Lantraz Co. Ltd

Westfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection of the service on 8 December 2015. Westfield Care Home provides accommodation for people who require personal care for up to 45 people. On the day of our inspection 21 people were using the service.

A registered manager was in post at the time of this inspection. 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.

During our inspection on 29 and 30 October 2014 we identified one breach of the regulations of the Health and Social Care Act 2008. This was in relation to the assessment and monitoring of the quality of service that

Summary of findings

people received. During this inspection we checked to see whether improvements had been made. We found improvements had been made in a number of areas but some further improvement was required.

The risk to people's safety was reduced because staff could identify the different types of abuse, and knew the procedure for reporting concerns. Staff had received safeguarding of adults training but others needed to complete this training. Assessments were in place to address the risks to people's safety.

Accidents and incidents were investigated. Regular assessments of the environment people lived in and the equipment used to support them were carried out and people had personal emergency evacuation plans (PEEPs) in place.

People told us they felt there were enough staff to support them. The staff we spoke with agreed. Appropriate checks of staff suitability to work at the service had been conducted prior to them commencing their role. People were supported by staff who understood the risks associated with medicines. People's medicines were stored, handled and administered safely, although the reasons for people receiving 'as needed' medicines were not always recorded.

People were supported by staff who completed an induction prior to commencing their role and had the skills needed to support them effectively. However some staff had not completed all required training. During our previous inspection we raised concerns that staff did not receive regular assessment of their work. During this inspection we saw improvements had been made. Staff felt supported in carrying out their role.

Staff were aware of people's individual preferences and people's consent was gained before care and support was provided. However the registered manager had not always ensured they had recorded how the principles of the Mental Capacity Act (2005) had been applied when decisions had been made for people. The appropriate processes had been followed when applications for Deprivation of Liberty Safeguards had been made.

People spoke highly of the food and were supported to follow a healthy and balanced diet. People's day to day health needs were met by the staff and external professionals. Referrals to relevant health services were made where needed.

Staff showed a positive and caring approach when providing care and support for people. People interacted well with staff and there was a friendly atmosphere in the home.

Staff supported people in a kind and caring way. Staff understood people's needs and listened to and acted upon their views. Staff responded quickly to people who had become distressed. We saw staff involve people with day to day decisions about their care and support needs, however there was little recorded evidence of involvement with longer term decisions within people's care records.

People were provided with information if they wished to access an independent advocate to discuss the care and support they received. However due to redecoration of the home this was not available at the time of the inspection.

People were treated with dignity and respect and their privacy was respected. There were no restrictions on people's friends or relatives visiting them at the home.

We observed staff spend time with people; however people were not supported to follow their hobbies and interests. During our previous inspection we raised concerns as to the lack of activities provided for people. We were told an activities coordinator would be recruited, this has not happened.

People were provided with a complaints procedure, however it could prove inaccessible for some people and was not provided in a format that all people could understand.

During the previous inspection we raised concerns that the registered manager did not have robust auditing processes in place. During this inspection we saw some improvements had been made but further improvements were needed as they had not identified all of the concerns raised within this report.

People and staff spoke highly of the registered manager and the provider, and they were supported by a management team that understood their roles. There were limited opportunities for people to access and to become involved with their local community.

Summary of findings

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 were supported by staff who could identify the signs of abuse and how to report concerns.

Assessments to the risks to people's safety had been carried out and plans put in place to reduce that risk.

Accidents and incidents were investigated and people were supported by an appropriate number of staff to keep them safe.

People's medicines were stored, handled and administered safely although the reasons for the administration of 'as needed' medicines were not always recorded.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were supported by staff who understood how to support them effectively, but not all staff had completed the required training.

People's records did not always show how the principles of the MCA had been adhered to when a decision had been made for them. DoLS processes had been appropriately applied.

People spoke highly of the quality of the food.

People were able to access external healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and caring way and treated them with dignity and respect.

Staff understood people's needs and listened to and acted upon their views.

People's privacy and dignity was maintained by staff and friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not always able to follow their hobbies and interests. There was limited opportunity for people to go outside of the home.

