AKD Care Limited

Bank House Residential Care Home

Inspection report

Gosberton Bank
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Tel: 01775840297

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 23 February 2018 and was unannounced.

Bank House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bank House Residential Care Home accommodates 30 people in one adapted building. The home is registered for provide care for older people or people living with dementia. There were 19 people living at the home on the day of our inspection.

When we inspected in June 2017 we found that the provider was not administering medicines in a safe manner and the provider was in breach of the regulations. At this inspection we found that medicines were stored and administered safely. Medicine records were accurate and allowed for the management of medicines to be audited. The provider had made the necessary improvements in the management of the medicines and was no longer in breach of the regulations.

There was a registered manager for the home. 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 previous inspection the service was rated as requires improvement, at this inspection the provider and registered manager had made the improvements needed and the home was rated as good.

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 in the service supported this practice.

Risks to people were identified and equipment and care was planned to keep people safe. People were offered a choice of food and the meal was personalised to their individual likes. Where needed appropriate equipment was in place and modified texture diets were available to people who needed them. People were supported to access drinks throughout the day.

There were enough staff to meet people's needs and recruitment checks ensured that they were safe to work with people living at the home. Staff received training and support to ensure that the care provided reflected best practice and met people's needs. Staff had received training in keeping people safe from abuse and were able to describe the actions they would take if they had concerns over people's safety.

Staff were kind and caring and knew people's background, relatives and their likes and dislikes. This supported them to provide care which was centred around people's individual needs. Activities were

provided to keep people entertained and connected with the world. People were encouraged to join in activities to increase their social interactions.

Care plans reflected people's needs and people had been involved in planning their care. People's end of life wishes had been recorded and partnership working with external agencies kept people pain free at the end of their lives.

People knew who the registered manager was and were happy to raise concerns with them. The audits in place were effective at monitoring the quality of care that people received and ensured that changes were made when needed. People were supported to give their views on the care they received.

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.

Medicines were safely managed.

Staff had received training in how to keep people safe from abuse.

Risks to people were identified and care planned to keep people safe.

There were enough staff to meet people's needs.

Staff worked to minimise the risk of infection.

The registered manager ensured that learning from incidents was shared with staff.

Is the service effective?

Good

The service was effective.

There were systems in place to ensure training reflected the latest guidance.

Staff were required to keep their skills up to date.

There was a choice of food and drink.

People were supported to access healthcare when needed and information about their health was shared appropriately.

The environment supported people's independence.

People's rights under the Mental Capacity Act 2005 were respected.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and knew how to support people's

needs.

People were offered choices in their lives.

People were treated with respect and dignity.

Is the service responsive?

Good

The service was responsive.

People were encouraged to be involved in planning their own care and care plans accurately reflected people's needs.

Activities provided supported people to be entertained and happy.

People were supported to have a pain free death.

People knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The registered manager was approachable and responded when concerns were raised.

Audits to monitor the quality of care were effective in driving improvements.

The views of people living at the home were used to improve the care provided.

Bank House Residential 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 home under the Care Act 2014.

This inspection took place on 23 February and was unannounced. The team consisted of an inspector, a medicines management inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

In preparation for our visit we reviewed information that we held about the home. This included the action plan completed by the provider following our last inspection. As well as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, two members of care staff, the cook and the activities person. We also spoke with six people living at the home and seven visitors to the home.

We looked at a range of documents and written records including four people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of care provision.

Good

Is the service safe?

Our findings

At our last inspection we identified concerns with the way medicines were managed at the home. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider they would have to improve the way they looked after medicines. At this inspection we found the provider had made the improvements needed and was no longer breaching the regulations. We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. One person told us, "Yes, I always get my tablets at 6.30. They don't seem to be late very often if ever."

We looked in detail at the medicines and records for six of the 19 people living in the home and these showed that people were receiving their medicines as prescribed.

Records were kept of medicines received into the home, given to people and disposed of. There were no gaps on the administration records and any reasons for people not having their medicines were recorded. Clear records were made of when to give the next dose of medicines to ensure that people got their medicines on time. Blood tests, to ensure that some people's medicines remained safe for them to take, were all clearly documented and up to date. Records showed that creams and ointments that had been prescribed were applied by the care staff. When people had patches applied records were being kept to ensure that they were being applied to different parts of the body and that the old patch was removed.

When people had been prescribed medicines to be given on a 'when required' basis they may not be given these medicines in a consistent way by the care staff. People's care plans contained brief information describing how decisions would be made by staff when people were not able make decisions themselves. Similarly, when people were given medicines hidden in food there was little information in their care plans describing how this was to be done. However, observations showed this was completed in a safe manner. Advice had been sought to check that it was safe to crush some specific medicines before they were given.

We observed people being given their medicines by the staff. We saw that they did this is a systematic way. They explained to people what they were doing and gave people the time that they needed to take their medicines. People were supported to look after and take their own medicines when they wished to do so. The risks to the individual of doing this had been assessed.

Medicines were being stored securely. Medicines in the drug fridge and main store room were kept at the correct temperature. But the temperature was not being monitored where the drug trolley was kept so we couldn't be sure that all medicines were being stored at the right temperature. Controlled drugs were stored securely and recorded correctly.

People were safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk.

