St Michaels Rest Home Ltd

St Michaels Rest Home

Inspection report

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14 November 2018

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected St Michaels Rest Home on the 13 and 14 November 2018. The inspection was carried out by an inspector and an expert by experience. The first day of the inspection was unannounced. St Michaels Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Michaels Rest Home provides accommodation for up to 27 older people in one adapted building. At the time of the inspection 20 people were living there. People were living with a range needs were associated with old age and dementia. Accommodation is provided over three floors with a passenger lift that provides level access to all parts of the home.

There was a registered manager at 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.

St Michaels Rest Home had been previously inspected in July 2017. Since then the owner of the home had changed their legal entity. Therefore, this was the first inspection of the home under this new legal entity. However, the owner and the management of the home remain the same. At the previous inspection the provider was meeting all the regulations. However, we asked the provider to make improvements to achieve a 'good' rating. At this inspection we found improvements had been made and a rating of 'good achieved. However, we asked the provider to make further improvements to in relation to some records. We found some staff lacked confidence and were not always comfortable in our presence. We made a recommendation about this.

People's dignity and privacy was respected. They were looked after by staff who knew them well and were kind and caring. Staff treated people with kindness, understanding and patience. People were supported to make decisions and choices about what they did each day, and helped to retain their independence.

People needs had been assessed and support and care was planned and delivered based on people's preferences and choices. Group and individual activities were organised for people to take part in if they wished.

Risks to people were safely managed. Staff had a good understanding of the risks associated with the people they looked after. Individual and environmental risk assessments were in place and provided guidance. People's medicines were ordered, stored administered and disposed of safely.

There were enough staff working to provide the support people needed. Recruitment procedures ensured only suitable staff worked at the home. People were protected from the risks of harm, abuse or

discrimination because staff had a good understanding of safeguarding procedures.

Staff were received the training and support to deliver care in a way that met people's needs. They had an understanding of the Mental Capacity Act 2005 and DoLS and the need to involve appropriate people, such as relatives and professionals, in the decision-making process when people lacked capacity.

Staff ensured people had access to external healthcare professionals, such as the GP and specialist nurses as necessary and had established good links with local community resources.
People's nutritional needs were met and people had access to food and drink that met their needs and preferences.

People and visitors knew how to make a complaint and would talk to the registered manager if they had any concerns. The registered manager was well thought of and supportive. They had a good oversight of the service and knew where improvements and developments were needed.

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.

People's medicines were ordered, stored administered and disposed of safely.

Staff had received safeguarding training, they understood abuse and how to protect people.

Risk to people had been assessed and there was guidance for staff to follow to ensure people's safety.

There were enough staff working at the home to meet people's needs. Recruitment procedures ensured only suitable staff worked at the home.

Is the service effective?

Good

The service was effective.

Staff received ongoing training to support people and deliver care in a way that met their needs.

People were given choice and staff understood the principles of the Mental Capacity Act 2005.

People's health and well-being needs were met. They were supported to have access to healthcare services when they needed them.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff. Relatives were made to feel welcome and encouraged to stay as long as they wished.

People were positive about the care provided by staff.

People were encouraged to make their own choices and had their privacy and dignity respected.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and understood their needs. People received care that was person-centred and met their individual needs and choices.

There was an activity programme which people enjoyed participating in as they wished.

Complaints had been recorded and investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements were needed in staff confidence and some records.

There was an effective system to monitor quality and identifying areas for improvement.

The registered manager was committed to developing and improving the service.

St Michaels Rest 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 13 and 14 November 2018 and the first day of the inspection was unannounced. The inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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 contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included four staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information about the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' two people living at the home. This is when we check that the care detailed in individual plans matches the experience of the person receiving care. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving care.

During the inspection, we met with all the people who lived at the home, and those who could share their views did. We used other methods to help us understand people's experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing people in communal areas

throughout the home. We were able to see the interaction between people and staff and see how they were being supported. This included the lunchtime meals.

