Norwood

Eretz

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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection which took place on 2 March 2016.

Eretz is registered to provide care for up to ten people. The service is situated in Ravenswood Village. The village is a community for adults with learning disabilities run by the charitable organisation, Norwood. People have access to the facilities and services provided in the village. These include a café, swimming pool and horse riding. The home provides a service for people with learning and associated emotional and physical disabilities. There were nine people living in the service on the day of the visit. The service offered ground and first floor accommodation. There was lift access to the first floor. One person lives in an annexe attached to the main house.

There is a registered manager running the service. 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 who use the service, staff and visitors' safety was carefully considered by the service. Staff were trained in and understood health and safety matters and how to protect people in their care from harm or abuse. Any risks were identified and action was taken to minimise them, as far as possible. The service's recruitment procedure checked, as much as possible, that staff were suitable and safe to work with the people who live in the home. There were enough staff to give people safe care.

People's individual needs were met by a knowledgeable well trained staff team. Staff helped people to make as many decisions and choices for themselves, as they were able. People were supported to keep themselves as happy and healthy as possible.

The registered manager and staff of the service took any necessary action to ensure they were upholding and protecting people's legal rights. The service understood the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care.

People were supported by a very kind, totally committed and exceptionally caring staff team who knew people and their needs extremely well. They had developed outstanding communication systems to ensure they fully understood people's needs and wishes. People were respected and their privacy and dignity was promoted at all times.

The staff were attentive and responded in a timely way to people and their needs. People were treated with dignity and respect at all times. Individualised care planning ensured people's equality and diversity was respected.

People were provided with a variety of activities which took account of their needs, preferences and wishes.

People had regular opportunities to make their views, about the care they received, known.

People's care was overseen by an effective registered manager. Comments about the registered manager included efficient, approachable and positive. People's and others views were listened to and actions were taken to make improvements which benefitted people. The formal quality assurance system was being improved to ensure quality audits were completed regularly and monitored any required or completed developments.

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 is safe.

Properly trained and knowledgeable staff protected people from any type of harm or abuse.

Any risks to people were clearly identified and staff were instructed how to reduce them, where possible.

The service made sure that staff were trained and assessed as able to look after peoples' medicines safely and give them correctly.

There were enough staff to care for people safely.

Is the service effective?

Good

The service is effective.

People were encouraged to make as many choices and decisions for themselves as they could.

Some people could not make some decisions for themselves. The service made sure any decisions were made in their best interests and their rights were always upheld.

People were helped to contact health and other professionals, when necessary, so that they could keep themselves as healthy as possible.

Staff were properly trained in all aspects of people's care to make sure they knew how to support people in the best way.

Is the service caring?

Outstanding

The service is caring.

People were supported by very kind and caring staff. They were treated with respect and dignity at all times. People's individual needs and lifestyle choices were noted and respected.

People were helped to keep relationships with people who were

important to them.

People were provided with information in a variety of ways. These included individual communication methods, pictures, photographs and symbols.

The staff team worked very hard to make sure they understood people and people understood them.

Is the service responsive?

Good

The service is responsive

People were provided with care which took into account their individual choices and preferences and met their assessed needs.

People's care needs were reviewed to make sure staff were giving relevant care which met their current needs.

Staff responded to people and met their needs and wishes quickly.

People were given a wide variety of activities to choose from. They were supported to join in activities that helped them to enjoy their life.

The service tried to make sure that it was easy for people to make complaints if they needed to.

Is the service well-led?

Good

The service is well-led.

The registered manager was highly thought of and managed the service very well.

People, staff and others involved with the service were listened to and their ideas and views were acted upon, as appropriate.

The registered manager regularly checked all aspects of the service to make sure it was giving good quality care. Actions were taken, to improve the service for the people how lived there.

Eretz

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 was unannounced and took place on 2 March 2016. It was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law. We had not received any safeguarding notifications since the last inspection date. We had received notifications relating to Deprivation of Liberties Safeguards (DoLS) referrals and medication errors which had not caused harm.

We looked at the five care plans, daily notes and other documentation, such as medication records, relating to people who use the service. In addition we looked at quality assurance records, health and safety documentation and a sample of other records such as staff files.

