

Pendene House Residential Home Limited

Pendene House

Inspection report

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Tel: 01162708911

Date of inspection visit:
07 September 2016

Date of publication:
14 October 2016

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

The inspection took place on 7 September 2016, and the visit was unannounced.

Pendene provides residential care to older people including people recovering from mental health issues and some who are living with dementia. Pendene is registered to provide care for up to 17 people. At the time of our inspection there were 15 people living at the home.

A registered manager was in post. 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.

At the last inspection of the service in May 2015 we asked the provider to make improvements in the storage of and administration of people's medicines. We received an action plan from the provider which outlined the action they were going to take. This advised us of their plan to be compliant by January 2016. At this inspection we found that improvements had been made. Medicines were ordered, administered and stored safely, and staff were trained to administer the medicines people required. Staff sought medical advice and support from health care professionals where needed.

At the last inspection we also asked the provider to take action to make improvements in staff knowledge of the pressure relieving equipment. We found staff were now aware of how the equipment was monitored and had set up a programme of regular checks to ensure it was used safely.

At the last inspection we also asked the provider to make improvements to the audits, checks and governance in the home. We received an action plan from the provider. A series of checks had been introduced that were overseen by the registered manager and then checked by the provider.

Staff told us they had access to information about people's care and support needs and what was important to people. People felt staff were kind and caring, and their privacy was respected in the delivery of care and their choice of lifestyle. However some of entries made by staff in the daily records did not always use the correct terminology and could be improved upon.

Relatives we spoke with were complimentary about the staff and the care offered to their relatives. People were involved in the review of their care plan, and when appropriate their relatives were involved. We observed staff positively interacted with people throughout the day and through the SOFI at lunch, where people were offered choices and their decisions were respected. People's care and support needs had been assessed and people were involved in the development of their plan of care. Staff had access to people's care plans and received regular updates about people's care needs. Care plans included changes to people's care and treatment and people attended routine health checks.

People were provided with a choice of meals that met their dietary needs. The catering staff were provided with up to date information about people's dietary needs, and sought people's opinions to meet their individual meal choices. There were sufficient person centred activities provided on a regular basis. Staff had a good understanding of people's care needs, and people were able to maintain contact with family and friends. Visitors were welcome without undue restrictions.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse. There were sufficient staff available to meet people's personal care needs and we saw staff worked in a co-ordinated manner.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. The provider undertook quality monitoring in the home supported by the registered manager. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals. We received positive feedback from the staff from the local authority with regard to the care and services offered to people. Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs.

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.

Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff understood their responsibility to report any observed or suspected abuse. Staff were employed in numbers to protect people. Medicines were ordered administered and stored safely.

Is the service effective?

Good ●

The service was effective.

Staff had completed essential training to meet people's needs safely and to a suitable standard. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005 and asked for people's consent to care before it was provided. People received appropriate food choices that provided a well-balanced diet and met their nutritional needs.

Is the service caring?

Good ●

The service was caring.

Staff were caring and kind and treated people as unique individuals, recognising their privacy at all times. People were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care that met their needs. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People told us they would have no hesitation in raising concerns or making a formal complaint if or when necessary.

Is the service well-led?

The service was not consistently well led.

The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this. However an absence of checking people's daily records resulted in staff using terminology that did not respect people's dignity. People using the service, their relatives and visiting professionals had opportunities to share their views and influence the development of the service.

Requires Improvement ●

Pendene 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 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.

The inspection visit took place on 7 September 2016 by one inspector and expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience's area of expertise was the care of older people and those living with dementia.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Pendene House. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home. We spoke with commissioning staff from the local authority who told us they had undertaken a quality monitoring visit, and found the provider was operating effectively.

The provider is required to send us a Provider Information Return (PIR). This allows the provider to provide some key information about the service, what the service does well and improvements they plan to make. This inspection was a follow up visit to check improvements had been made following a previous inspection visit, so the provider did not have an opportunity to complete this.

During this inspection, we asked the provider and registered manager to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our previous visit. We also asked the provider to forward more information following our visit, as some documents were not available on the day, and these were forwarded the day following the inspection.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported. We used the short observational framework tool (SOFI) to help assess whether people's needs

were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

To gain people's experiences of living at Pendene House, we spoke with two people and two visiting relatives. We also spoke with the provider, the registered manager and five care staff. We looked at three people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records.

Is the service safe?

Our findings

At our inspection of May 2015 we found the provider had failed to ensure the proper and safe management of medicines. We spoke with one person at the home about their medicines, one person told us, "My medication is given at regular times each day." We found improvements had been made and medicines were administered and disposed of safely.

