Ripon Care Limited

The Moors Care Centre

Inspection report

155 Harrogate Road
Ripon
North Yorkshire
HG4 2SB

Tel: 01765604107
Website: www.bluebrickhealthcare.com

Date of inspection visit:
02 May 2017

Date of publication:
06 June 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 2 May 2017 and was unannounced. The service registered with the Care Quality Commission (CQC) in June 2016 and this was the first inspection.

The Moors Care Centre is a care home with nursing provision for up to 70 people. The service provides accommodation and support to older people and people over the age of 18, who may be living with dementia, mental health problems, physical disabilities or sensory impairment. At the time of our inspection there were 55 people who used the service. The building is new and purpose built with a basement floor containing utility facilities and a cinema and a further three floors offering single room accommodation to people who use the service. The top three floors all have various communal spaces including lounges and dining rooms. The ground floor level also has a café facility and a hairdressing salon. At the front of the service is a car park for visitors and staff and there is disabled access into the building.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 were well cared for. The registered provider followed robust recruitment checks, to employ suitable people. There were sufficient staff employed to assist people in a timely way. Medicine management practices were being reviewed by the registered manager and action was taken to ensure medicines were given safely and as prescribed by people's GPs.

People that used the service were supported by qualified and competent staff that were regularly supervised and who were to receive their first appraisal in 2017 regarding their personal performance. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes, but the consistency of how this was recorded was variable. People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

Staff were knowledgeable about people's individual care needs and care plans were person centred and detailed. There was a range of social activities available and people's spiritual needs were met through in-house services and one-to-one pastoral care when requested.

People told us that the service was well managed and organised. The registered manager assessed and monitored the quality of care provided to people and this was checked during the registered provider visits.

People and staff were asked for their views and their suggestions were used to continuously improve the service.

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.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding adults procedures.

Assessments were undertaken of risks to people who used the service and staff. Written plans were in place to manage these risks. There were processes for recording accidents and incidents.

There were sufficient numbers of staff on duty to meet people's needs.

Medicine management practices were reviewed by the registered manager and action was taken to ensure medicines were managed safely and people received them as prescribed.

Is the service effective?

Good

The service was effective.

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

People received appropriate healthcare support from specialists and health care professionals where needed.

Is the service caring?

Good

The service was caring.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the

staff.

People who used the service were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs, their interests and preferences in order to provide a personalised service.

Staff supported people to maintain independent skills and to build their confidence in all areas and people told us there was a good range of activities and entertainment that met their needs.

The people who used the service were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager who supported the staff team. There was open communication within the staff team and they felt comfortable discussing any concerns with the registered manager.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there. The registered provider carried out regular visits and audits as part of their monitoring of the quality of the service.

The Moors Care Centre

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 registered 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 2 May 2017 and it was unannounced. The inspection team consisted of three adult social care inspectors and two experts-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. The experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and people living with dementia.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We also contacted Healthwatch who had recently completed an 'Enter and View' visit to the service. We reviewed all of the information we held about the service, including notifications sent to us by the registered provider. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service, which they are required to do by law. The registered provider submitted a Provider Information Return (PIR) in April 2017 within the given timescales for return. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection we spoke with six people who used the service, five relatives and three visiting health and social care professionals. We spoke with the registered manager, deputy manager, a company director and the area manager. We also spoke with the training manager and six members of staff. We used the Short Observational Framework Tool for inspection(SOFI). SOFI is a way of observing care to help understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and looked at the level of support provided to people throughout the day.

We looked at six people's care records, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We looked at how the service used the Mental

Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for three members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment.

Good

Is the service safe?

Our findings

All the people we spoke with at service said that they felt safe living there. Comments included, "It's brilliant, it's clean, good and there are people to help you when you need it" and "I feel safe now, I can come to no harm here. When I first came here I wanted to have a lock on my door. I have my own lock on the door but I don't use it, I have my door open and people pop in."

The service used a 'Dependency tool' to determine what levels of staff were required each week to meet the needs of people who used the service. We were also given copies of the last four weeks rotas; these did not define which staff were on shift in each unit, but gave the numbers for the whole building. The registered manager told us that staff were allocated a unit to work on at the start of every shift.

