider Information Return (PIR) was not available for this service. 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. On this occasion we had not asked the provider complete this document.

We spent time in the lounge and dining room areas observing the care and support people received. We spoke with five people who were living in the home, a visiting relative and an external healthcare professional. We also spoke with the operations manager, the registered manager, clinical nurse manager, a nurse, three care staff, a member of the life skills team, a laundry assistant and a cook. We also spent some time looking at seven people's care records, three staff recruitment and training files and a variety of documents which related to the management of the home.

Requires improvement

Is the service safe?

Our findings

One of the people we spoke with told us they felt safe living at Fairburn Chase. Another person we spoke with said, "It's wonderful here. I can leave anything anywhere and nobody takes it."

Our inspection on 1 and 16 October 2014 found the registered provider was not meeting the regulations regarding management of medicines. On this visit we checked and found that some improvements had been made.

We found that medicines were stored and administered safely. A monitored dosage system (MDS) was used for some medicines while others were supplied in boxes or bottles. We checked a random sample of medicines and found the stock tallied with the number of recorded administrations. We also checked a random selection of medicines which were stored in the controlled drugs cupboard. These are specific medicines which are classified under the Misuse of Drugs Act 1971 and where there are regulations regarding their management and administration. The stock tallied and each entry was completed and checked by two staff. We observed a nurse administering medicine to people and this was done safely.

However, we saw the entries on one person's medication administration records (MAR) had been handwritten by staff and there was no evidence the information recorded had been checked by a second suitably trained member of staff for accuracy. Having a second member of staff check hand written entries reduces the risk of a medicine error occurring.

We found medicines which required disposal were not removed from the home in a timely manner. For example, on one of the units we saw a number of medicines disposal bins and sharps disposal boxes were being stored. A staff member told us the external company responsible for collecting these boxes only visited the home every three months and so 'things pile up'. We brought this to the attention of the registered manager on the day of our inspection.

One of the nurses we spoke with told us they had received training in medicines management when they commenced employment at the home. They also told us they had been observed and deemed as competent prior to administering people's medicines unsupervised. When we reviewed the staff file for another member of staff who was responsible for administering people's medicines we saw an induction training pack which included evidence of formal training and a competency assessment regarding medicine management. However, we looked at a second staff member's training and found the last recorded evidence of medicine training was 2013. The clinical nurse manager told us all staff who were responsible for people's medicines were either completing or had completed training and competency through an external company. They said where staff had completed this, the evidence had been sent to the training provider. Following the inspection we reviewed the training matrix which had been emailed to us by the registered manager. We saw medicines training was included but nothing was recorded to evidence when staff had competed training. This meant we were unable to clearly evidence that medicines were only administered to people by staff who had the skills and competency to do so.

The registered provider's training matrix recorded that staff should refresh their safeguarding training every twelve months. The matrix recorded that 21 of the 95 staff listed had not refreshed this training for over fourteen months. This meant that not all staff may have up to date skills and knowledge to enable them to keep people safe from harm, in line with current standards of good practice. However, staff we spoke with were able to describe various forms of abuse, for example, physical and financial. Staff also told us that in the event of them having any concerns they would speak with the registered manager or the clinical nurse manager. All staff told us they were confident appropriate action would be taken should an incident be reported. A nurse we spoke with told us they had recently spoken with the local authority safeguarding team about a safeguarding concern. A member of staff told us that in the event of any incident, accident or concern being raised, staff completed an adverse incident form which was then forwarded on to a senior staff member. This demonstrated the registered provider had a system in place to record safeguarding concerns.

We asked the registered manager how they ensured they were aware of any safeguarding concerns at the home. They said they were either told verbally by staff or they were made aware when they received the adverse incident event which staff completed in the event of any safeguarding incident. We saw adverse incidents were logged and reviewed by the registered manager. This log

Requires improvement

Is the service safe?

included safeguarding concerns, accidents and incidents. We noted the analysis of one incident highlighted the need to update the training for some staff and this action had been implemented. This showed the home analysed incidents which may result in harm to people.