Summary of findings

People's care plan records did not always reflect people's current care and support needs.

People's care plan records were written in a person centred way and staff knew people's likes and dislikes and what interested them.

People were provided with the information they needed if they wished to make a complaint however the location of the complaints procedure could make it inaccessible for some people.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Audits were now in place to identify the risks to the service and to improve the quality of the service people receive, but these did not identify the issues within this report.

People were unable to access their local community without the support of their family or friends.

The registered manager understood their responsibilities and were liked and respected by people and staff.

Staff understood their roles and how they could contribute to providing people with safe and effective care.

Westfield 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 8 December 2015 and was unannounced.

The inspection team consisted of two inspectors.

To help us plan our inspection we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted Commissioners (who fund the care for some people) of the service and asked them for their views.

Many of the people who used the service had difficulty communicating as many were living with dementia or other mental health conditions. We spoke with four people who used the service, two relatives, four members of the care staff, the cook, a visiting healthcare professional, the registered manager and two representatives of the provider.

We looked at the care records of six people who used the service, as well as a range of records relating to the running of the service; including quality audits carried out by the registered manager.

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.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe living at the home. A relative said, "Since coming here [their relative] has become calm and collected and at ease. I am confident everything is ok."

The risk of people experiencing abuse was reduced because staff could identify the different types of abuse that they could encounter. The staff knew the procedure for reporting concerns both internally and to external bodies such as the CQC, the local multi-agency safeguarding hub (MASH) or the police. Records showed that some staff had received safeguarding of adults training; however some staff had not yet completed this training.

We were informed by the registered manager that there was information provided within the home that informed people who they could report any concerns to if they were worried about their or other's safety. However, due to redecoration at the home the noticeboard where this information was normally provided was not in place. The registered manager told us that once the redecoration was complete this would be put back in place.

The risk to people's safety had been reduced because individual risk assessments were in place for risks such as falls, moving and handling, development of pressure ulcers and malnutrition. These had been reviewed monthly to ensure they met people's current needs.

Regular assessments of the environment people stayed in and the equipment used to support them were carried out. Where people required specialised equipment to support them, the registered manager ensured they were regularly serviced to ensure they were safe. Regular servicing of gas installations and fire safety and prevention equipment were carried out. External contractors were used to carry out work that required a trained professional.

The registered manager told us each person had recently had a new personal emergency evacuation plan (PEEP) put in place to enable staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. However, the plans did not contain a date on which they were formed. The registered manager told us they would add the dates to each plan to ensure they could show that they were up to date and accurately reflected each person's needs.

We looked at records which contained the documentation that was completed when a person had an accident or had been involved in an incident that could have an impact on their safety. Records showed these were investigated by the registered manager and they made recommendations to staff to reduce the risk to people's safety.

Prior to the inspection some external healthcare professionals we spoke with raised concerns that there were not enough staff working at night. We asked people who used the service their views on the number of staff working at the home. The people we spoke with told us staff were always available when they needed help. One person said, "They [staff] come quite quickly when I call." Another person said, "Sometimes you have to wait two or three minutes, but at other times they come straight away." A person said, "There are always staff around, You are never without staff." A relative told us they felt there were enough staff on duty when they visited on a daily basis.

All the staff we talked with said they felt there were enough staff on duty to meet the needs of the people using the service. We asked them about staffing levels at night. The staff who had worked nights stated there were normally two staff on duty at night and they felt this was sufficient to meet people's needs. One person said, "There is a good routine at night and we are well organised." Staff told us that if they were short staffed outside normal working hours they would contact the managers. One staff member said, "The management will come in, if you ring."

We asked the registered manager how they ensured there were enough staff to meet people's needs. They told us they completed a dependency assessment which helped them to assess how many staff they needed throughout the day and night. They told us they were confident they had the right number of staff needed to keep people safe, but if people's levels of dependency changed, they would increase the number of staff on shift. Throughout this inspection we observed staff respond to people's requests for assistance in a timely manner.

