Warmest Welcome Limited

Westfield House Care Home

Inspection report

Ripon Road
Killinghall
Harrogate
North Yorkshire
HG3 2AY

Tel: 01423506344

Date of inspection visit:
21 June 2017

Date of publication:
08 August 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 21 June 2017 and was unannounced. The service registered with the Care Quality Commission (CQC) in September 2015 and this was the first inspection.

Westfield House is a care home with nursing. It provides accommodation and care to a maximum of 31 people over the age of 18. The service supports older and younger adults who may be living with dementia, have a sensory impairment, physical disability or a mental health condition. At the time of our inspection there were 23 people using the service, 19 of whom required nursing care.

The provider is required to have a registered manager in post and on the day of our inspection 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. Throughout this report we will refer to the registered manager as 'the manager'.

Medicine management practices were being reviewed by the manager and action was taken to ensure medicines were given safely and as prescribed by people's GPs.

Infection prevention and control practices within the service ensured the environment was clean and hygienic, but care staff and the laundry staff needed to work together to ensure best practice was followed.

People told us they felt safe and were well cared for. There were sufficient staff employed to assist people in a timely way and recruitment of staff was carried out safely.

People that used the service were supported by qualified and competent staff that were regularly supervised and appraised 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 and likes and dislikes. 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 manager assessed and monitored the

quality of care provided to people. 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?

Requires Improvement

The service was not always safe.

Medicine management practices were reviewed by the manager and action was taken to ensure medicines were managed safely.

The communal spaces and living accommodation were clean and hygienic, but care staff and the laundry staff needed to work together to ensure best practice was followed.

People were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures. There were sufficient numbers of staff on duty to meet people's needs.

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 person-centred and staff were knowledgeable about each person's support needs.

Staff supported people to maintain independent skills and to build their confidence in all areas.

People's complaints 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 manager who supported the staff team. There was open communication within the staff team and they felt comfortable discussing any concerns with the manager.

People told us that the service was well managed and organised. People and staff were asked for their views and their suggestions were used to continuously improve the service.

Westfield House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 June 2017 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We reviewed all of the information we held about the service, including notifications sent to us by the provider. Notifications are when providers send us information about certain changes, events or incidents that occur within the service, which they are required to do by law. The provider submitted a Provider Information Return (PIR) in February 2016 and we did not ask for another before this inspection. The PIR 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 used all of this information to plan our inspection.

During the inspection we spoke with four people who used the service and two relatives. We spoke with the director of care, the manager, deputy manager and chatted to two 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 three 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 created as part of 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.

Requires Improvement

Is the service safe?

Our findings

All areas in the service that 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.

We did observe that the laundry walls and floor were not sealed with paint or a washable material. This meant they presented a risk of infection as they were pervious to fluids and therefore not easily cleanable. We also saw that the care staff were not using the red dissolvable bags supplied by the provider for infected linen. This meant the laundry staff had to open black bin bags of dirty laundry and handle the contents, which in turn meant a higher risk of infection to these individuals. Discussion with the manager during the inspection indicated that they would speak to staff immediately about infection prevention and control risks. The manager also said they would arrange for work on sealing the laundry walls and floor to be carried out.

Staff had received medicines handling training and their competencies were assessed regularly to make sure they had the necessary skills. We looked at 23 Medicines Administration Records (MARs) and spoke with one nurse responsible for medicines.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the provider's policy.

We checked medicines which required cold storage and found records were completed in accordance with national guidance. However, the room temperature where medicines were stored was recorded daily, and these were not within recommended limits. The temperature of the medicines room was in excess of 25 degrees celsius (maximum recommended temperature). On the day of inspection it was recorded as 27.2 degrees celsius with 28 degrees recorded on four occasions in the last month, 29 degrees on one occasion and above 25 degrees on other days. This meant we could not be assured that medicines stored in the medicines room were safe for use. The manager arranged for an air conditioning unit to be moved to the medicine room immediately.

We looked at how medicines were managed within the service and checked a selection of MARs. There were a few minor issues that we discussed with the manager on the day of our inspection. These included missing signatures on the MAR sheets and a lack of information about where to apply external creams and lotions on the topical medicine administration records. We found no evidence that people had not received their medicines as prescribed, but there were some recording errors. The manager said the medicine errors would be followed up by giving staff supervision and additional training. Medicine audits would also be

completed to ensure staff practice improved.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that 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 the staff, maintenance team and nominated contractors.