The home provided a variety of equipment for people, including hoists, assisted baths and showers and height adjustable beds. One person we spoke with said they had fallen out of their bed. They said they now had bed rails in place and felt 'safer' as they had not fallen out of bed again. Bedrooms had a nurse call system, however, we observed this was not visible in one bedroom and it was tied up and out of reach in another bedroom and one of the bathrooms we looked at. This meant people may not be able to summon staff support should it be required. This was brought to the attention of the registered manager on the day of the inspection.

We noted one person had marks on the underside of their forearm. This was due to them resting their arm on the wheelchair arm rest which was broken. We asked a member of staff about this and they said the person should have a towel to rest their arm on. They also told us the wheelchair fault had been reported and was scheduled for repair the following day.

We saw risk assessments in each of the care plans we reviewed and these included moving and handling and skin integrity. The risk assessments were reviewed and updated regularly. One file we reviewed had a positive risk taking agreement regarding the person's refusal to accept a particular aspect of their care and support. The registered manager explained that in the event of a person refusing a particular aspect of their care, if they were assessed as having the capacity to make this specific decision, this document was implemented. We saw the document detailed the area of concern and the risks to the individual if they did not follow staff advice. This document was signed by the person and a member of staff. This showed us the home had a risk management system in place which ensured risks were managed without impinging on people's rights and freedoms.

We asked one staff member what action they would take in the event of the fire alarm being activated. They said they had completed fire training at the home. They said when the alarm sounded, one member of staff remained on each unit to ensure people were safe. Other staff went to the fire panel to receive information and instructions from the senior person in charge of the building. Regular checks were made on the fire detection system, emergency lights and fire extinguishers. We saw the registered provider had a business continuity policy in place. This showed us the home had systems in place in the event of an emergency situation.

Recruitment practices were thorough. We looked at three staff files and saw candidates had completed an application form, notes were kept of the interview and references obtained. One of the staff files we reviewed was for a member of nursing staff and we saw evidence the registered manager had confirmed their professional registration was current. This showed the registered manager had ensured staff members were continuing to meet the professional standards that are a condition of their ability to practise. Potential employees had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We asked one person who lived at the home if there were enough staff to meet people's needs. They said, "The care workers do a good job here but there should be more of them, there isn't enough." Another person we spoke with said, "They keep sending carers to other places. Sometimes it affects you getting care. Too many people and not enough staff."

All the staff we spoke with said they felt the home needed more staff, although three staff said the issues were around staff sickness. One staff member said problems occurred when they had to send staff to cover sickness on other units. Another staff member told us the registered manager seemed to be taking action with staff whose sickness record was problematic. When we spoke with a staff member who was not a support worker they said they often had to help the support staff with their duties. On the day of our inspection we were told that two support workers had rung in sick for the day. One staff member told us staff from another department had helped the staff with their duties that morning. During the inspection we observed staff to be busy but people's needs were met in a timely manner.

We asked the registered manager how the home was staffed. They explained there were various departments with designated 'heads of' who had responsibility for

Requires improvement

Is the service safe?

managing their own team. This included housekeeping, catering and life skills staff. The life skills team were a small group of staff whose roles was to provide activities and enablement programmes for people who lived at the home. The registered manager said agency staff were employed at the home but they tried to ensure they had the same staff where possible to ensure consistency for people. The registered manager also told us the home operated an on call rota. This recorded the name of a senior person employed at the home who staff could contact in the event they required support or advice outside of office hours.

The home was clean and tidy throughout. Personal protective equipment (PPE), for example, aprons and gloves were available and we saw instructions throughout the home reminding staff of appropriate hand washing techniques. This showed the home provided a clean environment for the people living there.

Requires improvement

Is the service effective?

Our findings

Our inspection on 1 and 16 October 2014 found the registered provider was not meeting the regulations regarding supporting staff. On this visit we checked and found that improvements had been made.

Each of the staff we spoke with told us they received regular training in a variety of topics. These included moving and handling, infection prevention and control and none abusive psychological physical intervention. We also saw evidence of recent training in the three staff files we reviewed. The clinical nurse manager told us that most training was delivered face to face with staff with much of the refresher training planned on a rolling schedule.