People's medicines were now managed so people received them safely and regularly. We looked at the medication administration records (MARs) for four people. All the MARs were signed appropriately. A signature sheet was in place which included staff initials to ensure that any discrepancies could be followed up. People in receipt of 'as required' or PRN medicines had instructions added to the MARs to detail the circumstances these should be given and included the maximum dose the person should have in any 24 hour period.

We observed how staff gave people their medicines and heard people being offered pain relief which was prescribed on an 'as required' basis. We saw the same staff member encouraged a person to take their medicine. They explained what they were, and stayed with them to ensure they were taken. That demonstrated that staff understood the safety and security around administering medicines.

We found that medicines were stored securely and the temperature of the room was regularly monitored, but not consistently recorded. We brought this to the attention of the registered manager who immediately put in place a temperature recording sheet for the room. Staff we spoke with knew the storage temperature limits and what to do if these were exceeded beyond the recommended maximum. The registered manager also amended the policy and procedure to reflect the need for staff to regularly monitor the room storage temperatures. Records showed that the temperature for storing medicines safely in a refrigerator were in place and within the recommended range.

The medication administration records (MARs) were kept with the medicines. These had people's photographs in place to reduce the risks of medicines being given to the wrong person. The MARs were completed with initials, signatures and countersignatures, where these were required. Information about identified allergies and people's preference on how their medicine was offered was also included. This helped to ensure that people received their medicines safely.

Staff received training to ensure people's medicines were administered appropriately and staff who administered medicines told us the registered manager carried out observations of their practice to ensure they continued to administer medicines safely.

At our inspection of May 2015 we found the provider had failed to ensure the proper and safe instruction for staff using pressure relieving equipment.

We found improvements had been made and staff were clear on how the equipment was monitored. Staff told us, and showed us how the equipment was checked on a monthly basis, which was the timescale

advised by the district nurse. We spoke with the registered manager who said that staff checked the pressure relieving equipment on a monthly basis. The registered manager told us a record of these was then placed in the person's file. Staff now have clear and have written instructions on who to report faulty equipment to or if it needed re-setting.

People told us that they felt safe and staff cared for them safely. The person said, "I am safe here. I have the equipment I need and the staff are good at helping me." Another person said that, "I have my own room and I can lock it, but I don't."

Care staff were confident that people were safe from harm and said they would report any concerns of abuse to a registered manager or senior carers'. They were aware how to contact external agencies such as the local authority safeguarding or CQC and said they would do so if they felt their concerns were not dealt with. Records showed that care staff had completed training on how to keep people safe and staff we spoke with confirmed they had been provided with relevant training and guidance.

One member of staff said, "If I did find unexplained bruising, I would talk to the registered manager. If there had not been anything done, I would call social services or CQC."

The staff we spoke with had a clear understanding of the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had occurred. All of the staff we spoke with were aware of whistle blowing, and said they had not seen anything that required reporting or gave them cause for concern.

Staff told us they believed staff were employed in adequate numbers to ensure people were cared for safely. We found staff were employed in numbers sufficient to ensure people's safety. Staff confirmed there was a senior carer plus two care staff in a morning, afternoon and evening, and two waking night staff. In addition to this there was the registered manager, domestic, laundry and catering staff.

Staff were able to demonstrate their awareness of people's individual needs, and the support they required to stay safe. People's care records included risk assessments, which were reviewed regularly and covered the activities related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided clear guidance for staff in respect of minimising risk. People told us they were involved in discussions and decisions about how risk was managed.

We spoke with the staff about what they would do if they suspected someone was being abused at the service. One member of staff said, "I would tell (named) or the registered manager, if nothing was being done I could go to safeguarding or the CQC."

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if they suspected abuse. Staff we spoke with had received training in protecting people from harm. Staff had a good understanding of the different types of abuse and were aware of their responsibilities to act on concerns they had about people's safety.

Staff were trained to recognise the different types of abuse and how to identify them. They were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on. They also knew which authorities outside the service to report any concerns to if required, which would support and protect people. The registered manager was aware of her responsibilities and ensured safeguarding situations were

reported through to the Care Quality Commission as required.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff, and found that the relevant background checks had been completed before staff commenced work at the service.

Is the service effective?

Our findings

While we were talking to a person using the service, they struggled to remember where they had lived before moving into Pendene House. A member of staff was passing and recognised the person's anguish, and was able to prompt the person where they lived previously, and what their previous job was. This showed the member of staff had a depth of knowledge and understanding of the person's life before moving into the home. The member of staff told us they had read the 'pen picture' provided by the person's family, which we later confirmed by looking at the care plan.

