

Four Seasons (No 11) Limited Brierfield House

Inspection report

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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

We carried out an unannounced inspection of Brierfield House on 8 and 9 August 2018.

Brierfield House is a 'care home' which is registered to provide care and accommodation for up to 42 older people including people living with a dementia. People in care homes receive accommodation and nursing care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Nursing care is not provided at Brierfield House. At the time of our inspection 38 people were using the service.

There was a registered manager at the service. A registered manager is a person who has registered with the 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.

At the last inspection on 28 and 29 June 2016 the service was rated Good overall. However, we found the provider was in breach of one regulation of the Health and Social Care Act (Regulated Activities) Regulations 2014. This related to the registered provider not ensuring the premises and equipment were suitable and safe for their intended purpose. The provider sent us an action plan outlining the progress to be made. We found sufficient action had been completed to make improvements.

At this inspection, we found the evidence continued to support the overall rating of Good. Some sustained progress was needed with ensuring the safety of the premises, however, there was no evidence or information from our inspection and ongoing monitoring that showed serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

We found there were management and leadership arrangements in place to support the effective day to day running of the service.

People told us they felt safe at the service. Processes were in place to make sure all appropriate checks were carried out before staff started working at the service.

Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns. Staff had received training on safeguarding and protection matters.

There were enough staff available to provide care and support; we found staffing arrangements were kept under review.

People's needs were being assessed and planned for before they moved into the service. People were supported with their healthcare needs and received appropriate medical attention. Changes in people's

health and well-being were monitored and responded to.

Each person had a care plan, describing their individual needs, preferences and routines. This provided guidance for staff on how to provide support. People's needs and choices were kept under review.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems at the service supported this practice.

People made positive comments about the caring attitude of staff. They said their privacy and dignity was respected. Throughout the inspection we observed staff interacting with people in a kind, pleasant and friendly manner. They were respectful of people's choices and opinions.

We found visiting arrangements were flexible. People were keeping in contact with families and friends. There were opportunities for people to engage in a range of group and individual activities.

Most people said they were satisfied with the variety and quality of the meals provided. We found various choices were available. People were involved with devising menus.

People spoken with had an awareness of the service's complaints procedure and processes. They indicated they would be confident in raising concerns.

There were adaptations and equipment to assist people with mobility and orientation. We found there was a good standard of décor and furnishings to provide for people's comfort and wellbeing.

A variety of audits on quality and safety were completed regularly. Arrangements were in place to encourage people to express their views and be consulted about Brierfield House, they had opportunities to give feedback on their experience of the service.

Further information is in the detailed findings below.

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 remains Requires Improvement.

Is the service effective?

Good 

The service remains Good.

Is the service caring?

Good 

The service remains Good.

Is the service responsive?

Good 

The service remains Good.

Is the service well-led?

Good 

The service remains Good.

Brierfield House

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 checked 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.

We visited Brierfield House on 8 and 9 August 2018 to carry out an unannounced comprehensive inspection. The inspection team consisted of one adult social care inspector and an expert by experience who attended on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service, including notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. We contacted the local authority contract monitoring team, the local authority safeguarding team, commissioners of care, social workers, district nurses and GP practices to obtain feedback about the service.

The provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection visit we talked with eight people living at Brierfield House about their experiences at the service and four visiting relatives. We carried out observations in the communal areas of the service and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime period. A SOFI is a specific way of observing care to help us understand the experience of people who used the service who could not talk with us. We spoke with three care workers, a team leader, the registered manager, deputy manager, a cleaner, cook and the resident experience manager.

We looked at a sample of records, including three care plans and other related care documentation, two

staff recruitment records, training records, menus, complaints records, meeting records, policies and procedures, quality assurance records and audits.

Is the service safe?

Our findings

We looked at the processes in place to maintain a safe environment for people who used the service, visitors and staff. At our last inspection we found call points had been tied up and were not accessible to people and there was a lack of suitable locks on some bedroom and bathroom doors. This resulted in a breach of regulation. At this inspection we checked call points and door locks and found improvements had been made.