We noted that the health and safety water temperature records for the past three months showed that one toilet facility had recorded water temperatures of the wash hand basin at above 50 degrees celsius. This presented a scald risk to people washing their hands and the maintenance person said they would get a valve restrictor and fit it straight away. We later received information from the service to say that a plumber had been booked to carry out the work, but at the time of our writing this report it had not yet been completed. Until the work was completed the provider had closed this facility for safety reasons.

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, a full work history check, a formal interview, previous employer references and a Disclosure and Barring Service check (DBS). 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. Staff were provided with job descriptions and terms and conditions; this ensured they were aware of what was expected of them. The manager had carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

People we spoke with who lived at the service told us they thought there were enough staff to deal with their needs. Comments from all of the relatives we spoke with aligned with this view. One relative said, "The staff are fantastic and the care given is excellent." During the day, we saw that call bells were answered within a reasonable time frame and observed that people were settled and relaxed in the service. People received a good standard of care.

The manager told us that currently a dependency tool was not used to assess the levels of staffing needed to meet the dependency levels of people who used the service. However, the staff to people ratios observed in all contexts were appropriate for participation and safety in the activities of daily life. The duty rotas we looked at showed that there was always someone in charge of the service in the form of the manager, deputy manager or lead nurses. Staff told us, "There are enough staff most days to get our work done to a good standard" and additional ancillary staff were employed to cover maintenance, domestic, kitchen and laundry duties.

Agency staff were used to cover any gaps in the shifts and the service was actively recruiting for additional care staff and trained nurses. We saw the manager obtained agency staff profiles which detailed the agency staffs' qualifications and experience, and they tried to use the same agency staff for continuity of care.

The provider had policies and procedures in place to guide staff in safeguarding adults. The manager described the local authority safeguarding procedures and our checks of the safeguarding file showed that there had been no alerts raised by the manager in the last twelve months. We received feedback from the local authority safeguarding team that they had no on-going concerns about the service. We spoke to staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to either the nurse in charge or the manager.

There were care notes and risk assessments in place that recorded how identified risks to people should be managed by staff. These included risk of falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a monthly basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the manager. There had only been one serious injury in the service in 2017 and this had been notified to CQC.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date and had been reviewed in November 2016, and staff had completed fire evacuation drills in February and May 2017. The 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.

The provider had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. This had been reviewed and updated in November 2016.

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, "The general level of care is good and it is a nice atmosphere in the service. Staff are very kind and look after us very well."

One relative told us, "I admire the service for how they manage my relative's mental health needs and care. The staff understand what they need and work with [Name of relative] to enable them to have as much choice and options as possible. The staff communicate with me if they have any concerns about my relative, which is appreciated by me and my family. All in all they are doing an excellent job of caring for them."

Observations showed that people got on well with the staff and there were some very positive interactions with a lot of laughter and good humour. People who used the service were interested in what we were doing in the service and we saw staff communicate effectively with them using verbal and non-verbal methods. For example, one person who used the service had a communication board to express their needs to staff and others.

There was an induction and training programme in place for all staff. Information in the staff development plan drawn up by the provider for 2017/18 indicated new starters would complete the 'Care certificate' induction after an initial orientation to the service and completion of basic training. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

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 and yearly appraisals had been completed.

The service had its own in-house trainer and their qualifications and certificates were made available for inspection. The staff training programme covered mandatory subjects and more specialist training. Each member of staff had their own training record. We saw that staff had access to a range of training deemed by the 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 nurses received support from the provider and manager to complete their registration requirements (revalidation) for the Nursing and Midwifery Council (NMC). Each nurse had their own portfolio for training, reflection and feedback. When the time came for them to renew their registration their portfolio of work was discussed with the manager who then signed it off.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that people had been assessed for capacity, and DoLS referrals were being made to the local authority. Where authorised DoLS were due to expire, further requests for renewal had been sent. An overview sheet showed that the manager was monitoring and updating these as needed. We saw there was recording of best interests decisions and the manager told us they were working on ensuring that families provided copies of Lasting Powers of Attorney's (LPA) where they had been registered with the Office of the Public Guardian (OPG).

The staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and decisions. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans. People and relatives told us about, "The excellent communication with staff" and we observed people being offered choice and asked for consent before staff carried out day to day tasks. Consent forms in the care files had been signed by people who used the service who were assessed as having capacity and for others we saw their families or LPA had signed on their behalf.

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. People received regular check-ups and staff provided people with support to attend their appointments. We asked people who used the service what happened if they did not feel well and one person told us, "The staff are lovely, they would arrange for us to see our GP or the district nurse straight away." We saw that staff recorded daily charts for food and fluid intake/output and repositioning charts were completed for individuals who required pressure relief on a regular basis.