The risk of people receiving support from staff who were unsuitable for their role was reduced because the provider had ensured that appropriate checks on a potential staff member's suitability for the role had been carried out. Records showed that before staff were employed, criminal record checks were conducted. Once the results of the checks had been received and staff were cleared to work,

Good

Is the service safe?

they could then commence their role. Other checks were conducted such as ensuring people had a sufficient number of references and proof of identity. These checks assisted the provider to make safer recruitment decisions.

People who used the service and their relatives did not raise any concerns with us about how their medicines were managed by the staff. Staff told us they had completed training in medicines administration and had undertaken assessments of their competency to do so regularly.

There were processes in place to ensure people's medicines were ordered on time and were stored safely. All medicines were stored in locked cabinets, trollies or fridges to prevent people accessing medicines which could cause them harm. Regular checks of the temperature of the room and the fridges were made and recorded, to ensure medicines were stored at the appropriate temperature so as not to reduce their effectiveness.

We observed the administration of medicines and saw the administration was completed in a timely manner. We saw appropriate checks were made prior to the administration of people's medicines and staff stayed with each person if needed, to ensure they had taken them. Staff provided an explanation to people about what they were taking and why, and offered encouragement to people to take their medicines where necessary. We saw one person was receiving medicines for a specific condition that were required at specific times of the day to ensure their condition was safely managed. The member of staff administering medicines was aware of this and told us the person received their medicines on time every day.

People's medicines administration records (MARs), used to record when people had taken or refused their medicines were appropriately completed. However we did find one example where a record was needed to show where an external application had been administered to ensure they were rotated in line with best practice. Records showed this had not always been completed.

Each record contained a photograph of the person to aid identification and people's allergies were also recorded. This ensured the staff member administering the medicines had the information they needed to do so safely. The MARs did not contain information about how people liked to take their medicines but this was available in their care plans. The staff member we observed showed a good understanding of each person's preferred way of taking their medicines.

Records showed that some people received their medicines covertly. We saw involvement of the family doctor, specialist nurse and pharmacist had been requested to ensure the decision was appropriate, necessary and in the person's best interests.

When medicines had been prescribed to be given only as required, protocols were in place that enabled staff to be aware when they should be administered. However there was not always a record of the reasons why the medicines had been needed when they had been given. This could lead to an inconsistent approach to the administration of these medicines.

Requires improvement

Is the service effective?

Our findings

People told us the staff had the right skills and knowledge to support and care for them in an effective way. One person said, "They [staff] all know what to do." Another person told us staff understood their needs.

Staff had carried out an induction to provide them with the skills needed to support people in an effective way. The registered manager told us staff who were new to the service would complete the newly formed 'Care Certificate' training to ensure they had the most up to date skills required for their role. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives people who use services and their friends and relatives the confidence that the staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Once the induction was complete staff were then provided with a training programme to provide them with the skills they needed to support people effectively. The staff we spoke with told us they had completed nationally recognised qualifications such as NVQs and Diplomas in adult social care and they had also completed mandatory training including safeguarding of adults and moving and handling. Other training was also offered in areas such as equality and diversity, dementia care and supporting people with dignity. The staff told us they felt they had received the training they required to meet people's needs, to provide people with safe and effective care and felt supported by the management team. Our observations of the staff supported this.

We checked the provider's training register to see what training each member of staff had completed. Although staff had completed training in a number of areas, there were still some gaps or refresher courses needed for each member of staff. The registered manager told us they had identified the areas of training that needed addressing and had assigned on-line training course programmes to each member of staff to complete. They told us they would be reviewing each member of staff's progress and where training had not been completed, this would be addressed in their regular supervision and competency checks.

Records showed that staff received regular assessment of their work and the registered manager showed us examples of annual competency assessments that each member of staff had completed or will complete once they have worked at the service for a year. The registered manager told us this enabled them to address any areas where staff required support in carrying out their role.

We observed people giving their consent to decisions about the care and support they wanted throughout the inspection. People decided where they wanted to sit for lunch, whether they wanted to go back to their bedroom or if they wanted staff to support them with their personal care.