Staffing levels were high and the staff to people ratios observed in all contexts were appropriate for participation and safety in the activities of daily life. On the day of our inspection there were 55 people using the service, but only 12 required nursing care. We found there was one nurse, two team leaders and nine care staff on duty during the day. At night the numbers of staff reduced to one nurse and six care staff. Additional ancillary staff were employed to cover maintenance, domestic, kitchen and laundry duties.

The majority of people who used the service were satisfied with the levels of staff and told us, "The staff do talk and interact with me," and "I never have to wait long when I press the buzzer." However two relatives said, "No, not enough staff full stop" and "Sometimes you don't see staff about particularly at the weekends." We explored this further with staff and the registered manager, looking at people's needs and the rotas. We found no evidence that there were staff shortages, unless the service was given short notice of staff illness. We spent time observing daily life on all units and we found that staff did not appear rushed during our inspection and there was a good atmosphere in the service. Staff told us, "We are well supported by the management team and at the moment are fully staffed."

Staff received training on making a safeguarding alert so they would know how to follow local safeguarding protocols. Staff told us they would have no problem discussing any concerns with the registered manager and were confident any issues they raised would be dealt with immediately. There was written information around the service about safeguarding and how people could report any safeguarding concerns. The service had linked with the local authority who provided in-house safeguarding training for staff around people with dementia and safeguarding. The staff told us, "Where people exhibit anxious behaviour we talk to them calmly and keep calm ourselves. We try to get them interested in something else, This is part of the distraction techniques we use."

We looked at the recruitment files of three members of staff and saw the staff recruitment process was safe. It included completion of an application form, full work history check, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with

job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

There were care notes and risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. Accidents and incidents were recorded, analysed each month and were audited to identify any patterns that might be emerging or improvements that needed to be made.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. A copy of the fire procedures was seen in people's bedrooms and a fire risk assessment was in place. People who used the service had a personal emergency evacuation plan (PEEP) in place; a PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency. We discussed with the registered manager that these could be improved by having the date of completion on them and they agreed to do this immediately.

Service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by staff, maintenance team and nominated contractors. These environmental checks helped to ensure the safety of people who used the service.

Fire drills had taken place but we saw not all staff had taken part in a fire drill to ensure they had the confidence and competence to do this. Fire drills were not practiced to understand if the actual number of staff on shift could carry out the process, because they were completed when large volumes of staff were in the building such as for meetings. The registered manager had noted this as part of their monthly quality assurance and the maintenance officer had arranged for the fire brigade to attend and support a practice evacuation with night staff.

People we spoke with said that they got their medicines regularly and thought they were given as they should be. One person said, "I used to do my own when I was at home. Since coming here I cant be bothered and having the staff do it for me means it is one less thing to worry about."

Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge was checked daily and recorded to monitor that medicine was stored at the correct temperature. There was a thermometer on the wall of the medicine rooms and we saw that staff were recording the room temperatures daily.

CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. These were regularly monitored by the nurses. We found that the CD register was completed accurately and CD stocks matched those recorded in the register.

The deputy manager was able to tell us about how they returned unused and unwanted medicines to the pharmacy supplier. There was a 'return medicines' book in place and appropriate storage containers for return medicines to be kept in. The return medicines were picked up by the pharmacy on a regular basis.

We found that handwritten entries on the MAR charts did not have two staff signatures to show that what had been recorded by the staff matched the instructions on the pharmacy label of the medicine packet or bottle; this is considered to be good practice. The registered manager told us that they would speak to the

staff immediately and ensure best practice was followed at all times.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). We found no evidence that people had not received their medicines as prescribed, but there were some recording errors. These included missing signatures on the MAR sheets and a lack of recording of medicine quantities and stock balances on the hand written medicine sheets. These were discussed with the registered manager who said medicine errors would be followed up by giving staff supervision and additional training. The deputy manager would also carry out daily audits until staff practice improved.