Input from specialists such as the Speech and Language Therapy (SALT) team, dieticians, district nurses, continence nurses and physiotherapists was used to develop the person's care plans and any changes to care were updated immediately. Within people's files we found care plans relating to nutrition. These included likes and dislikes, level of understanding and methods used to encourage independence. There were risk assessments relating to nutrition, choking and swallowing and where appropriate referrals had been made to the dietician or SALT team. Dietary requirements for health or culture were provided for and the catering team were trained to provide these. Specialist diets were supervised by the nurses.

Picture menus were available for people living with dementia to aid them in making their own menu choices. Observation of the lunch time meal showed that people were able to have a choice of food to eat and the empty plates going back to the kitchen indicated it had been enjoyed. Staff offered people appropriate support with eating and drinking and their actions were patient and focused on the individual they were assisting. People told us, "Food is very nice, staff are very good," "It's always lovely. We have plenty offered" and "Very happy with the meals." One person said, "Food is quite good. Not your own home cooking, but they do their best."

We noted bowls of fresh fruit on the side in the lounge area; also snacks such as crisps were available and easily accessible for people to help themselves. There was a drinks machine full of juice and plentiful side tables in the lounge for people to put their drinks on. Everyone we met was sat with a drink to hand.

Good

Is the service caring?

Our findings

One person said they were very happy with their care and their visitor told us, "The service has a lovely homely feel and the staff are very good. All of them know me by name and I have no problem talking with them about my relative's care."

People said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. One person told us, "Staff help me to get up as I cannot walk. They treat me with the utmost respect and I do feel my dignity and privacy are respected." A second person said, "Staff genuinely care for the people who live here. They do not make you feel like 'an old person'." One visitor told us, "The staff treat [Name of relative] with dignity and respect; they are very supportive and will discuss [Name's] care with me."

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. One person told us, "I am very happy with my care and there is a lovely atmosphere in the home. Staff are kind and we are looked after very well. It is nice here."

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 observed were watching television, chatting or reading their newspapers and magazines. They told us, "If I want to do some shopping, I ask the staff and they will go with me" and "Nothing is too much trouble for the staff."

We were told by staff that people could have a bath or shower whenever they wished and information in the care files and bathing records showed that these usually took place on a regular basis. One person told us, "I get a shower twice a week" and another person said, "I get my hair done every fortnight by the hairdresser."

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the 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 were recorded in some of the care files.

People were able to move freely around the service; some required assistance and others were able to mobilise independently. We saw that people were able to spend time where they wished either in the communal spaces or in their own bedrooms. The bedrooms we saw were individually decorated and furnished to meet people's own tastes. One person told us, "I love my room and the view from the window."

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 advocacy was available in the entrance hall of the service. An advocate is someone who supports a person so that their views are heard and their rights are upheld. Relatives who spoke with us were aware of people's rights and a number of them said they had a power of attorney for finances or health and wellbeing.

We found that the service supported people at end of life. One person had an advanced care plan/thinking ahead document which detailed the need to work with the person to formulate an end of life plan. Three other people were receiving end of life care. There was no specific end of life care plan in their care file, but care had been adjusted to meet people's changing needs. We spoke with one visitor whose relative was at end of life. They had arranged for a priest to visit to give last rites. They told us, "The service is fantastic and the staff are great. I have never had any concerns about my relative's care."

Good

Is the service responsive?

Our findings

The staff were knowledgeable about the people who used the service and we found that they provided people with personalised care which was based upon their individual assessed needs and personal preferences.

The nurses carried out a variety of clinical interventions as part of their role of caring for people who used the service. They used nationally recognised risk assessment tools to assess people's level of need and reduce the risk of harm. We saw they had completed nutritional risk assessments using the Malnutrition Universal Screening Tool (MUST) and assessed people for risk of developing pressure ulcers by using a Waterlow screening tool. People's pain levels were also monitored using the Abbey pain score.

We reviewed the care files of three people who used the service and we found that the care plans contained information which detailed the person's support needs and how they preferred to receive that support. Some care files contained picture guides to support the staff to provide complex elements of care. There were risk assessments in place which summarised how to keep people safe whilst enabling them to maintain their independent abilities and maintain self-direction. One person told us, "I can't speak too highly about the kindness of the staff and the general care; I'm very happy and content."

We saw that where people had the capacity to contribute towards their assessments, care plans, and care reviews, they were encouraged to do so. Their care plans were reviewed and updated monthly with their involvement, or with their next of kin's involvement, where appropriate. One visitor told us, "The staff talk to me a lot about my relative's care, I still feel very involved in their life."