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. We checked whether the service was working within the principles of the MCA.

When people lacked the capacity to make some decisions for themselves records showed that mental capacity assessments had been completed for some decisions but not others. For example one person had a capacity assessment and best interest decision in place for decisions about their personal care and sleeping in a chair. However they did not have an assessment for the management of their medicines. Another person had two capacity assessments for health and welfare and for finance but they did not have specific capacity assessments for use of a sensor mat by their bed to alert staff to their movement at night. This could increase the risk of decisions being made for people that did not follow the appropriate legal guidance.

We saw 'Do not attempt resuscitation' (DNAR) documentation was in place for people where they, or their relatives if they were unable to give their consent, had decided that they should not be resuscitated if it could have a detrimental effect on their long term health. However, records showed for one person that they had 'Allow natural death' (AND) documentation within their care records following a recent hospital admission. This would not have been valid in the care home environment. We were told by the registered manager that the DNAR form for this person was sent with them when they were

Is the service effective?

admitted to hospital, but it was not returned when the person was discharged, presenting difficulties for the home. The registered manager told us they would contact the hospital immediately to request this form was returned to enable this person's wishes to be adhered to should it be needed.

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). Records showed that applications to the authorising body had been made for people that required them and further assessments were on-going for others who the registered manager believed may need them.

People spoke positively about the quality of the food. One person said, "Oh it is good. I tell them [staff] what I want and they do it for me." They also told us there was always a choice and they were happy with the menu. Another person said the food was good; it was always hot and they had plenty to eat. They said they were offered alternatives if they didn't want the choices on the menu. Other comments about the food included, "I have no complaints about the food." And, "The food is the top job. It is wonderful. I am not a very good eater but I am happy with it."

We observed the cook ask people to choose from the menu in the middle of the morning and they showed people pictures of the alternatives to help them to choose. Staff also checked people's choices with them when they served their meal. The cook told us that if people changed their mind about their choice and decided they wanted something else, there was enough flexibility in the amount of food cooked to be able to provide this.

The staff told us that although the meal times were set each day people were able to access food and drink at other times of the day if they wanted it. One staff member told us they offered people cake or biscuits with the suppertime drinks and if someone asked they would prepare additional snacks. They named three or four people who sometimes liked to have cheese on toast at suppertime.

Care records contained assessments of people's dietary needs and their food and drink preferences. Where people had been assessed as requiring nutritional supplements to be taken with their food these were provided in line with their prescription. Where people were at high risk nutritionally, they were weighed weekly. In the care records we looked at we saw where people had been identified as either putting on or losing weight staff sought the input of the person's GP or dietician. Food and drink charts were used to record people's food and fluid intake when it had been identified they were nutritionally at risk.

People told us their day to day health needs were met by the staff. One person said staff were quick to notice if they were unwell and would call the doctor if they needed it. They also told us their chiropodist visited them regularly. Another person said, "They [staff] always know when you aren't well, they see it in your face and they ask how you are. I've had the doctor in many times."

There was evidence within people's care records of the involvement of other professionals such as the dementia outreach team, community psychiatric nurse, optician and chiropodist. On the day of the inspection, we saw staff contact a GP practice to request a visit from the person's GP. An advanced nurse practitioner visited in place of the GP to assess the person.

During the inspection we spoke with a health care professional who regularly visited the home. They told us staff contacted them when a person who used the service required additional visits for wound care and they said staff acted on their advice and instructions. They said staff knew people well and were knowledgeable about their needs and preferences.

Good

Is the service caring?

Our findings

All of the people we spoke with spoke positively about the staff. One person said, "They [staff] are kind." Another person said, "It is fine here. I am comfortable with the staff." Another said, "It's like being at home. Anyone would think you are their sister or mother the way they care for you. They remember things you like, it comes automatic with them. I have always been happy here." A visiting relative told us staff had a very good rapport with people who used the service and made them feel at home.