All areas we observed were very clean and had a pleasant odour. We saw that personal protective equipment (PPE) was available around the service and staff could explain to us when they needed to use protective equipment. Ample stocks of cleaning materials were available. We saw that the domestic staff had access to all the necessary control of substances hazardous to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely. People who used the service said, "The home is kept very clean" and "It always smells nice and there is always staff cleaning."

Good

Is the service effective?

Our findings

We asked people who used the service if they felt the staff were sufficiently skilled and experienced to care and support them to have a good quality of life. All of them said "Yes." One person told us, "Well I don't know what they should be trained like, but they look after me okay" and another person said, "I would say it's improved. Staff seems better trained and they know how to look after me properly."

There was a robust induction and training programme in place for all staff. Staff who were new to the caring profession were also required to complete the Care Certificate; this ensured that new staff received a standardised induction in line with national standards.

New staff were mentored by more experienced workers until their induction was completed and they received additional supervision during their probationary period. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. There was a staff supervision plan in place and the staff files showed that staff received regular supervisions. The registered manager told us that yearly appraisals would be started later on in 2017 after the service had been open more than a year.

The staff training programme covered mandatory subjects and more specialist training. Each member of staff had their own training record kept on the computer system. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards, Mental Capacity Act 2005 and equality and diversity.

The registered provider was interested in the development of the qualified nurses and care staff so there were different training opportunities available to them. For example, a staff member was being supported and paid for by the registered provider to complete an open university nursing course as part of their continued development. Also a student nurse form the University of York was due to start on placement. The professional development officer (service trainer) had worked with the University to ensure their induction was thorough.

The district nurse had worked with the nurses to complete training on male catheterisation and supra-pubic catherisation. Training had also taken place with regard to use of a syringe driver and the district nurse also did competency checks. The nursing team had been working with the district nurse team to understand when assisted hydration would be appropriate in the end of life, they now had the knowledge to deliver this treatment if ever required alongside the GP and district nursing service. Some staff had completed the 'react to red' train-the-trainer course. This is a national initiative to improve carer knowledge of pressure area care and early identification of skin deterioration. It was planned that the trained staff would begin rolling out knowledge to the whole team.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty

Safeguards. 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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people had been assessed for capacity, and where appropriate DoLS had been sought. There was recording of Best Interest decisions and the service also ensured that families provided copies of Lasting Powers of Attorney's where they had been registered with the Office of the Public Guardian (OPG).

Staff showed awareness of people's rights and MCA. In discussions staff were clear about how they gained consent prior to delivering care and treatment. One member of staff told us, "We try to gain consent by explaining to people what we wish them to do. You can see either through words or facial expression if they are happy or not sure. I would leave the person who was not sure and re-try later. I would always leave if a person refused." We observed staff working to the principles of the Mental Capacity Act 2005. We saw they offered choice and allowed people time to process information and make their own choices. One person made such a choice about an activity they were asked to join. We saw staff respected their decision.

Information in the care files indicated people who used the service received input from health care professionals such as their GP, dentist, optician and podiatrist. We asked people who used the service what happened if they did not feel well and they told us, "The staff are lovely, they would arrange for us to see our GP or the district nurse straight away." One visitor told us, "I think they have a Doctor that comes in every week. If my relative needs to see a Doctor in-between they would get one immediately." A visiting healthcare professional told us, "It is good here. The care staff are good at letting our team know of any problems that arise."

Relatives said there was good communication with the staff especially if their loved ones were poorly or their health conditions changed. We saw that staff completed a daily handover sheet which included details of any professional visits such as from the GP with the outcome for the person who used the service. There was also a verbal handover for staff at the start of each shift so they knew of any changes in people's conditions.

People's special dietary requirements and their likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. Observation of the lunch time meal showed that staff were patient, caring and encouraging towards people who needed assistance with eating and drinking. Although on two units we saw staff stood over people as they assisted them to eat. The registered manager said they would speak to the staff directly as this was not appropriate practice. Lunch consisted of two courses and on the day of the inspection a choice of two hot meals were on offer. If people did not want either of the options then an alternative was offered. People were also offered a choice of hot and cold drinks. One person told us, "I have no complaints about the food, it is beautiful. We get two choices and if I don't like what is on offer they will bring me something else to eat."