At our last inspection, we found there was a lack of health and safety risk assessments on people accessing the enclosed garden. At this inspection, we noted risk assessments had been completed on general matters including; grass cutting, mossy areas and individual slips, trips and falls. However, there was nothing specific to the garden areas. We were told the provider had no processes in place to support this type of risk assessment. During the inspection the registered manager proactively devised and completed a thorough risk assessment of the enclosed garden areas.

We found health and safety checks were carried out on the premises on a regular basis. Records showed arrangements were in place to check, maintain and service fittings and equipment, including lifts and hoists, electrical safety, fire extinguishers, call points and water temperatures. We found one person's bedroom door lock was not operating effectively, which meant there was a risk to their privacy and well-being. We noted the gas safety inspection certificate had recently expired. The registered manager took action to resolve these matters during our visit. Following the inspection, we received evidence to confirm that the gas safety inspection had been completed. We found fire safety risk assessments were in place. Fire drills and fire equipment tests were being carried out. There were accident and fire safety procedures available. There were contingency procedures to be followed in the event of emergencies and failures of utility services and equipment.

We looked at the way people were supported with the proper and safe use of medicines. Processes were in place to assess, record and plan for people choosing to self-administer their own medicines. This system should be developed to proactively demonstrate that these decisions are in people's best interest. Most of the people spoken with were aware of their medicines, all said they got them on time. One person commented, "They do see to my medicines and my eye drops."

We checked the procedures and records for the storage, receipt, administration and disposal of medicines. Medicines storage areas were found to be clean, tidy and secure. Appropriate storage and administration was in place for controlled drugs, which are medicines which may be at risk of misuse. Appropriate records were kept to monitor the temperature of the medicines storage areas. We noted the temperature had increased towards an unsuitable level we therefore advised appropriate action be taken to maintain the optimum storage conditions.

The electronic medicines administration records (MAR) we reviewed were appropriately kept, complete and accurate. Each person had a 'medication profile' which included, a photograph of the person, prescribed medicines, diagnosis and known allergies. There were care plans providing person-centred instructions for

staff to follow on supporting people safely with their medicines. There were individual protocols for the administration of medicines prescribed "as necessary" and "variable dose" medicines. These were to ensure staff were aware of the individual circumstances when this type of medicine needed to be administered or offered.

There were processes in place to complete ongoing audits on aspects of medicine management practices. The service had medicine management policies and procedures and recognised good practice guidance, which were accessible to staff. Records and discussion showed staff providing support with medicines had completed training. There were arrangements in place to assess, monitor and review staff competence in providing safe, effective support with medicines.

It was a policy of the service not to stock 'over the counter remedies.' The registered manager had ensured pain relief medicines were available for people. We discussed the value of people having appropriate access to items for treating minor ailments. The registered manager was to pursue this matter for the comfort and well-being of people using the service.

We checked how the service protected people from abuse, neglect and discrimination. All the people spoken with said they felt safe at the service and expressed confidence in reporting concerns. They told us, "The staff are really good with me," "I don't wish to complain about anything," "They certainly make sure I am safe" and "If I go downstairs, someone goes with me." One relative told us, "We have complete trust in the service."

Prior to the inspection, we reviewed the information we held about the service relating to safeguarding incidents and allegations of abuse. We reviewed some of the previous incidents and ongoing concerns with the registered manager. Systems were in place to record and manage safeguarding matters. We found action had been taken to keep people safe and mitigate risks. The registered manager had appropriately liaised with local the authority and other agencies, in relation to allegations and incidents.

Staff spoken with expressed an understanding of safeguarding. They were aware of the various signs and indicators of abuse and were clear about what action they would take if they witnessed or suspected any abusive practice. The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. Staff spoken with were aware of the service's 'whistle blowing' (reporting poor practice) policy.