We spoke with three people who live in the home. However, generally, people have their own method of communication and were able to respond by means other than speech. We observed the care people were offered throughout the duration of our visit. We spoke with three staff members and the registered manager. After the visit we received written comments from two family members, four local authority professionals and a health professional.

Good

Is the service safe?

Our findings

People indicated by nodding or repeating the word safe that they felt safe in the home. People were confident to approach staff and seek their help or attention. A professional who visited the home told us, "during my visit, I did not observe anything that I was not comfortable with" and "service users appeared at their ease in the presence of staff, and I did not observe any signs of discomfort when they had to approach staff". Another professional told us they were happy people were safe and they had never seen anything they were uncomfortable with when visiting the service. Relatives told us they were confident their family member was safe. We spoke with a local authority representative, who told us their only concerns about the service were the medication errors, which were being dealt with.

People were protected from abuse and poor care by staff who understood and fully embraced their responsibilities to safeguard people in their care. Staff had received safeguarding training which was up-dated regularly. The local authority's and provider's latest safeguarding procedures were available to staff and people who lived in the home. Staff described, in detail, what action they would take if they identified any safeguarding concerns. They told us they would report issues to appropriate external organisations, if necessary. However, staff members told us they were totally confident that the registered manager would take immediate action to ensure the safety of people who live in the service.

People were kept safe because staff developed individual risk assessments. These included areas such as bathing, personal safety, skin integrity and any other daily living needs which posed a potential risk for people. Risk assessments were incorporated into people's individual care plans and gave staff detailed information about how to minimise risks for that person and others. Everyone was supported with bathing and the water temperatures were tested before people got into the bath or shower. However, this was not always recorded to check that all staff followed the process to ensure people were kept safe from scalding. People had a personal emergency evacuation plan in place.

People, staff and visitors to the home were kept as safe as possible by staff adhering to robust health and safety procedures and policies. The service had a representative who met with the representatives from other services to discuss any health and safety issues identified. These were passed on to the health and safety team located at the head office of the provider, as necessary. Checks were undertaken to make sure equipment and the environment were safely maintained. These were completed at a variety of intervals and included weekly fire alarms and emergency lighting checks.

Additional measures were taken if any health and safety problems were identified. For example, additional water temperature checks were made, under the guidance of the environmental health agency, because some issues had been noted with the water purity in the service. These included flushing water outlets daily and external specialists completing monthly water checks. Other health and safety maintenance checks included gas safety (last tested February 2016), lifting equipment checks (February 2016) and the electrical installation check (2013, due every five years). The service had a business continuity plan (emergency plan) which covered a variety of emergency events. These included electricity outage, flood and other weather problems. Staff had access to an emergency grab bag which was located by the front door and provided

information and guidelines to assist staff in difficult situations.

The service learnt from any accidents or incidents that occurred. The staff team recorded all accidents, incidents and 'near misses'. Accident and incident forms were added to the provider's computer system to ensure that any learning was shared with other services run by the provider. Investigations and any actions taken were clearly recorded on the forms and added to care plans or risk assessments, as necessary. Accidents and incidents were a standing agenda item, for discussion, at staff meetings.

People were given their medicines safely. There had been eight medication administration errors during the previous 12 months, none had caused harm. However, the service had taken action to reduce the risk of errors. These included setting up a new clinical room where staff would not be disturbed when preparing to administer medicines and re- training and special training (for epilepsy medicine) of staff. The service had returned to classroom rather than e-learning training for medication administration, as they felt it was more effective to train and assess staff in that way. They had transferred to a new and simpler monitored dosage system (MDS) and up-dated the administration procedure in December 2015. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. Staff told us that the new MDS system, "was simpler to use and if you followed the new procedure you could not make a mistake".

There had been one recording rather than administrative error when giving people their medicines, in the two months of 2016. The medication administration records (MARs) were accurate and showed that people had received the correct amount of medicine at the right times. People had guidelines for the use of any PRN (to be taken as necessary) medicines and a stock check list of them was kept. The pharmacist visited in December 2015 and had made six recommendations which had been completed.