We spent time talking with the chef who had only recently been employed. They explained they were aware of people's special dietary needs and could identify people who required a soft/blended diet, a diabetic diet or an enriched diet. The chef had lists on the kitchen wall of people's birthdays and the information about

people's personal preferences was informally directed to the chef from the staff. One person who used the service told us, "The food's good now there is a new chef, they have not been here very long."

Good

Is the service caring?

Our findings

People who spoke with us were very satisfied with the care and support they received from staff and made a number of positive comments. One person told us, "I wasn't very well last night and the carer really looked after me, they were brilliant." A member of staff said, "I enjoy my role and I would feel confident for my mum to live here. It's friendly, helpful and clean. The food is lovely and you can see the staff care, I have watched other carers be really compassionate."

The SOFI we carried out showed that staff interacted with people appropriately and continually checked that they were happy and their needs were being met. Staff were attentive and spoke with people in a low respectful tone. People were offered choice and staff knew their preferences.

We saw that a person who was poorly during the inspection was being checked every 15 minutes to monitor their needs. Staff had made the environment safe and ensured low music was playing, the window was open a little for fresh air which the person liked and they were positioned so they could see and hear their pet budgie, which was important to them.

We observed that people had their own mobility equipment such as wheelchairs, walking sticks and walking frames, which helped them move freely around the service and spend time where they wanted to. People were observed to be encouraged to be independent and signage supported people living with dementia to orientate themselves and find their way around.

People were at ease in the service and the conversations being held between them and staff were friendly and relevant to the person's interests. The care being provided was person-centred and focused on providing each person with practical support and motivational prompts to help them maintain their independence. We saw staff explain to people what was going to happen during the day, using appropriate language and giving time for people to process what was being said. People we spoke with thought the staff knew them well. One person told us, "I am the cheeky one I like to have a laugh and a joke with the staff, they are very good with me".

People said they were treated with compassion, dignity and respect. Staff told us, "To protect a person's dignity I always ask and never assume what a person wants. I make sure when supporting with personal care I take the person somewhere private, I also make sure doors and curtains are closed." People and visitors confirmed to us that staff addressed them by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when completing care tasks. People told us, "Personal care is always done privately" and "The staff always asked before moving me. Everything is explained to me first."

We observed that staff spoke and handled people carefully and professionally. For example, one person who had communication difficulties needed some help with translation and staff were on hand to help. The person pointed to their teeth indicating there was a problem with them and they needed re-fixing. Staff sorted the problem straight away and ensured the person was comfortable before leaving them.

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation was recorded in the care files.

Information was provided, including in accessible formats, to help people understand the care available to them. Discussion with people and relatives revealed that they had been involved in assessments and plans of care. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Good

Is the service responsive?

Our findings

The service was responsive. People's care plans were person-centred although the consistency of how this was recorded was variable. The registered manager told us that this was something they were addressing through staff supervision and training. Families were encouraged to input to the care files where people were unable to contribute. Visitors said, "When my relative first arrived at the service I had a few niggles. These got sorted and we are informed of everything that happens to them and this reassures us" and "Yes, we discuss everything as a family and the service has helped us."

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. We looked in detail at six of these files. The information recorded was detailed and person centred. Records evidenced that the information had been gathered from the person themselves and/or their family. The records gave staff an insight into the wishes, choices and needs of the person using the service, which helped them give care and support in line with the wishes of the person.

The majority of the care information was on a computerised system, which each member of staff had their own password to access. This ensured information was confidential and secure. However, during our inspection we asked staff where to find various pieces of information and some staff struggled to know where to look. For example, care plans for challenging behaviour sat under moving and handling on the care plan assessment. This created confusion for the staff we spoke with. Where to go to assess a change in need seemed to be hard to communicate for staff we spoke with. Discussion with the registered manager indicated that they were aware of the problems some staff had with the computerised files and this was being addressed through additional support and training. Despite the minor issues with the documentation of care needs our observations of the service showed that people received care and support appropriately and in a person-centred way.