We observed staff interact with people throughout the inspection and people responded positively to them. It was clear that staff had a good rapport with the people they supported. Staff were relaxed when supporting people and were friendly, warm and caring in their approach. Staff had a good understanding of people's behaviour and preferences and knew how to support them in the way they wanted to be supported.

Where people showed signs of distress or discomfort staff reacted quickly and calmly and used a variety of techniques to calm and reassure the person. For example we saw a person had been standing up and staring out of the window and had become upset. Staff responded to this person by putting a reassuring arm around their shoulder and whispering in their ear. When a song the person liked came on the radio the person smiled. The staff member asked them if they wanted to dance and they did. The knowledgeable and reassuring approach of this staff member was one of many good examples that we saw throughout the inspection.

People told us they were given choices about their care and support needs and staff respected their wishes. There were processes in place to ensure that people were provided with information about their care and to enable them to contribute to the decisions made. However people's care records did not always reflect this. The staff we spoke with told us they involved people as much as they could with decisions about their care, but due to the complex nature of some people's mental health needs, not all were able to understand. The registered managers told us that not all people were able to contribute to decisions but agreed that they needed to do more to show how they could involve people, even on a limited basis.

The registered manager told us that information was available for people about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. However due to the redecoration of the area where this information was usually placed, it was not currently available for people. The registered manager assured us it would be returned to its normal position once the redecoration was complete.

People told us they were treated with dignity and respect. Staff told us when they supported people with their personal care they ensured their bedroom doors, curtains and blinds were closed to ensure their dignity was not compromised. They also said they kept them covered as much as possible when assisting people with personal hygiene. We saw people being moved using a hoist. Staff explained what they were doing and offered reassurance when they moved them.

When staff members discussed people's health or personal care needs with each other, they did so in a respectful way. They lowered their voice and ensured that others could not hear them. This ensured people's dignity was protected. People's care records contained guidance for staff on how to maintain people's dignity when providing personal care support for them.

People told us staff respected their privacy although one person told us staff didn't always knock on their door, but, "They shout I'm here [before entering their room]." We observed a member of staff ask a person if they wanted company; the person told them they did not and the staff member respected their wishes. There was plenty of space within the home if people required some time alone, or time with their family or friends.

We observed people receive support from staff to complete tasks independently. People were supported to go to the toilet and to access other parts of the home if they wanted to. Some people required the use of a walking aid and required staff to be close by. When staff supported them they offered reassurance and encouragement without impeding the person's independence.

The registered manager told us that people's relatives and friends were able to visit them without any unnecessary restrictions.

Requires improvement

Is the service responsive?

Our findings

People told us staff knew their needs and what they liked and disliked. One person said, "The staff know me quite well and they know what I like." People's care records were written in a person centred way that described how people would like their care to be provided. We saw examples such as people's preferences regarding personal care and how often they would like a bath or shower had been recorded.

People were provided with a 'service user guide' which provided people with information about the care and support they could expect to receive at the home. It provided them information about the aims and objectives of the home, how they should expect to be treated with dignity and respect and how they could become involved with decisions relating to their care.

People's care records were detailed and there was evidence of monthly reviews taking place. However, some of these did not accurately reflect the care some people received at the time of the inspection. For example, a care plan indicated a person required a fortified diet and when we spoke with the cook they told us the person had a good appetite and did not require their diet to be fortified. Another person's mental capacity assessment indicated the person should have a recliner chair as they were unwilling to sleep in a bed. This was not in place. Records also showed that another person should have had a pressure relieving mattress on their bed and this was not in place. We were assured by the registered manager that people received the care and support they needed from staff, but acknowledged there was more that needed to be done to ensure each person's records reflected this.

There was limited evidence of people being supported to follow their preferred hobbies and interests. A relative told us there weren't many activities but felt it was difficult for staff to identify activities which would be suitable. They told us their relative used to like to play snooker and staff had enabled them to watch it on the television recently.