We looked at how risks to people's individual safety and well-being were assessed and managed. Four people told us they believed that any risks to their health and wellbeing were managed well. There were risk assessments and risk management plans, to guide staff on minimising risks to people's wellbeing and safety. The risk assessments included, moving and handling, skin integrity, nutrition, choking, behaviours and falls. Risk assessments were kept under review. Staff spoken with had an awareness of the risk assessments and told us how they were shared with the staff team and kept up to date. Records were kept of any accidents and incidents. Processes were in place to monitor any accidents and incidents so the information could be analysed for any patterns or trends. Referrals were made to relevant health and social care agencies as appropriate. Each person had a PEEP (personal emergency evacuation plan) in the event of emergency situations.

We checked if people were protected by the staff recruitment procedures. We reviewed the recruitment records of the two newest recruits. The process included candidates completing an application form and attending an interview. Character checks including, identification, references and employment histories had been completed. A DBS (Disclosure and Barring Service) check had been carried out. The DBS carry out a

criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. All new employees completed a probationary period to monitor their work conduct and competence. The service had disciplinary procedures in place to manage unsafe and ineffective staff conduct.

We reviewed how the service managed staffing levels and the deployment of staff to support people to stay safe and meet their needs. People had no complaints about staffing levels. Their views ranged from "Probably enough" to "Definitely enough." One person said, "They always seem busy, but I do get the odd chat occasionally." We looked at the staff rotas, which indicated arrangements were in place to maintain consistent staffing levels. There was a structured process in place to monitor and review staff deployment at the service; this took into consideration people's dependency needs, the layout of the building and staff skills and abilities. We observed sufficient staff were available to safely respond to people's needs.

We reviewed how people were protected by the prevention and control of infection. People spoken with did not express any concerns about cleanliness, five told us they thought the home was kept clean and one person said it mostly was. The areas we looked at were kept clean. Suitable cleaning equipment and laundry facilities were provided. Protective personal equipment, including gloves, aprons and anti-bacterial hand wash was available. Guidance on effective hand hygiene was displayed. There were processes to audit, monitor and respond to infection prevention and control measures at the service. This meant arrangements were in place to check, maintain and promote good hygiene standards.

Is the service effective?

Our findings

People's needs and choices were assessed and their care and support delivered to achieve effective outcomes. The registered manager described the process of initially assessing people's needs and abilities before they used the service. People were encouraged to visit the service and stay for trial periods. This was to support the assessment process and provide people with the opportunity to experience the service before moving in. One person told us, "I chose to come in here and I have never regretted it." We looked at recent records which showed wide-ranging needs and preferences assessment had been carried out.

People's consent to care and treatment was sought in line with legislation and guidance. All the people spoken with, said staff asked for their consent when providing support with medicines or personal care. Visitors spoken with expressed confidence in their relative's freedom to make choices on everyday matters. We observed examples where staff consulted with people on their individual needs and preferences and involved them in routine decisions. Staff spoken with described how they routinely involved people in making decisions and asked for their consent before delivering care. The care records we reviewed included agreements on consent to care.

The service was working within the principles of the MCA Mental Capacity Act 2005 (MCA). The 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 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 found that decision specific capacity assessments had been completed and relatives had been involved in best interests decisions relating to their family members' care and support. There was information to show appropriate action had been taken to apply for DoLS authorisations by local authorities in accordance with the MCA code of practice. There were applications which had been assessed and authorised by the relevant local authority. Policies and procedures were available to provide guidance and direction on meeting the requirements of the MCA. Staff spoken with said they had received training on the MCA, they indicated an awareness of DoLS and the legal status of the interventions and agreements in place.

People were supported to live healthier lives, had access to healthcare services and received ongoing healthcare support. They were offered the opportunity for physical exercise. People's medical histories, healthcare needs and records of consultations, were included in the care planning process. Their wellbeing was monitored daily and considered as part of ongoing reviews. One person told us, "I am well cared for," another said, "The staff can tell how I am feeling when they get me up each morning." All the visitors spoken with, considered healthcare needs were met and said they were kept informed on any changes relating to their relative's health. The service had access to remote clinical consultations; this meant staff could seek professional healthcare advice at any time. The service was part of the 'Red Bag Scheme.' This was an

information sharing initiative, to improve the transition process when people accessed other services.