When we reviewed the registered provider's training matrix we saw this listed the staff employed at the home, the name of the training course, the time frame for refresher training and the date the training had been completed. Where people had gone over the time frame to update their training, these cells were highlighted red. We saw that a significant number of staff were not up to date with their refresher training. For example the matrix recorded 18 of the 95 staff listed needed to update their infection control training, 21 of the 95 staff listed had not refreshed their safeguarding training for over fourteen months. and 21 staff needed to refresh their moving and handling training, 18 of which had not refreshed this training for over 14 months. The matrix recorded this should be refreshed every 12 months. The staff training matrix also indicated that training in the Mental Capacity Act 2005 was to be updated every 12 months. However, 31of 95 staff had not refreshed this training for over two years and the matrix also indicated the registered manager had not completed this training.

The clinical nurse manager told us the mandatory training dates were planned on a rolling schedule. They showed us the duty rota for the coming month which indicted where some of the staff were listed to attend the required training. This showed that while not all training was up to date, plans were in place for staff to update their training as required. Ensuring staff receive regular updates to their training means staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

Staff who had been employed in recent months told us they had received role specific induction and all the staff we spoke with said they received regular supervision. We saw evidence in the three staff files we reviewed of supervision between staff and their manager. This showed staff were now receiving support and supervision to monitor their performance and development needs. One of the files we reviewed was for a staff member who had been employed at the home for over five years. We only saw one appraisal record in their file but as this was not signed or dated we were unable to evidence if this had been completed recently. The registered providers policy recorded staff should receive an appraisal of their performance on an annual basis.

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.

The registered manager told us they had begun to submit DoLS applications to the local authority but as yet none had been approved. This showed that although some people had been deprived of their liberty, the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure a person's rights were protected. The registered manager also said there were a further eight or nine people for whom they still needed to submit an application.

Staff we spoke with were aware that the people they supported may need help with decision making. For example, one staff member told us how they involved the people they supported in making decisions. They also said that if more complex decisions were needed and the person lacked the capacity to make these decisions they would involve other people in this process, for example, the

Requires improvement

Is the service effective?

person's family and social worker. Another staff member talked to us about the people they supported and their differing levels of capacity. They told us how one person had full capacity but another person's capacity fluctuated.

One of the care plans we reviewed had a capacity assessment and this recorded the person's level of cognition and how this affected their day to day decision making. We also saw evidence in the care plans we reviewed where people had signed their consent to having their photograph taken and to being weighed.

We asked one person about the quality of the meals they received. They said, "Some days it's fantastic, other days it's not." Another person told us, "The food is marvellous. If I don't like it I say 'take it away' and they bring me something else."

Staff told us people chose what they wanted to eat from the menu. We saw a food order sheet in one of the dining rooms and this listed a choice of three main courses and three deserts for one of the meals. We observed lunch on one of the units and saw the portion sizes served to people were large and people were also offered bread and butter with their meal. Condiments were available for people to use and we saw one person was provided with a plate guard to support their independence. On another unit where we observed lunch we saw there was a good selection of hot food and people were offered a choice, although bread, condiments and drinks were not available on the tables and people had to ask staff for these items.

Care plans recorded the support people needed. For example one care plan detailed the position the person needed to be in for them to eat. Another person's care plan recorded, '(person) would put large amounts of food into their mouth and struggle to chew it, this would put them at risk of choking'. The care plan instructed staff to encourage the person to eat in the dining room where they could be observed but the care plan did not record the action staff should take in the event the person declined to eat there.

We saw drinks machines were available for people to access as they wished and when people asked for a drink, this was provided. We reviewed a food and fluid chart for one person and found it was completed in sufficient detail to provide an accurate record of what the person had eaten and drunk throughout the day.

We saw evidence in each of the care plans we looked at that people received input from external health care professionals. For example, the GP, dietician and a respiratory nurse. The home also employed a physiotherapist and a physiotherapy assistant. This showed people using the service received additional support when required for meeting their care and support needs.

Fairburn Chase was a purpose built building with accommodation and communal areas over two floors. One of the units we saw people's bedroom doors had their names on. Many of these were hand written with art work done by the person whose room it was. Communal areas were homely in character with chairs and sofas for people to sit on. Wet rooms and assisted bathing facilities were available for people.

Good

Is the service caring?

Our findings

We asked people if staff were kind and caring. One person said the staff looked after them and treated them well. Another said, "Staff are fairly nice, they help me get into my chair." A staff member said, "I love it here, it's a good home, I have banter with people when I am doing my job, they (people) enjoy that."