One person we spoke with said they had very little to do and were limited by their long term condition in relation to activities. However, they said they would have liked to spend some time outside the home. They told us they were able to go church every Sunday as people from the local church came to the home to take them to the service and they appreciated the opportunity to do this. The registered manager acknowledged that opportunities to support people with leaving the home were limited but hoped to address that by recruiting an activities coordinator. However during our last inspection in October 2014, we raised this issue with the registered manager and they told us then they were looking to recruit a person for this position. The registered manager told us they had tried to recruit a person for this role but had not found anyone suitable. The lack of progress since our last inspection has impacted on people's ability to undertake the activities that were important to them.

We did observe some positive one on one activities taking place between people and staff. Staff told us they were willing and able to spend time finding out what people were willing or able to engage in at that particular time and gave them dedicated attention to maximise their participation. We saw a person who had limited eyesight, dancing with a member of staff. The person responded positively to this and they danced around the lounge in time with the music. We also saw staff encourage people to become involved with activities to reduce the risk of people becoming socially isolated.

People received specific care and support they needed in terms of their age, disability, race or religion. For example records showed that a person had very specific religious needs and these were supported by the staff.

A complaints procedure was in place; however the location it was placed within the home could make it inaccessible for some people. Additionally the format of the procedure, written in small font, could mean some people may find it difficult to read. People told us they were unsure how to make a formal complaint, but did feel that if they spoke to a member of staff about any concerns they had that they would be dealt with. Staff told us if someone wanted to make a complaint they would look into the issue, report it to the manager and record it in the appropriate place.

We viewed the complaints register and saw the registered manager had ensured that when a complaint had been made this was dealt with quickly and people were responded to in a timely manner.

Requires improvement

Is the service well-led?

Our findings

During our previous inspection on 29 and 30 October 2014 we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

Regulations 2014. The registered manager did not have robust quality monitoring and auditing processes in place that enabled them to assess and review the quality of the service people received. They had also not ensured that staff received regular assessment of their work. People's views were not always gained to aid development of the service and 'resident meetings' to discuss people's views had not been held.

During this inspection we found that some improvements had been made but further improvement was required in some areas. Auditing processes were now in place in a number of areas such as safe management of medicines, care plan reviews and the environment. However these audits had not always identified some of the issues as outlined within this report. We raised this with the registered manager. They told us they felt they had made improvements since their last inspection but agreed there were still further improvements required.

Staff now received regular supervision and processes were in place to assess their ability to carry out their role in a wide range of areas.

People and relatives were now encouraged to provide feedback via questionnaires or 'resident meetings' on how they felt the service could improve and develop. We saw people and relatives were asked their views on a number of areas within the home including; the quality of the staff, bedroom and the food. People were also provided with information about the redecoration of the home and how long this would affect them.

The atmosphere within the home and the relationship between the staff and the management team had improved since the last inspection. Staff spoke highly of the management team. A member of staff said, "I can talk to the manager and to the owners about anything. If they are not here they are always on the other end of the phone." People also spoke highly of the management team. One person told us they regularly saw and spoke with them.

The staff had a clear understanding of the aims and objectives of the service. Each staff member we spoke with told us the aim of the service was to provide everyone with a good standard of care, keep them safe and maintain their dignity. They said they wanted to ensure they provided a high quality of care. A member of staff said, "We are a good caring team." They also told us the more experienced staff supported new staff to ensure they understood what was expected of them.

People did not have regular access to the wider community in which they lived. People were unable to access to external services and amenities unless they were supported to do so by their family and friends. The registered manager acknowledged more needed to be done to enable people to feel part of the community.

People were supported by staff who had an understanding of the whistleblowing process, were willing to raise concerns and followed the provider's whistleblowing policy.

People and staff were supported by a registered manager and representatives of the provider who were available to them when needed. Both understood their role and responsibilities. They had the processes in place to ensure the CQC and other agencies, such as the local authority safeguarding team, were notified of any issues that could affect the running of the service or people who used the service.

Staff were able to contribute their views during regular staff meetings and were encouraged to raise any concerns they might have about the care and support provided. The registered manager told us they welcomed staff views about the service and wanted them to feel their views were welcomed and valued. They also told us they held daily handover sessions with staff to ensure they were aware of the risks to people's safety and how they could contribute to reducing those risks.