People were supported to eat and drink enough to maintain a balanced diet. Most people spoken with made positive comments about the food and catering arrangements. Their comments included, "The food is good," "I am visited every morning for me to choose my meals," "I am often asked whether I want any more" and "The food here is pretty good and I am offered alternatives if necessary." There was a new four-week rotating menu. This included the offer of a balanced diet with various choices and alternatives. A visitor told us, "The fact that [my relative] has company and regular meals has made the difference in her. She can always get something to eat or drink if she wishes, the kettle is never off!"

Individual dietary needs and food preferences were known and planned for. People's dietary intake was monitored and their weight was checked. This helped staff to screen risks of malnutrition and support people with their diet and food choices. Health care professionals, including GP's, speech and language therapists and dieticians were liaised with as necessary. Specific diets could be catered for, including fortified diets and pureed meals.

We observed the meals service at lunch time in both dining rooms. We saw examples of people being sensitively supported and encouraged by staff with their meals. Various choices and alternatives were offered. The meals served looked plentiful and well presented. There was plenty of conversation and people were not rushed in any way. We discussed with the registered manager and staff, ways of developing the catering service, to further enhance people's mealtime experience.

The service made sure that staff had the skills, knowledge and experience to deliver effective care and support. Most of the people we spoke with, were confident the staff had the necessary skills and experience. Records and discussion showed arrangements were in place for staff learning and development. One member of staff said, "We have all year round training. It's really good it keeps us fresh." Processes were in place to support an induction training programme for new staff, which included the completion of the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

People's individual needs were met by the adaptation, design and decoration of premises. The home was furnished and decorated to a good standard. People had been supported to personalise their bedrooms. One visitor explained, "[My relative can alter things in her room more or less how she likes." Suitable equipment was available to support people with their mobility and there was signage to help with orientation. We noted some bedroom windows had become opaque, which meant people could not see out. During the inspection, the registered manager proactively took action to address this matter and we were assured the windows would be replaced.

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. Most people spoken with described staff as 'good' and 'caring.' They told us they liked the staff who cared for them. One person said, "The staff do their best and mostly come when you need them." A relative said, "The care is excellent here," another told us, "I watch them with admiration. They have the patience of saints." We observed positive and friendly interactions between people using the service and staff. Staff showed kindness and sensitivity when responding to people's needs.

The service supported people to express their views and be actively involved in making decisions about their care and support as far as possible. All the people spoken with said they could make everyday choices. One person told us, "I can choose not to have a male carer and I feel that I have a say in things." A visitor explained, "[My relative] can choose either a bath or a shower and choose which day. People had care plans which recorded their individual needs and preferences and how they wished to be supported. Most people we talked with were aware of their care plans and said the staff knew their needs and choices.

People's dignity and individuality was upheld. People had 'one page profiles' which included details on people's life history, important memories, relationships, family contact, preferences, cultural heritage and spiritual needs. We saw that staff were respectful and kind, when supporting and encouraging people with their daily living activities and lifestyle choices. A visitor said, "[My relative] looks clean and smart whenever I visit and is obviously happy."

Positive relationships were encouraged and visiting times were flexible. One person told us their family had visited on their birthday and that, "They were all made very welcome by the management and staff." The provider had recently introduced a new initiative to ensure all staff spend some time with each person using the service on a regularly basis. The registered manager told us initial feedback from both residents and staff had been very positive. The initiative was a valuable communication tool that helped staff build relationships and understand residents as individuals. The registered manager also described how the service had involved people with the staff recruitment process, which had provided the opportunity for involvement, decision making and a valued contribution on staff selection.