An external health care professional who was visiting the home on the day of the inspection said, "Staff are always happy to help and to listen."

During the time we spent at the home we observed caring, friendly interactions between staff and people who lived at the home. For example, we saw one person's nose was running and a staff member promptly provided a tissue and helped the person to wipe their nose. Another person was leaning in their wheelchair and a staff member asked them if they were comfortable and then used a cushion to support the person. When this did not work, they took the person from the room. We saw that when they returned the cushion had been placed in a position which meant they were no longer leaning in their chair.

We asked staff if anyone who lived at the home had an advocate. Staff told us one of the units that no one had use of an advocate but on another unit they said a person had an advocate to support them with their money. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

We saw certificates on the wall for two staff who were dignity champions at the home. When we spoke with one staff member, they told us they were a dignity champion and explained why they felt this was important to them and the people they supported. Dignity champions are staff designated to ensuring all staff are committed to taking action, however small, to ensure people are treated with compassion, dignity and respect. We asked staff how they maintained people's privacy and dignity. One said, "We knock on doors, close doors and curtains. We also keep people covered with towels." Another said, "We knock before we enter (rooms) and we keep people covered up at all times, be discreet." This staff member went on to tell us how staff maintained one person's dignity when they ate their meals. They also said, "Give people the respect you would want to receive. Don't make an issue out of things, resolve things quickly."

However, we also saw one example where two staff knocked on a person's bedroom but entered the room without waiting for a response. We also heard a staff member tell a person they needed to use the toilet. This was said loudly in front of other people who were present.

People's care and support plans were stored in a staff office which was accessed by a coded lock. This prevented unauthorised access to people's records.

Care and support plans recorded the goals people wanted to achieve. One person wanted to be able to go home. The registered manager told us there had recently been two people who had gone to live elsewhere as they no longer required the 24 hour support provided at the home. They explained the focus of the Athena unit, which was not yet in use, would be around enablement. This is about helping people become more independent and improve their quality of life. It focuses on helping individuals learn or relearn how to do everyday tasks for themselves rather than someone else doing the tasks for them.

Good

Is the service responsive?

Our findings

We asked people how they spent their time at the home. One person told us about the activities they participated in. This included arts and crafts, gardening and Tai Chi. Another person told us they had been on trips to Whitby and Scarborough.

We saw information on display throughout the home about the activities available for people to participate in, including a Halloween disco that had been held on 31 October a coffee morning and a proposed trip to the theatre. There was a pool table on one of the units and we saw a selection of newspapers in another communal lounge.

We observed an activity session on one of the units and this involved nine people and a member of staff. This activity was memory and reminiscence themed and we saw the staff showing people photographs of places where they had visited. This prompted chatter and conversation between people and the staff. We also saw one person returning to the home with staff following a Christmas shopping trip. We looked at the record of activity for one person. This detailed how over a period of four days, they had participated in gardening, visited Blackpool illuminations and had a massage. Enabling people living in a care home to participate in meaningful and enjoyable activities is a key part of 'living well'.

We spoke with a member of the life skills team. They said the home employed a dedicated team of life skills staff. They said this team had been in place for a year and this had improved the social and activity provision for people who lived at the home. They said the home had a minibus but this could only take two wheelchairs at a time and therefore they tried to ensure everyone who needed the use of a wheelchair had the opportunity to participate. They also told us about the cooking club and they explained this supported people with life skills, for example, going to the supermarket and choosing food items.

One person we spoke with told us their family member visited regularly and in one of the care plans we reviewed we saw evidence their relative spent time with them on a regular basis. This demonstrated these people were supported to maintain family relationships.

Each of the care and support plan files we looked at was neatly organised and contained a variety of care plans, including, personal hygiene, mobility and eating and drinking. Care plans were written in a person centred way and recorded people's likes, dislikes and personal preferences. One care plan we reviewed recorded the person's preferred eating times and their preferences regarding the clothes and shoes they wore. Another care plan detailed where the person preferred to spend their time and that they enjoyed an alcoholic beverage every day. One care plan described the person's behaviour if they became angry, although we could not see a strategy recorded to advise staff how to deal with this situation or to reduce the individual's anxiety.