Care plans were well written and provided staff with information to deliver effective care that met people's individual needs. Staff told us they felt they had enough training and did not feel they had any gaps in their knowledge. There was evidence that following their recruitment, staff had commenced induction training. This was followed by training in safeguarding, moving and handling, food and hygiene, fire awareness, health and safety and mental health awareness.

We saw from the training matrix that some staff had not had some essential training. The registered manager said the training dates had been arranged and all staff training would then be updated. This information was made available following the inspection. The registered manager has also attended a 'train the trainer' course that has enabled her to deliver training updates in the future.

A member of care staff confirmed that they had asked for and received additional training arranged through their supervision meetings. This resulted in training of end of life care which was provided by a local hospice. The registered manager added that she looked for training opportunities and when they arose looked for staff to build their knowledge on that subject.

Staff felt the support and communication between the staff team was good. There were daily handover meetings which provided staff with information about people's health and wellbeing. Staff also told us they were supported through regular staff and supervision meetings with the registered manager, and one person confirmed they had arranged extra training through these sessions. Staff supervision is used to advance staffs' knowledge, training and development by regular meetings between the management and staff group. That benefited the people using the service as it helped to ensure staff were more well-informed and enabled to care and support people effectively.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We looked at how people's consent to care and treatment was sought in line with legislation and guidance. We overheard people being asked for consent to care before this was undertaken. We heard a member of staff asking, "Your son would like you to have your hair done. Is that okay?" The person agreed and was assisted to have their hair done. We heard staff asking for similar levels of consent throughout our visit. For example, where people were asked about meals and drinks or being assisted with personal care.

Records showed that people using the service had mental capacity assessments in place with regard to making certain choices and decisions. When people lacked the capacity to give their informed consent, the law required registered persons to ensure that important decisions are taken in their best interests. A part of this process involved consulting closely with relatives and with health and social care professionals who know a person and have an interest in their wellbeing.

We found that the registered manager had ensured that six people were protected by the DoLS. Records showed that they had applied for the necessary authorisation from the relevant local authority. Some of these people have been represented by a family member or visited by an Independent Mental Capacity Assessor (IMCA). An IMCA will work with people who lack capacity to find out their views, wishes and feelings, and involve them in the decision-making process as much as possible. They can represent the person's views to those responsible for making decisions about their care and treatment, and check those working with the person adhere to the main principles of the Mental Capacity Act and act as a safeguard for the person's rights.

When we spoke with care staff they recalled their training on MCA and DoLS. Care staff told us that they felt they would be able to recognise if a person required a DoLS application completed. Records we viewed confirmed that care staff had been trained in both the MCA and DoLS.

People were supported with a nutritious and healthy diet that helped maintain their weight. People told us they were happy with the meals provided. One person said, "I have enjoyed my lunch" and "It is always good here."

Menu preferences were discussed at regular meetings between people using the service, their relatives and staff. Information on people's likes and dislikes were recorded in their care plans, and distributed to staff. This information and details of food allergies was made available for catering staff.

People had the choice to eat in the dining room, lounge or their bedroom. We used a SOFI to observe three people at lunchtime, they looked relaxed throughout the meal. We saw some people had been provided with adapted cutlery and crockery to enable them to eat their meals independently. Others required prompting and some required one-to-one assistance to eat their meal. This was done at a pace to suit the person, and staff were positioned to enable good eye contact.

The atmosphere at lunchtime was relaxed and staff supported people to eat without rushing them. Staff were attentive and responded to requests when people wanted second helpings or assistance with cutting their food into smaller pieces. We saw all staff maintained relaxed conversations with people throughout the meal. Fluids such as water and cordial were freely available in the dining area. This was in addition to regular drinks rounds provided by care staff. Staff were observed to give choices to people throughout the meal.

Bowls of fruit were placed around the home. People also had the choice of other snacks between meals which included home baked items.

We saw people's dietary needs had been assessed and where a need had been identified, people were

referred to their GP, speech and language therapist (SALT) and the dietician. This ensured any changes to people's dietary needs were managed in line with professional guidelines. One person was recorded as having a poor appetite. Records showed how much the person should eat and drink as a minimum and staff monitored their food and fluid intake to ensure they had sufficient to maintain their health. The registered manager said if they had concerns about the health of anyone monitored this way, they would seek further medical advice. This approach helped to ensure that people received effective support with their nutrition and hydration.

People's care records showed that they received health care support from a range of health care professionals and were accompanied by staff to routine medical appointments. Records we viewed confirmed people were subject to regular health checks by the GP, specialist nursing staff and hospital consultants.