People's privacy was respected and promoted. Everyone we talked with said their privacy was maintained. One person explained, "My privacy is no problem. The staff always knock on the door before entering." All the bedrooms were single occupancy and had en-suite toilets. People could spend time in their rooms whenever they chose. One person said, "I am happier staying in my room. I have my meals in my room." Bedroom doors were fitted with suitable locks to promote privacy of private space. We saw staff respecting people's private space by knocking on doors. We discussed with staff how they upheld people's privacy within their work, by supporting people sensitively with their personal care needs and maintaining confidentiality of information.

The service enabled people to be independent. All the people we spoke with agreed that they were

supported to be as independent as possible. We observed people doing things independently and making their own decisions, some with staff support. Promoting choices and encouraging independence was reflected in the care plan process. Staff spoken with explained how they encouraged independence, in response to people's individual abilities, needs and choices.

There were notice boards at the service which provided information for people and their relatives. Included were forthcoming events, records of meetings and advisory information, such as local advocacy services. Advocates are independent from the service and can provide people with support to enable them to make informed decisions. There was an information pack for people, providing details of the services and facilities available at Brierfield House. The provider had an Internet website which also provided information about the service.

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People we spoke with said the staff knew their needs and they got the care they needed and how they wanted it. One person commented, "They really make you feel at home and I would not change a thing." A visitor told us, "[My relative] is doing very well here and I can't praise the staff enough." We received some comments from people which suggested their preferences were not always responded to. We discussed these matters with the registered manager, who proactively reviewed with each person, their specific needs and choices and updated their care plans accordingly.

Each person had a care plan which was designed to meet their individual needs. The care plans and other related records we reviewed, included people's needs and choices. There were person centred details on how people's care and support was to be provided. All care plans had been regularly reviewed and updated where necessary to ensure they were an accurate reflection of people's needs. Records showed people or their families had been involved in the process. Staff spoken with knew people and understood their role in providing people with person centred care and support. They had access to the care plans and were aware of people's individual needs, preferences, backgrounds and personalities. Staff had received equality and diversity training. Equality is about championing human rights and diversity relates to accepting and valuing people's individual differences.

We looked at whether the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

People's communication and sensory needs were assessed, responded to and reviewed in the care planning process. We noted some of the service's material was available in different formats and we discussed with the registered manager ways of producing information, to help with meeting the expectations of the Accessible Information Standard.

All the people spoken with were aware of the range of activities provided at Brierfield House. One person told us how they enjoyed the trips out and the bingo. Another commented, "I do know about the activities they do, but I am not interested, but I will say that Christmas in here is very good." A visitor said, "Yesterday they had a good trip out in the minibus but the rain rather spoiled the day!"

People had 'my journal' and 'my choices' records which identified people's individual interests, hobbies and life experiences. There was a notice board in the entrance hallway which had information on the programme of daily activities. Another notice board included details of church services, resident's meetings and visiting entertainers. There were 'rummage bags' containing various tactile items for people to engage with. The 'sensory room' had visual lighting effects and scented aromas. The recently introduced 'activity corner' provided opportunity for planned and spontaneous craft sessions.

People's concerns and complaints were listened and responded to and used to improve the quality of care. People's comments included, "Any concerns I have raised their response has been pretty good" and "If I did raise any concerns I am sure they would do something about it." All the visitors we talked with said they had no complaints to make at all. One had previously raised a concern with the management and told us it had been managed to their satisfaction.

The complaints procedure was on display in the entrance hallway and provided directions on making a complaint and how it would be managed, including timescales for responses. There were processes in place to record, investigate and respond to complaints and concerns. There had been one complaint in the last 12 months. Records showed action had been taken to investigate and resolve the matters raised.

Resident's/relatives meetings were held and three people we talked with said they had attended. Records of meetings showed various topics had been raised and discussed. Including activities, mealtime choices and changes in the wider organisation. One visitor said, "I think it's a good thing that they hold a meeting for residents every three months." Another commented, "The meetings they hold are useful and the food has been better since the last meeting."