During the inspection, we spoke with two visitors and nine staff members, this included the registered manager and owner. We also spoke with one healthcare professional who was visiting t the service.

Good

Is the service safe?

Our findings

At the previous inspection in July 2017 we asked the provider to make improvements to their recruitment processes. At this inspection we found improvements had been made and people were protected, as far as possible, by a safe recruitment practice. Staff files included the appropriate information to ensure all staff were suitable to work in the care environment. This included disclosure and barring checks (DBS) and references. Any gaps in employment had been explored and all checks took place before staff started work at the home.

People were protected against the risk of abuse, harm and discrimination. Staff received safeguarding training, they understood their own responsibilities to protect people. They told us what actions they would take if they believed someone was at risk of harm. This included reporting their concerns to the registered manager or, if appropriate, to external organisations. There was information about safeguarding displayed around the home. Staff told us they would refer to this information if they had any concerns. When safeguarding concerns were raised, the registered manager worked with relevant organisations to ensure appropriate outcomes were achieved. Information about safeguarding concerns and outcomes were shared with staff. Throughout the inspection we saw people were comfortable in the presence of staff. They approached them freely and were happy to be in their company. One visitor told us "I am happy to leave [person's name] here and know he is safe."

People were supported to remain safe. Individual and environmental risk assessments were in place and staff understood the risks associated with people's care and support. They told us how the ensured people who remained in bed had their positions changed regularly and how they supported people to remain mobile and safe. Risks were well managed and helped people to remain safe without unnecessarily restricting their freedom or independence. There were a range of risk assessments which provided further guidance to staff. Risk assessments contained information about people's mobility, skin integrity, and nutrition. Where people were at risk of developing pressure wounds there was guidance about regular position changes and the use of pressure relieving mattresses. We observed this taking place throughout the inspection. Where people needed support with their mobility this was done safely with the use of equipment such as handling belts and standing hoists when needed. Accidents and incidents had been recorded and included details of actions that had been taken. Individual analysis of incidents helped to identify if there were any themes or trends. Staff were aware of the importance of recording any incidents or accidents that occurred.

There were enough staff working in the home to provide the support and care people wanted and needed. There were four care staff working each day plus a cook and housekeeper. The registered manager worked in addition to these numbers. The registered manager told us staffing numbers were based on people's assessed needs and they used a dependency tool to help identify the support needed. Staff told us they often covered staff shortages, for example during leave or sickness. In addition, staff from a nearby sister home would provide cover and this happened during the inspection. One of the senior carers from St Michaels Rest Home was on leave, therefore a senior carer from the sister home covered the absence. Throughout the inspection we saw staff attending to people in a timely way. Staff told us there were

occasions when they would like more staff to be working but staffing numbers were sufficient to meet people's needs.

Medicines were managed safely and records showed people received their medicines as prescribed. Medicines were ordered, stored, administered and disposed of safely. Medicine administration records (MAR's) were completed. Some people had been prescribed 'as required' (PRN) medicine. People only took this when they needed it, for example if they were in pain or anxious. Where PRN medicines had been prescribed there were individual, detailed, protocols to ensure people received these appropriately and consistently. Where people had been prescribed PRN medicines for anxiety there was information about what staff should do before giving the medicine. This included alternative approaches such as reassurance and distraction. There was information within the medicine file which showed how people liked to take their medicines, for example before or after their meals. Only staff who had received medicine training and been assessed as competent were able to give medicines. Medicine audits were completed to help identify and address any shortfalls.

Systems were in place to ensure the cleanliness of the home was maintained at an acceptable standard. The home was generally clean and tidy throughout. However, we did identify areas where further cleaning was required. This had been identified through the audit system and action was being taken. The registered manager told us the housekeeper was new in post and was working to improve the cleanliness. On occasions, we noted odours around the home. These were addressed promptly and the registered manager was able to explain the cause of these. Again, these issues had been identified within the audit system and were being addressed. There was an infection control policy and Protective Personal Equipment (PPE) such as aprons and gloves were available and used during the inspection. Hand-washing facilities were available throughout the home. The laundry had appropriate systems and equipment to clean soiled linen and clothing.