People's finances were looked after by a variety of methods. Each person had a financial file stating their expenditure and income. However, it was not always clear who held overall legal responsibility for people's finances. The registered manager undertook to clarify this issue with the provider. The service had a robust system of recording the personal money they held on behalf of people. Financial records were accurate and up-to-date. People's money was checked whenever it was accessed and by the registered manager on a regular basis. An auditor checked people's money a minimum of annually. People paid a contribution to the cost of vehicles from their benefits and then paid a contribution to fuel usage. A vehicle book clearly recorded all contributions to fuel costs.

The service followed a recruitment procedure designed to ensure people were supported by staff who were suitable and safe. The service was supported by a human resources office that completed recruitment checks prior to people being offered a post. These included Disclosure and Barring Service (DBS) checks to confirm that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults. Fully completed application forms and validated references were available to the registered manager, who viewed them prior to making an appointment. Interview notes were held on staff files and used to form a basis for future supervision and training.

There were enough staff to ensure that people were supported to enjoy a meaningful lifestyle designed around their needs, choices and preferences. There were a minimum of five staff on duty from 7am until 9.30 pm and two staff awake during the night. They were supported by a registered manager who spent time in the service, generally on week days but sometimes at weekends, and a small number of ancillary staff. The service used bank staff, staff working extra hours and agency staff (in emergencies) to cover staff shortages. There were always staff on duty who knew people well. Rotas for January 2016 showed that staffing numbers did not drop below those identified by the service as minimum. Staff members told us that there were, ''enough staff to keep them [people] safe and help them enjoy themselves". The registered manager

was able to make daily decisions about staffing levels to ensure people's comfort and safety based on their needs and activities.

Good

Is the service effective?

Our findings

People indicated by nodding and smiling that they were well looked after. Relatives told us, " the manager with her staff are very good to [name] . Their care package is very good and staff get on well with [name]. Another told us, "I also believe that all of [name's] needs are being met, with regard to their day-ops, including physio therapy, and recreation". A professional told us, "They have ensured they have made contact with relevant medical professionals in a timely and appropriate manner".

People's health needs were identified and effectively addressed. Part of the care plan was entitled, "In order to keep me healthy and safe" which noted people's health needs. People received annual health and well-being checks and were referred to other health professionals such as dieticians and speech and language team (SALT). Detailed, accurate records of health appointments, health referrals and actions were kept. Records were kept, if necessary, of health issues such as epileptic seizures. A professional noted, "during the review meeting the home manager stated that the care team has been in liaison with the GP and any other relevant professionals when they had concerns regarding the client's health". Another told us, "they have ensured they have made contact with relevant medical professionals in a timely and appropriate manner". People's individual care needs were included in their care plans. The plans were very detailed and clearly described the action staff were to take to meet people's current needs. Care plans included all areas of care, such as continence, mobility and personality and behaviour, relevant to that person. Each care plan had a simple overall care plan summary presented in a format of pictures, symbols and simple English. Staff and people could find the most important information about the person and how to support them very quickly. These summaries cross referenced with the detailed care plan and risk assessments.

People were supported and encouraged to choose a well-balanced nutritious diet. People chose their own breakfasts and lunches on a daily basis. They helped to develop weekly menus for the main meal. Photographs of different meals were used to help people make their food choices. The service followed Jewish food guidelines and provided kosher food. The service followed eating, drinking and swallowing guidelines for individuals, supplied by SALT and health eating guidelines supplied by the dietician. Food and fluid charts and weight records were kept and reviewed regularly if they had been identified as necessary. Meals were made from fresh meat and vegetables and fruit was available for snacks, as requested. Food stocks were plentiful, varied and properly stored.

The service provided people with equipment and an environment which supported their mobility and enabled them to retain as much independence, dignity and enjoyment of daily life, as possible. Examples included a ceiling hoist in a person's bedroom, if they needed to be helped out of bed. This meant that people could be supported with minimum fuss to rise and retire. A new 'sensory' bath had been supplied to enhance people's bathing experience. The bath had lights, scents, bubbles and music for people to enjoy whilst attending to their personal care. Bathing or showering had been a difficulty for some people. One person who had not been persuaded to bathe for many months had used the new bath and very much enjoyed it. They, now, enjoyed attending to their personal care. People who needed to be away from other people were provided with their own space, in which they could fulfil the functions of their daily lives alone. They were able to choose whether they joined other people for daily or special activities. The provision of

appropriate space for individuals positively impacted on their lifestyle. It reduced behaviours likely to cause harm or distress and enabled them to lead a fuller life with more choices and control of their life. The overall environment was homely and welcoming. People's handicrafts and artwork was used to enhance the décor and give people a pride in their home.