Is the service caring?

Our findings

People told us the staff were caring and approachable. One person said, "They [staff] know me very well. I have a good relationship with them." Another person said, "I am really happy here, I have no problems."

We spoke with a visiting relative who commented, "Staff are lovely, caring, thoughtful and treat mum really well" and added, "They are good, they always bring me a drink even if I don't ask for one."

People were treated with kindness and compassion by a caring staff group. We observed staff interactions with people throughout the inspection which showed that staff were caring, helpful and people were treated respectfully. Staff demonstrated patience when supporting people to allow them to maintain a pace that was comfortable for them. For example, we saw a person being helped to mobilise from the dining room by wheelchair into the lounge. The staff instructed the person thoughtfully and allowed them to move at their own pace. We saw another person who started to mobilise out of the lounge, but could not remember where they were going. A member of staff observed the person was hesitant. They ascertained where the person was going and then gave thoughtful prompts, till the person reached where they wanted to go. We observed care staff had a good rapport with people, and engaged people in conversation.

We saw where another person had been diagnosed with dementia, that part of activities offered to the person needed to include a special piece of clothing, specifically designed to provide an activity suited to their diagnosis. Records confirmed the person was regularly assisted by staff to use this.

The registered manager and senior staff understood and promoted respectful and compassionate attitudes by the staff team. Staff told us this way of respectfully relating to people was regularly discussed at meetings and supervisions, and was an accepted part of caring for people.

Some people were unable to express their views and opinions. Records showed that family members had been involved in care plan reviews and there was information in care plans to ensure people were referred to by their preferred name.

The registered manager confirmed some people's family relatives were involved in care planning and reviews. Some care records were not signed by the individuals or a family member, but staff told us care plans were read to people and their comments recorded. The registered manager said care plans reflected people's needs and were reviewed every month. Staff said people were asked to take part in care plan reviews but only a few of them chose to take part in this process. Staff added relatives were informed when people's health or wellbeing changed.

We observed that staff checked on people's well-being throughout the day. Individual choices, preferences and decisions made about people's care and support needs were recorded. The daily records included the care and support people received, and demonstrated that staff supported people's decisions about how they were cared for. However the terminology used by staff in these records was not respectful and did not demonstrate a dignified approach to report writing by staff. Terms such as, 'woke up on the wrong side of

the bed' and 'X was really grumpy' were some of a few that we noted. We spoke with the provider and registered manager about this. They said they would challenge the individual staff members and ensure staff report writing was subject to more scrutiny. They added training would be provided to staff that required this.

We observed two members of staff who assisted people to eat their lunch. Both members of staff ensured the people's clothes were protected from food spillages, which assured their dignity. That demonstrated staff took steps to promote people's dignity.

We also observed a member of staff putting their arm around one person affectionately. We observed the same member of staff take another person to the window to look out at the garden and then a different person by the hand to dance in the afternoon. That showed that people were responsive to people's needs for friendliness and reassurance.

Staff understood the importance of caring for people and they described to us the caring qualities all staff had at Pendene House. They said there was a good staff team who knew people's needs and they all helped each other. They all said they enjoyed working at the home and got on well with the people they supported.

Is the service responsive?

Our findings

We saw that people received personalised care that was responsive to their needs. We spoke with a visiting relative who said, "The registered manager has been good at improving the bedroom, there's a hydraulic bed in place." The person went on to explain they felt this had improved the care offered to their relative and concluded by informing us of other more personalised care offered by the staff.

We looked at three care plans which included pre-admission assessments. The registered manager said these were carried out for people prior to them moving into the home. That ensured that staff could meet the person's needs. The exception to this was if anyone moved in on an 'emergency' basis, where the registered manager would complete this as soon as possible following admission.

One person told us they could not remember seeing their care plan or being involved in the planning or review process for their care.

Care planning was linked to people's needs which ensured care plans were individualised. We saw evidence of information on allergies, likes, dislikes, wishes and aspirations, and detailed life histories completed by people's families. Staff were able to explain and demonstrated through the care we observed the support that people required.

Staff had access to people's plans of care and received updates about their care needs through daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, suggesting the care process was responsive to people's changing needs.

We saw people enjoyed and joined in the activity that was arranged for the afternoon when we visited. This involved musicians who sang and played a variety of instruments. Some of the people joined in and played and sang along. One person told us about the 'fun day' that had taken place recently. They said they enjoyed seeing all the people visiting and having a good day.

Activities were arranged on a daily basis, and a photo board that evidenced people had taken part.