Staff demonstrated a good understanding and knowledge of people who used the service. They told us, "Some people are already up on a morning when we arrive because they are early birds, other people like a lie in, we know what people like." Staff knew people's preferences around activities and could describe what people liked the best, one example was chair aerobics, music and dancing. Staff said that people were able to do crafts, jewellery making and people could join in with what was on offer. One member of staff said, "I know people's preferences from working with team members and we share knowledge, and finding out for myself."

We spoke with the activity coordinator at The Moors Care Home. They were employed for five days a week and, from the following week after our inspection, there was another member of staff starting who would support them with the activity programme. This meant there would be seven days per week provision of formal activities. The activity coordinator went around the building, to each person who used the service, every Monday to discuss the week ahead and ask for ideas.

Each person had a 'Map of my life' in their bedroom and the activity coordinator had been working on

developing the detail with people so a real sense of their lives was reflected and therefore staff could use it for reminiscence. The activity coordinator had looked for pictures of places where people were married and places they liked to go on holiday. They felt that once the 'Maps' were completed, staff and people could use them to real benefit to develop relationships and to look for activities people may like to try.

Activities taking place were a mix of group sessions and one-to-one interactions. The activity coordinator ensured people who chose not to join in group sessions were taken time with. The activity coordinator had planned a Hawaii event in coming months and people were helping to make decorations and prepare. People were really excited about it. One person told us, "There are quite a few things to do here. I like the exercise classes and old songs."

People told us there was a good range of activities and entertainment that met their needs. Some people told us they preferred to follow their own interests and pursuits while others enjoyed the games and quizzes offered daily. People were able to celebrate Easter and Christmas time and birthdays were celebrated as people wished. People's spiritual needs were met through in-house services and one-to-one pastoral care when requested.

Although there was visual evidence of activities taking place, the documentation of events could be better. The electronic records did not reflect that people were socially stimulated or if people spent large parts of their day alone with no interactions. There was a function in the electronic care plan to log activities separately so that staff could monitor progress, but this was not being used. The registered manager assured us that this would improve as staff confidence in the computerised system grew. Discussion with the activity coordinator indicated they were aware of the need to maintain better activity records and this was on their 'to do' list once the second activity coordinator joined the team.

People had access to a copy of the registered provider's complaint policy and procedure in a format suitable for them to read and understand. There was a complaints form for people to complete as they wished and we saw that formal complaints were responded to in writing by the registered manager in line with the registered provider's policy and procedure.

The people we spoke with said that they would have no issues if they had a complaint and were confident about talking to the staff or the registered manager. One person said, "I cannot remember ever complaining but I wouldn't hesitate if I needed to." Most people we spoke with were happy with the service. They felt if they had a problem they would be listened to.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager and qualified nursing staff. The majority of people who spoke with us was able to tell us the name of the registered manager and were confident about raising any issues with them. One person told us, "The top people are good they listen to you and help you." People told us they felt the service was well run and they were happy there.

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open, transparent and the registered manager sought ideas and suggestions on how care and practice could be improved. The registered manager was described as being open and friendly and there was an open door policy as far as they were concerned.

Feedback from people who used the service, relatives, health care professionals and staff was usually obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was analysed by the registered manager and where necessary action was taken to make changes or improvements to the service. We found an engaged, friendly and experienced staff team in place. All staff were encouraged to share ideas and reflect on their performance through team meetings and supervisions, which the registered manager said would be used to inform the staff appraisals in 2017.

Staff told us they felt well supported by the management team. One person said, "We work well as a team. There does seem to be a quick turnover of staff and I don't know why because I get on with everyone, I have always felt welcomed. Always felt I could approach the managers and [Name of registered manager] listens and reacts to sort stuff out for you." Another staff member said, "Staff meetings are useful, we are asked to come to join them. We learn new things and if anything needs changing we agree how to do this. We share practice and reflect on our work."

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. The registered manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audits were completed in March and April 2017 and covered areas such as recruitment, complaints, staffing, safeguarding, health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit. We also saw that audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. The registered provider also monitored the effectiveness of the service when they carried out visits to the service. We saw the audits and action plans completed as part of this process.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.