There was an ongoing maintenance and a maintenance program. The registered manager was aware of areas where improvements were needed and re-decoration at the home was ongoing. Maintenance staff were available when needed. Servicing contracts included fire safety, gas, electrical appliances, the lift and moving and handling equipment. Where works had been identified through the servicing contracts work was on-going to address these.

Environmental and equipment risks were identified and managed appropriately. Personal emergency evacuation plans (PEEPs) helped to ensure staff and emergency services are aware of people's individual needs in the event of an emergency evacuation. Regular fire checks took place and this included fire alarm testing and fire drills.

Good

Is the service effective?

Our findings

At the previous inspection in July 2017 we asked the provider to make improvements to ensure staff training was effective, especially in relation to moving and handling and their understanding of mental capacity. At this inspection we found improvements had been made and staff had a good understanding of the training they received. People received support from staff who received regular training to help ensure they had the knowledge and skills to support people effectively.

The training program included moving and handling, mental capacity, infection control, dementia and safeguarding. Most training was provided online, but practical training such as first aid and moving and handling was provided face to face. Following online training staff were required to complete and pass a test to assess their learning and knowledge. If staff did not pass the test the training would be repeated. Staff received regular supervision. This helped identify any areas where further support or development was required. There was information displayed in staff areas to remind and inform staff, this included infection control procedures and the differences between accident and incidents. Staff knowledge was also discussed during supervision. For example, staff had recently been asked about their understanding of safeguarding. Where needed staff would receive extra supervision and support. Staff told us they felt supported and could discuss any concerns with the registered manager. Staff were supported to continue their learning and development through further training. This included the Diploma in Health and Social Care in levels 2 and 3.

When staff started work at the home they completed an induction. This included an introduction to the home, the general day to day running, they read the policies and were introduced to people. They completed some training and spent time shadowing regular staff, until they were competent and confident to provide care unsupervised. Staff who were new to care completed the Care Certificate. This is a set of 15 standards that health and social care workers follow. It helps to ensure staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

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. Mental capacity assessments were in place and identified where people lacked capacity. Where appropriate, best interest decisions had been made. These were recorded and showed people, their representatives and health and social care professionals were involved in the decisions.

Throughout the inspection we saw staff offering people choices and asking their consent before offering care and support. Staff received training and understood MCA and the importance of offering people choices and respecting those choices. Staff told us they offered people alternative choices and discussed their decisions with them but understood the importance of respecting people's choices. Where people, were less able to express their choices, staff used their knowledge of people and discussions with relatives to help them make choices.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been submitted for people who did not have capacity and were under constant supervision. There were eight DoLS authorisations in place. Copies of the applications and authorisations were available to staff.

Staff completed equality and diversity training. They demonstrated how they promoted people's rights to a good standard of care, independence and treating people with respect. Staff equality and diversity was also respected. Where staff wished to celebrate religious and cultural occasions adjustments had been made to the staff rota to allow this.

People's needs were assessed and care and support was delivered in line with current legislation and evidence-based guidance. For example, people's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow risk assessment. These assessments were used to identify which people were at risk of developing pressure wounds and action taken included appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses. The Malnutrition Universal Screening Tool (MUST) was used to assess people's likelihood of people becoming malnourished or dehydrated. Staff also received advice and guidance from visiting healthcare professionals which helped ensure care and support was up to date and appropriate.

People told us they enjoyed the food. One person said, "The food is good". Another person, when asked about the food said, "The lady who made the food has done a good job." People were offered a choice of food and drink at each mealtime. They were seen to enjoy their meals and plates were returned empty. Where people needed support at mealtimes this was provided appropriately. Some people required prompting and encouraging, others needed specialised equipment such as divided plates or plate guards. This enabled people to retain their independence. Throughout the day people were offered a choice of hot or cold drinks and snacks.