We spoke with the registered manager about how activities are decided in the home. They said people were asked through the regular meetings for those in the home. People were also asked to comment through the quality questionnaires that were also sent to their relatives and visiting professionals.

We looked at the copies of the 'residents meetings' which regularly included discussions around the menu, activities, staffing changes and changes to the home environment. Suggestions from these included more trips out and live music, both of which were evidenced at our visit.

The relatives meetings are held separately at a time more convenient to them and are advertised in advance. Those that were unable to attend had communicated suggestions by email, and these were included in the meeting minutes. One of these suggestions was a staff 'photo board', which is in the process

of being completed with a few photographs to be obtained. Another congratulatory email communicated the relative's thanks for the Easter party, and thanked the staff for putting on the party.

We spoke with staff about what activities people preferred to do. They told us that some people liked to sit outside, and we saw a patio area in the garden for this purpose. Staff also told us other people enjoyed painting and playing games, and we saw a person playing a game of 'pairs' with a staff member. They added that an activities plan was in place, but if people wanted to do something else, then staff would provide alternatives.

We noted that toilet, shower and bedroom doors were not clearly distinguishable for a person living with dementia. We recommend that areas of the home could be made more 'dementia friendly'. Information can be obtained from nationally recognised bodies, for example the Alzheimer's Society which would enable subtle changes to make areas of the home distinct and clearer for people.

The provider had systems in place to record complaints. One person said, "I have no complaints, I am happy here." A visiting relative said, "If we had any concerns we would talk to them straight away."

None of the people we spoke with said they knew how to make a complaint, which was possibly due to short term memory problems. Records showed the service had received one written complaint in the last 12 months. An outcome had been provided, and changes were made to the service, as a result of this. Analysis by the registered manager did not reveal any patterns or themes with previous complaints. The information was fed back to staff through staff meetings or individual supervision sessions, so that staff were aware of the issue and any change required.

Is the service well-led?

Our findings

At our inspection of May 2015 we found the provider had not ensured adequate checks and audits and failed to ensure regular reviews of safety systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 15 of the Health and Social Care Act 2008.

The provider sent us a plan that they would be compliant by January 2016. At this inspection we found that improvements had been made.

We discussed the checks and audits the provider and the registered manager conducted in order to ensure people received the appropriate support and care. The registered manager told us there were regular audits undertaken by the provider and staff in order to ensure health and safety in the home was maintained. We saw records of these checks that had been completed to ensure the building was safe for people. These included weekly checks on the medicines system, care plans, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements.

We saw there was an absence of checks on the records staff completed to describe people's daily activities. Some staff used terminology that did not respect people's dignity. This was also highlighted by the local authority at a recent monitoring visit. We spoke with the provider and registered manager about this, and training will be provided to staff to ensure the language used in records is always respectful. The registered manager said there would be closer scrutiny of the records to ensure recording always promoted people's dignity.

The provider spent two days a week in the home, and checked with the registered manager, any changes implemented and to ensure that people who lived in the home were safe and well cared for. Staff confirmed the provider regularly spent time in the home.

We saw a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. There was an in house maintenance person who undertook repairs on a regular basis.

Staff were aware of the process for reporting faults and repairs, and had access to a list of contact telephone numbers if there was an interruption in the provision of service. Other information included instructions where gas and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

The registered manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required.

We saw evidence that people who used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process. They were sent questionnaires, so were enabled to comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary staff assisted them in completing questionnaires. We saw some of the feedback had been adopted by the provider. For example, a 'shop' trolley was introduced to allow people to purchase toiletries and confectionary.

People who lived at the home and their relatives were also invited to meetings with the registered manager. We looked at the minutes of the meeting. We saw that people requested to be able to have live music and trips out, both of which were evidenced at our visit. That meant the provider embraced the quality assurance process and also provided evidence of a culture which was person centred and empowering.

The provider understood their responsibilities and ensured that we were notified of events that affected the people, staff and building. The provider had a clear understanding of what they wanted to achieve for the service and they were supported by the registered manager and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

Staff had detailed job descriptions and had regular staff and supervision meetings. These were used to support staff to maintain and improve their performance. Staff confirmed they had access to copies of the provider's policies and procedures. They understood their roles and this information ensured that staff were provided with the same information. This was used to provide a consistent level of safe care throughout the home.

A visiting relative told us they could make comments or raise concerns with the management team about the way the service was run. They had noted that after being laundered some clothes had not been returned to their relative's bedroom. The registered manager had acted on this issue and subsequently employed a laundry assistant, which had resulted in fewer mistakes taking place.

A copy of the last inspection report was displayed in the foyer of the home.