People were encouraged to make their own decisions and choices, as far as possible. The plans of care included how people could and should be involved. They included areas such as, "you can help me to express myself by", "I indicate yes by", "I indicate no by" and, "the people involved in my plan". Staff described how they helped people make decisions in their day to day life. They explained that it depended on the person and what helped them most. Some people used photographs or pictures, some were shown two things to choose from and some people used particular communication methods to express what they wanted.

Consent, mental capacity and DoLS were understood by care staff. The service supported people's rights under the Mental Capacity Act 2005 (MCA). 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 the least restrictive option. 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 Deprivation of Liberties Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met.

The registered manager understood DoLS and had made nine applications to local authorities. Three had been accepted and returned and the service was meeting any conditions noted on the authorisations. Staff had received Mental capacity Act 2005 and DoLS training. They had a good understanding of what constituted a deprivation of liberty, what restraint was and when a DoLS referral may be necessary. Best interests meetings were held, as necessary and included areas of care such as health interventions and medicines.

Staff were well trained and had the skills and knowledge to enable them to meet people's individual needs. Training was delivered by a variety of methods which included computer based and classroom learning. The service had recently returned to classroom based learning for some areas such as safeguarding, MCA and DOLS and fire safety. Staff told us they were provided with very good opportunities for training. They had easy access to training and were actively encouraged by the management team to participate in all available training.

Staff received individual supervision four to six weekly and could ask for support whenever they felt they needed it. All staff received an annual appraisal, which resulted in a development plan for the individual staff member. 14 of the 18 permanent care staff had a relevant health and social care qualification and a further two staff were completing a qualification course. Staff told us they had received a thorough induction which fully prepared them to care for people.

Outstanding ☆

Is the service caring?

Our findings

Staff treated people with kindness and patience at all times. There were enough staff to ensure people could, generally, have one to one staff time, if required. A staff member told us, "it is a really lovely home, we really care about our residents , they get the best because that's what we're here for". A professional commented on how staff treated people with respect. They commented, "I also observed the home manger apologising to the client when during the meeting we were discussing delicate issues in relation to the client's behaviour, and explained to her that the purpose of sharing such information was not to judge the client but to identify the best way to support". A relative said, "my daughter seems very happy in Eretz. The home manager and staff are very good and [name] seems to have a very good relationship with them all. The way she and the other clients are treated make it a very happy home and it comes across that this is so from the moment you enter the home, the atmosphere is great".

Staff told us the registered manager cares for them as well as the people who live in the service. They gave an example of how she notices if staff appear stressed or not working to their usual level. They said she discussed any issues with them and offered additional support, as necessary. Additionally she made sure that staff did not take on too much work and complimented them on good work.

There was a high level of understanding of how important it was for people to keep in contact with their family and friends and people were actively helped to maintain relationships with them. The service worked closely with families and kept them as involved in the person's care as was appropriate. A relative told us, "she visits our home on a regular basis, she is always very happy to return after a visit, she always has a smile for everyone". Other relatives told us they were in constant contact with the service and were kept informed of any developments. Staff were knowledgeable about the needs of people and had developed strong relationships with them, their families and friends. Some people were helped to visit family members with staff offering the necessary support. For example one person was supported to visit their family with a one to one or two to one staffing ratio to ensure the visit was as positive, as possible. A positive visit had major impact on the person's feelings of well-being and contentment for the following week or two. This meant that they were happy and in a positive frame of mind to participate in and enjoy their lifestyle.

People were supported to have access to technological equipment, as appropriate, to help them keep in touch with families and friends. For example a person was helped to use a tablet to contact their family overseas via a live picture link. They were able to see and talk to a family member they had not seen for several years. This had created a real excitement for the person and enhanced a very important relationship for them. They were delighted to communicate their pleasure at seeing their family member and how they enjoyed using the tablet. Other people used such technology to enhance their communication with others, by using symbols, pictures and photographs. People had access to a computer equipped with a special keyboard so it could be used by people with sight issues.