People's nutritional needs were assessed and met. Where people required a specialist diet such as pureed or fortified foods, this was provided. If people chose not to follow the specialist diet then discussions were held with appropriate professionals to ensure people's choices were respected. People's weights were monitored along with people's appetites and a nutritional risk assessment was completed. This identified if anyone was at risk of malnutrition or dehydration. When nutritional concerns were identified, specialist advise was sought through the GP.

People were supported to be as healthy as possible and receive on-going healthcare support. They were able to see their GP when they wished and when there was a change in their health. When necessary referrals were made through the GP to healthcare professionals. for example, the speech and language team (SaLT). Records and discussions with staff demonstrated people received regular visits had been arranged for the chiropodist, optician and dentist were available if needed.

The design and adaptation of the home helped ensure people's needs were met. There was a lift which provided level access throughout the home. There were adapted bathrooms and toilets to support people. The home had been decorated in a way that helped people retain their independence and orientation around the home. There were signposts throughout the home which helped people find their way around. There was a long walkway from the dining room to the lounge, this had been decorated with a 'brick' style wallpaper. There were also large murals of a post office and a grocer's shop. When people were walking

from the dining room to the lounge we heard one person saying, "I need to walk down this street now don't I?"

People were able to move freely around the home as they wished. There was level access, throughout the home and into the garden. People went out into the garden independently throughout the inspection. One person told us, "I can use the garden when I like." Another said, "I love the garden." There were seating areas throughout the garden which was well-maintained. The registered manager told us, and audits showed the design to the home was regularly reviewed to ensure it met people's needs.

Good

Is the service caring?

Our findings

At the previous inspection in July 2017 we asked the provider to make improvements to ensure people's dignity was always maintained. At this inspection we found staff maintained people's dignity. They ensured personal care was provided in private, they spoke to people respectfully and used their preferred name. People were supported to maintain their own personal hygiene and appearance. People wore clothes that were well laundered and of their own choice. Staff were observant to situations which may impact on people's dignity and discreetly supported them as necessary.

People told us, "I am very happy here, they are very kind", another person said, "I don't think you could get better than this place, they are very kind." A visitor told us they were happy with the care their relative received and commented, "You could not get better I would give this 10/10 you would not get better staff." A staff member said, "I came into care to care. If I can I want to make people feel better. If they want a chat or a cuddle then that's what I do."

The registered manager and staff understood the importance of supporting people to maintain relationships with relatives and friends and develop new friendships. One visitor told us how the staff had arranged for them to stay with their loved one for the night on their 60th wedding anniversary. An extra bed had been moved into their relative's room and staff had sprinkled rose petals over the bed. The visitor told us this made the occasion special and they were very touched by this gesture.

Some people had moved into the home as a couple and staff supported them to maintain their relationship. Staff also understood people's needs to likewise be considered as an individual within a relationship. One couple liked to spend time apart and this was supported through the use of a separate bedroom which one person would choose to use on occasions. Another couple liked to spend their time together and would become distressed if separated for any length of time. Staff were mindful of this when providing care and support. Some people had developed friendships within the home and these were supported by staff.

People were supported to make their own choices and decisions and maintain their independence. One person told they received care and support, "If it's necessary, they don't overdo it." People could get up and go to bed when they liked and were supported to make decisions about what they did each day. Some people enjoyed walking around the home and garden were able to do this freely. If people wished to remain in their rooms then this was respected. Where people were less able to make their own decisions, staff promoted their independence through prompting, encouraging and supporting them.

People were comfortable and relaxed in staff presence. People demonstrated they were pleased to see staff through smiles, greetings and hugs frequently throughout the day. Staff always responded and this included appropriate hugs and other gestures of affection, greetings and smiles. Staff knew people really well and had a good understanding of people's physical, emotional and health needs, their likes and choices and what was important to each person. Staff told us about the people they looked after, their personal histories and how this affected people on a day to day basis. They spoke about people's individual care needs and preferences for example, what time they liked to get up and what they liked to do during the day.

Good

Is the service responsive?

Our findings

At the previous inspection in July 2017 we asked the provider to make improvements to ensure people's care plans contained all the relevant information to help staff meet people's needs. We also asked them to make improvements to ensure people were able to engage in activities that reflected their individual preferences. At this inspection we found these improvements had been made.