The service used technology to creatively responds to people's needs and choices. For example, there was an electronic feed-back system. This was a Wi-Fi linked 'touch screen' digital device/tablet. People could share any concerns or comments about the service instantly with managers. The system was monitored to ensure matters were acknowledged and responded to as appropriate.

End of life care was provided in response to people's preferences and changing needs. The service worked with other agencies as appropriate, when responding to people's specific needs. The registered manager explained that plans were agreed and recorded, to ensure care was delivered in line with the person's wishes and ensuring the person was supported to be as dignified, pain free and comfortable as possible.

Is the service well-led?

Our findings

We reviewed how the service's management and leadership processes achieved good outcomes for people. We asked people to describe the culture and atmosphere of the service, their responses included, "Good," "Very good," "Calm" and "Busy." All the people spoken with thought the service was well managed. Likewise, visitors told us the service was well managed and organised and had a good atmosphere. One commented, "They have a good, well-managed, set-up and it shows." There was an 'open door' policy that supported ongoing communication, discussion and openness at the service. People and their visitors said they found all the staff and the registered manager to be easily approachable. We found the atmosphere to be friendly and supportive.

There were ongoing audits and tracking systems on various processes, including care plans, risk assessments, infection prevention and control, medicine management, staffing levels and staff deployment, staff training, financial records and health and safety checks. The service had a 'rolling programme' of refurbishment and decoration. At this inspection, we found some of the governance systems needed to more effectively identify and manage the maintenance of the premises for people's well-being, comfort and safety. Following the inspection, we received confirmation that action was being taken to ensure more robust processes were in place.

At our last inspection, there was no registered manager at the service. However, the manager had successfully achieved registration with the Commission. The registered manager was experienced and had commenced QCF (Quality and Credit Framework) diploma in health and social care level 4. They had also updated their skills and knowledge by completing the provider's mandatory training programme and attending the provider's Home Manager Conferences. In October 2016, the registered manager was awarded - 'New Home Manager of the Year North West.' Throughout the inspection the registered manager expressed commitment to the ongoing improvements at the service and was proactive in response to the inspection process.

There was a management team in place which included the registered manager, deputy manager and team leaders. The management team were supported by a regional manager who visited Brierfield House on a regular basis, to provide oversight on the day to day running of the service. The registered manager also had access to a range of support networks within the provider organisation.

All the people we talked with said they felt staff understood their responsibilities. There were clear lines of accountability. Staff had been provided with job descriptions and contracts of employment which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates were brought to their attention. The service's vision and philosophy of care was reflected within the services written material including, the information pack, statement of purpose and policies and procedures. The service's vision and ethos statement was on display in the entrance hallway.

Staff spoken with were enthusiastic and knowledgeable about their working roles. They indicated team work and management at the service was good. Various staff meetings were being held. We looked at the

minutes of the last meeting and noted various work practice topics had been raised and discussed. One staff member commented, "We can make suggestions and raise issues. They listen and definitely deal with problems."

The service encouraged regular feedback from people. There were the residents/relative's meetings and there was a suggestion box in the entrance hallway. The 'touch screen' digital device/tablet, enabled people to instantly share their experience and views. Processes were in place to analyse, collate and respond accordingly to all comments and suggestions. The system was used to identify trends, staff training needs and share learning and best practice across the provider's services. The results of the last consultation were presented as a 'you said' and 'we did' display. This showed people had influenced improvements, including tidying up the garden, decorating, staff training and menus. Staff had opportunity to share their views annually via a national computer based staff survey within the organisation.

There were procedures in place for reporting any adverse events to the CQC and other organisations, such as the local authority safeguarding and deprivation of liberty teams. Our records showed that notifications had been appropriately submitted to the CQC. We noted the service's CQC rating and the previous inspection report were also on display at the service, the rating was also displayed on the provider's Internet website. This was to inform people of the outcome of the last inspection.