A daily record was maintained for each person who lived at the home. One of the records we reviewed was very detailed and evidenced the care the person had received, the food they had eaten and the activities they participated in. This meant we were able to evidence the care and support the person had received.

We asked the registered manager how people and/or their relatives were involved in reviewing their care plans. They said some people's plans were reviewed quarterly and other people's annually. The review included the person and where appropriate, their family. We saw evidence in one of the files we reviewed of a review being held in May and September 2015. The document recorded the names of those who attended and the matters discussed. Regular reviews help in monitoring to ensure care records are up to date and reflect people's current needs so that any necessary actions can be identified at an early stage.

We asked one of the people we spoke with what they would do if they were not happy with the care and support they received. They said, "I would tell my (relative) and they tell the staff."

We asked the registered manager how concerns and complaints were dealt with. They said any issues raised were logged in the complaints file. We looked at the complaints log and saw 21 complaints had been logged in 2015. These included minor verbal concerns, by both people who lived at the home and visitors, and a formal written complaint. The log recorded the date the complaint was raised, a brief description and the date the matter was resolved, although there was no record to evidence if the complaints had been resolved to the satisfaction of the complainant.

Good

Is the service responsive?

We saw the registered provider had a complaints policy. This recorded how to raise a complaint, the time frame for the registered provider to respond to the complaint and information about who the complainant could speak with in the event they were dissatisfied with the registered provider's response.

Good

Is the service well-led?

Our findings

One staff member we spoke with said, "I love it here. This job is like a friendly family and if you have any problems, (registered manager) and (clinical nurse manager) are here." A visiting healthcare professional told us they felt the home was 'going in the right direction'.

The registered manager told us they had been in post for a year and they had registered with the CQC in March 2015, the clinical nurse manager for approximately six months. Both the registered manager and the clinical nurse manager had a clinical background. The registered manager told us the home employed a number of nurses from different professional backgrounds, including physical and mental health and learning disability.

The registered manager was clear about their role and responsibilities. This included ensuring they reported notifiable events to the CQC for example in the event of person suffered an injury or if a safeguarding alert was raised.

We asked the registered manager who monitored their performance to ensure they were meeting the registered provider's standards. They said the operations manager visited the home on a regular basis. During their visit they reviewed and monitored the home's performance and produced a compliance report which they followed up at their next visit.

Monthly statistics were completed by the registered manager and clinical nurse manager each month. This included information regarding safeguarding incidents, complaints, people's weights and any pressure ulcers. The statistics documented any changes or actions taken, for example, a referral to the dietician. The clinical nurse manager said they were responsible for a number of audits which were completed at the home. They said this included a random sample of two care and support records a month. They explained they may complete a comprehensive audit of all the person's records or the audit may be targeted where they reviewed a particular area. Audits were also undertaken in a range of areas such as management of medicines, premises, kitchen management and health and safety and infection control. Where actions were identified, these were recorded and acted upon to drive continuous improvement. This demonstrated the registered provider had a system in place to continually monitor the quality of the service people received.

The registered manager told us a meeting for the heads of department were held weekly and individual unit meetings were held on alternate months. They said a general staff meeting had not been held for some time and this was scheduled for later in the week. We saw a notice on display informing staff of the date for this meeting. Staff also told us they attended regular staff meetings. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment for people living at the home.

One person we spoke with told us they attended resident meetings. A member of the life skills team said resident meetings were held monthly and everyone was invited. The meetings also had time allocated to a food forum where people were asked what they thought of the food, access to drinks, the menus, and availability of staff support to eat, if required. Notices for resident meetings were displayed on a notice board in each unit highlighting the date of the next meeting.

The registered manager told us they had introduced a 'you said we did board'. This was on display in the reception area and clearly displayed actions taken from resident meetings. One of the points listed was, 'you said "we want computers". We did, five lap tops were set up in a lounge'.

These examples demonstrate that people who lived at the home, their representatives and staff were asked for their views about their care and support and these views were acted upon.

A survey had been issued to people who lived at the home and/or their relatives during 2015. The operations manager told us the completed forms were posted to head office where they were analysed. They added that in the event any issues were raised which required prompt attention, this was highlighted to them to enable appropriate action to be taken. The surveys covered a range of topics including the general issues, food and drink, complaints and involvement.