Before people moved into the home the registered manager completed an assessment to ensure they could meet the person's needs, choices and preferences. These were completed with the person and where appropriate the person's relative or representative. Information from the pre-assessment was used to develop risk assessments and care plans. Since the previous inspection the provider had introduced a computerised care planning system. In addition to the care plans and risk assessments there was an overview of each person's care needs on the computer. This gave staff 'at a glance' information about people's support needs and was easily accessible. Care plans contained the information staff needed to support people. They were detailed and reflected each individual. For example, one care plan informed staff the person wished to continue with the same routine they had at home. Another person wished to get washed and dressed before they had breakfast, and this was the support they received. One person had a catheter and wished to maintain this independently. The care plan informed staff of this but also contained information about what observations they should be making and what to do if they had any concerns. Where people needed support to maintain their skin integrity, continence or nutrition this was provided appropriately. In addition to the care plans, staff had a good understanding of people's needs and preferences and how to provide care and support that was person centred. These were reviewed regularly, with people and where appropriate their relatives, to ensure they continued to reflect people's needs. Relatives told us and records demonstrated they were informed of any changes or concerns with their loved one's care.

Group activities were provided for people each day. There was an activity rota so that people knew what was going on each day. During the inspection the group activities were provided by external entertainers who clearly knew people well. People participated and enjoyed the experience. One person told us they enjoyed the entertainment and said, "It was lovely, I loved them all singing." A visitor told us, "Something's going on all the time, the staff also sit and talk to the residents." Some people did not enjoy group activities. One person's care plan stated they preferred their own company but on occasions may participate in small one-to-one activities. There was information in care plans about people's individual interests and staff engaged with people and talked about these interests throughout the day. Conversations were spontaneous and staff were happy to engage for as long as people wished. Some people engaged in activities of their own choice throughout the day, for example watching television and reading the paper. One person had demonstrated an interest in puzzle type activities, during the inspection we saw this person with a puzzle provided by staff. There were activity care plans to guide staff about people's interests and individual histories were being developed. The registered manager told us these were on-going as it was not always possible to obtain this information about people. Therefore, these were reviewed as staff got to know people over time.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the

Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Communication care plans contained information to guide staff. This included whether people wore glasses or hearing aids and to be observant of people's body language when people were less able to communicate. Staff communicated appropriately with each person and understood the importance of communicating in a way that met people's individual needs.

There was a complaint's policy in place and records showed complaints raised were responded to and addressed appropriately. People's concerns were addressed as they arose to help prevent them becoming formal complaints. We saw people approaching staff throughout the inspection if they had any concerns. One person told us if they had any complaints, "I would tell the manager or the deputy." Where appropriate, any complaints received were discussed with staff. This helped to ensure, as far as possible, that lessons had been learnt and actions taken to prevent a reoccurrence.

The registered manager and staff worked with other professionals to ensure, as far as possible, people were supported to remain at the home until the end of their lives. This included anticipatory or 'just in case' medicines which had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use so that there are appropriate medicines available for the person to have should they require them at the end of their life. Staff were aware of the support people needed to keep them comfortable and pain free in their last days. End of life wishes had been discussed with people and their families. Some people and their families had chosen not to discuss end of life wishes and this was also respected. The registered manager had developed end of life care plans for each person, where possible these had been personalised with the relevant information. The registered manager told us this helped to ensure staff were aware how to support people if they health deteriorated.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in July 2017 we asked the provider to make improvements to ensure quality monitoring processes were effective and to ensure records were kept securely. At this inspection we found people's records were stored securely. Paper records were securely stored. Care plans were stored securely on the computer and were password protected. Only staff with appropriate authority could access them. Improvements had been made to the quality monitoring processes and this included a range of audits and checks. However, we found other areas that needed to be improved.