The service understood the importance to people of continuity of care. Wherever possible only staff who knew individuals supported them. If agency staff were used, those who had worked in the service previously were requested. They always worked alongside experienced staff members who knew people well. The

registered manager worked hard to minimise the turnover of staff by being supportive and valuing them. A relative commented, "You also know that things are good there because of the very little turnover of permanent staff". Staff knew people extremely well and were able to communicate with them very effectively. Staff were able to identify if people were not particularly happy and change their mood with appropriate interventions. For example one person who was withdrawn and uninvolved was positively persuaded by humour, using their communication system to participate in the daily life of the home.

People and their families or representatives were as involved in their care planning and annual reviews, as far as they were able and was appropriate. People's key workers discussed their care with them every month. They used people's individual communication systems to ensure they were able to understand and comment upon their care plan. People were encouraged to express themselves and make as many decisions as they could.

People were given information in a way which gave them the best opportunity to understand it. Care plans included the person's communication plan and described what the best way to offer information was. Each person's communication system was different and this was clearly described in their individualised care plan. Examples included a communication chart for somebody with little speech. It noted, "at this time if [name] does {this} we think it means {this} and we do {this}". Additional headings were, "good ways of talking to me", "how I give you information", "you can help me express myself by" and, "I particularly enjoy communicating about". These were amongst a large number of other communication guidelines noted on people's individual plans.

Staff were highly skilled at interacting with the people in their care. They used a system called, "great interactions". This taught staff how to interact with people, who may or may not use speech as their main communication method, in a positive way. The system ensured staff could show 'warmth' and responsiveness and could observe and listen to people effectively. The registered manager and staff told us this had a very positive impact on people's involvement and participation in daily life. They gave an example of how a person who had not been out on the community for years was regularly going out with staff support and encouragement. Throughout the visit staff were communicating and interacting with people in a respectful and positive way.

People were treated with respect and their privacy and dignity was promoted at all times. Staff described what action they took to ensure they upheld people's privacy and dignity. They gave examples of knocking on doors, using technology and offering person centred care. The use of appropriate assistive technology helped staff to respect people's privacy and dignity. A specialised IT team provided equipment such as movement alarms which were designed to meet an individuals' safety needs whilst ensuring they had as much privacy as possible. These meant that staff no longer had to open people's doors and intrude on their privacy or inadvertently wake them, for regular safety checks. The registered manager and staff told us people had benefitted because they had much more privacy and dignity.

Staff were committed to providing compassionate and skilled end of life care. The service respected people's choices with regard to where and how they wished to be cared for at the end of their life. They worked with and followed advice from other professionals such as community nurses and a specialist hospice charity. They ensured that they sought the necessary help and training to enable them to give people the best possible care and keep them as comfortable as possible. One professional told us, "I have been very impressed with the way they have supported an individual who is at end of life planning stage. They have taken into account the needs and wishes of the person respecting their dignity at every step of their illness". People were kept comfortable, pain free and were able to enjoy their lives as much as possible. Plans of care showed they were amended in response to people's changing needs and

preferences. Daily notes showed how compassionately and sensitively people were cared for.

Good

Is the service responsive?

Our findings

People's care plans showed that staff listened to them and supported them in the way they wanted. Throughout the visit staff responded to people's needs and requests for attention. They were able to identify any needs displayed even if the individual could not verbalise or communicate them clearly.

People were offered totally person centred (individualised care) which focused on their individual needs. Any special needs were met as part of the strong culture of equality and diversity. Staff had received training in, "person centred approaches to learning disabilities", "person centred active support" and, "person centred key working". Staff told us that the service was absolutely committed to person centred care and ensured that staff understood and worked to its principles. Equality and diversity training was provided and this was reflected in staff's day to day work. Support plans gave very detailed descriptions of the people supported and they were provided with activities, food and a lifestyle that respected their choices and preferences.