There was evidence of people's life histories being taken into account when devising support planning documentation and when planning activities both within the home and within the community. The life story work was very detailed and built up a picture of each person's history, their expectations, their life experiences, and family relationships. We also saw evidence of good transitional work and information sharing between services, such as comprehensive pre-admission assessments.

It was evident that the information contained in the care files enabled the staff to provide a personalised service to the people they supported. For example, one person who used the service liked to go shopping to buy make up and clothes. It was detailed in their care and support plan that they did this activity with friends regularly. Each outing, and the staffs' efforts to facilitate this, was documented within their daily notes. Another person's care plan said they like poached eggs on toast for breakfast. We saw in their daily notes that they'd had this meal for breakfast during the week we visited. Another person's care file said that they preferred female carers to support them during personal care interventions and this was reflected within the staffing rotas provided to us and also documented in the person's daily notes. We also saw that people's cultural and spiritual needs were accommodated at times of their choosing, a Priest was in attendance whilst we were at the service.

Activities were on offer daily and these were facilitated by an activities coordinator. People had the choice of

joining in the planned activities, although some people preferred not to join in and chose to spend time in their room or in the other communal areas within the home. The activities coordinator had plans in place to spend time with people who chose to stay in their rooms if they wished.

One person told us the activities coordinator visited them in their room and they had a talk about what activities they would like to do, such as making pom-poms, listening to music and using their I-Pad. We were told that the home had Wi-Fi access throughout and that person told us, "The access to Wi-Fi in my room is very important to me, it is one of the reason's I chose this service." Another person told us "They have a very nice married couple who come in to sing, they encourage you to join in and it's very nice. If anybody had any suggestions for activities they'd arrange it." There was an activity tree on display which held suggestions from residents and relatives and an activity board in the lounge documented what activities were taking place the week of our inspection.

A hairdresser visited the service at least once per week and there was a salon where people could go to have their hair styled if they wished to do so. There was also the opportunity for people to have their finger nails manicured and painted if they wanted this.

We saw that relatives and friends were made welcome when visiting the service. One visitor told us, "I pop in quite a lot and I am made very welcome. All of the staff know me by name; I have no problem talking to any of them." Another visitor told us, "It's the little things that make the biggest difference, like letting you bring the dogs in to visit too, it's lovely."

We observed two books which were situated in the hallway which enabled relatives and visitors to document their observations as to the maintenance or decorating issues that the users of the service may have. The books evidenced that the home was responsive to observations from visitors and actions were taken to resolve the identified issues. We also saw that the service was responsive to concerns and complaints. The service had a policy in place for dealing with complaints. The service had received one complaint this year and we saw that complaints were acknowledged, taken seriously, actions taken and apologies and explanations given where required.

Good

Is the service well-led?

Our findings

There was a manager in post who was supported by a deputy manager and qualified nursing staff. Our observation of the service was that it was well run and that people who used the service were treated with respect and in a professional manner. During this inspection we received positive feedback about staffing, the environment and positive comments about the manager. One person who used the service said, "The manager is fantastic."

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 manager sought ideas and suggestions on how care and practice could be improved. The manager was described as being open and friendly and there was an open door policy as far as they were concerned.

We saw regular checks were completed by the manager and deputy manager alongside the staff team to ensure they provided a quality and safe service. For example, checks on medicines, care plans and health and safety. The provider also completed regular checks to confirm the manager's findings. Some of the issues we found during the inspection with regard to infection prevention and control and medicine management had already been identified. We saw the provider had a business plan in place for 2017/18 and an annual development plan which set out the aims of the service and their vision of the future. The manager monitored progress against the development plan to ensure improvements were made. This meant the quality assurance system was effective.

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. Satisfaction surveys were sent out in February 2017, 30 went out and 11 were returned (37%). An analysis of the feedback was completed by the 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 were used to inform the annual appraisals.

We found the manager was responsive to staff issues and pro-active at resolving them. For example, in May 2017 the meeting minutes recorded some staff had issues with staffing levels. The staff concerns were discussed and solutions reached and agreed with staff. Infection prevention and control practices were discussed with staff and reminders were given about using good practice techniques.

The manager told us they tried to carry out monthly meetings for people who used the service, but people did not attend. The last meeting minutes were dated December 2016 when 13 people attended. The manager said they would look at different methods of capturing feedback including speaking to people on a face-to-face basis.

We asked for a variety of records and documents during our inspection. We found these were 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 manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.