We found two areas where records needed to be improved. Some medicines needed to be stored separately with details of the name of the medicine and the dose. However, for the most recent record this had not been completed correctly. Instead of recording the dispensed dose, for example 5mg, staff had recorded the dose the person was to receive which was 2.5mg. Consent forms had been completed and signed by the registered manager to demonstrate people agreed to care and support. The registered manager did not have legal authority to consent on people's behalf. The registered manager told us these consent forms were in fact a reflection of the best interest decision's which we had seen on the computerised care planning system. However, this had not been reflected within the consent form. These issues did not impact on the care and support people received. We discussed these with the registered manager as areas that needed to be improved.

Staff told us they felt nervous in our presence and lacked confidence in talking with us. We were told that staff were concerned about getting things wrong and letting the provider down. This lack of confidence and concerns about speaking with the inspector meant, on occasions staff were not able to explain the rationale of what they were doing. For example, the fridge temperature had been recorded as 'off,' we asked the staff member about this and they were unable to explain that the fridge had been switched off as it was not in use. Although people were supported to participate in a range of activities there were occasions where staff did not take full advantage of an occasion to engage with people. For example, when the entertainer was present staff did not take part in the activity with people. Staff could have supported people who were less able to engage more with the activity. The registered manager told us this was something staff would usually do but were not comfortable to do so in our presence. Although this did not impact on people at this time, we recommend the provider works with staff to improve their relationship with staff and help develop staff confidence and communication skills.

From our observations, informal conversations with staff and discussions with people and visitors it was clear staff had good knowledge and understanding of people and their care needs and interactions were ongoing and positive.

The registered manager worked at the home most days. They were a visible presence and knew people, their relatives and staff well. People knew the registered manager, they told us they would discuss and concerns with them. People approached the registered manager freely throughout the inspection and demonstrated that they knew her well. The provider visited during the inspection and people were heard to say, "Here comes the boss."

The registered manager had good oversight of the service and where improvements and developments were needed. Changes were made as necessary. For example, staff recorded where needed, how much people drank each day. The registered manager was concerned that the computerised records may not be accurate therefore staff were also completing hand written forms. At the time of the inspection we found both types of recording had been well completed. The registered manager also identified improvements could be made to the accident and incident audit to help identify any themes or trends. Therefore, in addition to the computer generated audit had also developed her own to give better information.

Staff were supported by the registered manager and they were able to talk with her at any time and discuss any concerns. There were regular staff meetings and staff were thanked for their hard work. Meetings were used to identify any concerns, inform staff about changes and planned improvements. They were also used to remind staff of their individual responsibilities and develop knowledge. A recent meeting by the provider had discussed the findings and share learning from an inspection at a sister home owned by the provider. These meetings allowed staff to raise any matters they wished.

There were a range of audits that had been completed, where areas for improvement had been identified an action plan was completed to show when actions had been taken. The registered manager also addressed issues as they arose. Infection control audits had been completed, these looked at various aspects of cleanliness including staff presentation. This included staff fingernails length and whether they were wearing nail varnish. Within the audits no staff had been wearing nail varnish. However, during the inspection we saw two staff wearing nail varnish. The registered manager had also identified this and told us they had discussed the matter with the staff. Regular audits were completed by an external consultant and action plans were in place to demonstrate when areas identified for improvement had been completed. The registered manager told us they found these audits very useful to improve and develop the home.

There was a range of policies and procedures in place. The registered manager had identified some of these did not contain all the information they may need to inform practice. The registered manager had contacted the company who had produced the policies to request they were reviewed. The policies had been related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, during the inspection we identified policies that had been related to the incorrect regulation. The registered manager made further contact with the company to ensure these were addressed.

People's feedback was sought through regular meetings and surveys. Surveys were sent out each month and analysed three monthly to identify any areas for improvement and development. Resident meetings took place monthly and these provided people with the opportunity to discuss life at the home and any changes they may wish to make. Meetings regularly discussed meals provided and activities. People were also asked for their feedback about staff and what they would do if they had any worries. There was an action plan from the September meeting which identified the deputy manager was going to further develop individual activities with people.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. There was a procedure in place to respond appropriately to notifiable safety incidents that may occur in the service.