People's needs had been assessed before they moved in to the service. They and their families, social workers and other services were involved in the assessment process. A care plan was written and agreed with individuals and other interested parties, as appropriate. Care plans were reviewed every month by the key worker and the individual and a formal review was held once a year and if people's care needs changed. A professional commented, "The home manager produced an annual progress report on the client in order to highlight any significant events which occurred in the past year, which gave me the opportunity to identify and address any concerns/issues as well progresses". Another said, "They have been quick to react to changes in the individual's health and have offered great support to the individual's mother".

People's care plans were detailed and up-to-date. Staff were very knowledgeable about the care they were offering and why and were able to offer people individualised care that met their current needs. Staff communicated with each other by a variety of methods, such as written and verbal handovers, daily diary entries and people's daily records. Plans of care included areas such as personal care routines and, "these are my favourite ways of spending time with people". The detailed information contained ensured staff could respond appropriately to people's individual preferences and wishes to try to make sure they enjoyed their lifestyle, as much as possible.

People had individual activity programmes which were developed with the person. Part of the care plan was entitled," activities I have and enjoy". They were flexible and could be changed spontaneously depending on people's health, mood and choices. A record was kept of the activities people participated in and comments made about their enjoyment of them. The service supported people to access a variety of activities that were meaningful and relevant to them. Activities included carriage driving, swimming, attending day centres and community activities. Staff told us they were always looking for new activities and opportunities for people. They gave examples of people participating in power boating, hot air ballooning and wheelchair ice-skating, they said their next project was wheelchair tobogganing.

Most people were not able to make a formal complaint without the assistance of staff or friends and

families. Staff were aware of this and described how they would interpret body language and other communication methods to ascertain if people were unhappy. Information was provided for individuals in a way that they may be able to understand such as in pictorial and symbol formats. One informal complaint had been received by the service in the previous 12 months. This had been successfully resolved at the informal stage.

Good

Is the service well-led?

Our findings

Staff and other professionals told us the registered manager was efficient, knowledgeable and very approachable. Staff members felt very supported and spoke of the registered manager's ability to 'model' good care practice. A staff member said," the team is very valued and listened to, the manager is very supportive and well liked". Another told us, "this is a really lovely home with a positive and homely atmosphere. There is an open culture and the service users are the centre of all we do". A professional commented (with regard to the registered manager's efficiency). "The home manager provided me with all the information and documents I needed in order to complete my work".

The care people received was assessed, maintained and improved by the service. There were a number day to day and overall monitoring systems to ensure standards were maintained. Examples included night monitoring visits and health and safety audits. A quality assurance audit was completed every three months. However, there had been a gap in the completion of these audits of several months, the registered manager had recently completed one. There was, currently, no regular monitoring of the quality of the service undertaken by the provider or management external to the home. This meant there was not an objective overview of the quality of the service. However, the provider was responding to discussions with the Care Quality Commission and a visit by the provider's quality and compliance manager was planned for 7 March 2016. Whilst records of quality checks were not always kept or up-to-date this did not reflect on the quality of care the service offered. Improvement needed had been noticed by the registered manager and staff team and had been actioned. Examples included environmental refurbishments and changes to medicine administration.

People's views were listened to at three monthly key worker meetings where people were encouraged to discuss their care plans and lifestyles. During the reviews staff used people's individual communication methods to gauge their satisfaction levels and what changes people may want. Additionally staff observed people closely and responded to any different or unusual behaviours. The service held regular team meeting which included discussions about the policies and procedures, people who live in the service and the daily life of the service. Changes made as a result of listening to people and staff included increasing the variety of activities available and using ,"Great Interactions" methods of interacting with people who live in the service more effectively. A relative commented on the overall standard of care offered, "of course I realise that this is a care home, but from my experience I don't think [name]could do better than where she is now"

Staff were kept up-to-date with any new developments by various means. Examples included up-dating training regularly and attendance by a staff member at conferences for specific conditions, the content of which was shared with colleagues. Additionally the provider's quality and compliance manager and manager meetings shared information across services in the village.

People's needs were accurately reflected in detailed plans of care and risk assessments. People's records were of good quality and fully completed. Records relating to other aspects of the running of the home such as health and safety maintenance records were accurate and up-to-date (with the exception of some auditing processes).