Staff were about to tell us about how they kept people safe from harm, For example, by monitoring people if they did not feel safe with visitors or if they person did not wish to see the visitor by refusing them entry into the home. Staff were clear that they could raise concerns with the registered manager at any time and were confident that the registered manager would take appropriate action. Staff also knew that they could raise concerns direct with the local authorities safeguarding team.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. For example, where people needed support to move around the home a full assessment had been completed which identified how many staff were needed to support the person and which equipment was the most appropriate for the person to use. Information which would support staff to provide safe care was also recorded in their care plan. For example, one person's care plan noted that staff needed to be aware that they had muscle weakness and pain in both their legs.

Where needed specialist equipment was in place and care needs such as regular repositioning for relive of pressure areas was recorded. A relative told us that staff ensured that equipment was used properly. They told us that staff made sure that their family member sat on their named pressure cushion and that when they had needed a pressure relieving mattress it has been made ready to use as soon as it had arrived.

People had been assessed on their ability to react to an emergency and the provider had assessed what care and support they would need to stay safe in such a situation.

The registered manager told us that they had carefully established how many care staff and other members of staff needed to be on duty. They said that they had taken into account the number of people living in the home and the care each person needed to receive. A person living at the home told us, "If I want the toilet I ring the bell and I'm never made to wait." During our visit we saw that there were enough staff on duty to meet people's needs and call bells were answered quickly.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

We found that suitable measures were in place to prevent and control infection. A relative said, "The place is always clean and tidy and there is never that smell you get in some places."

The home was clean and each toilet had soap and hand wash available for people to use. Staff told us how they worked to minimise the risk of infection, this included wearing equipment such as gloves and aprons and ensuring that they washed their hands between tasks.

The registered manager had audited the cleanliness of the home and the local authority infection control team had recently visited the home. The registered manager had completed the actions identified for improvement. The kitchen had recently been inspected and had been awarded the highest highline rating of five. This meant that infection control processes in the kitchen were established and maintained.

We found that the registered persons had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the registered manager carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence. For example, we saw that the registered manager investigated any

medicine errors and identified why the issue arose. They then ensured that the systems in place helped to reduce the risk of the incident re-occurring. If needed extra training was completed for staff and the registered manager completed observations to ensure that staff were competent and followed best practice when administering medicine.

Good

Is the service effective?

Our findings

We found that robust arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. The manager had emailed out to staff explaining how important it was that they all attended refresher training so that they remained up to date with changes in best practice and guidance. They had emailed out the dates for the year and ensured staff were aware that if they did not attend the registered manager would remove them from the staff rota. This ensured that only staff who were up to date with best practice were able to provide care for people.

Records showed that new care staff had received introductory training before they provided people with care. In addition, they had also received on-going refresher training to keep their knowledge and skills up to date. The training for the year had been planned and advertised to staff so that they all knew what was expected of them. The registered manager had staggered training so that there was more than one opportunity for staff to attend.

Staff told us that they had a structured induction to the home. This consisted of learning about the skills needed to provide safe care and shadowing a more experienced member of staff so that they could get to know people and how they liked to be cared for. A senior member of staff told us how they observed new staff giving care so that they could be sure that they were competent and working in line with the provider's policies.

Staff told us that the registered manager and provider supported them to gain qualifications in related subject areas. In addition regular supervisions with the registered manager enabled staff to raise any training needs they had identified.

People's nutritional needs were well supported. One person living at the home said, "There's a good choice of food, especially puddings. I've eaten puddings I've never heard of before." Each person had access to a jug of juice near their chair. Where people may not always drink enough to ensure they stayed hydrated staff would offer encouragement to the person. This was important as drinking enough would protect the person against illnesses such as constipation or urinary infections.

We saw that over lunch time the television was turned off and music was put on. This ensured that people had a pleasant atmosphere to eat their lunch in but were not distracted. This increased the probability that people would eat a suitable amount at meal times and reflected best practice in dementia care.

We saw that people were offered a choice at meal times and if they chose not to have either of the two options available were able to request any meal that they would like. For example, at the midday meal the main meal offered was a Cornish pasty with chips with a salad as the second option. We saw that one person had chosen to have egg on toast. Staff explained to people what was on the plate as they served the meal which ensured that people with poor eyesight knew what they were eating.

In addition meals were served to encourage people's appetite. For example, one person requested to have

a small plate of food as an overfull plate would put them of their meal. This was served as requested. In addition people were able to personalise their meals an example of this was a person who requested a dressing for their salad and was left to add as much or as little as they wanted. Everyone was asked if they wanted second helpings. All these attentions to detail ensured that people maximised their food intake and reflected best practice.

One person left the table and when they returned staff asked them if they preferred to sit in the lounge rather than at the table. They chose this option. Staff told me that they sometimes preferred that. The chef offered to plate up a meal for them to eat later.

Where people were at risk of being unable to maintain a healthy weight, staff encouraged them to eat more and if needed they were referred to their doctor for supplements to increase their calorie intake. Records showed that this approach had been successful and people's weights had increased.

Where people were unable to eat safely they had received an assessment by a healthcare professional. We saw that the staff followed the advice given, for example, by providing food of a consistency that was safe for the person to eat and by ensuring their posture helped them to swallow.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. People had an emergency grab sheet in the care files which included important information about them. This could be taken to hospital with them so that important information about the person was shared. In addition we saw that staff continually passed information to each other about how people's days were progressing and they shared if they had concerns over people. Staff worked together as a team to ensure that people's needs were net. For example, the activities coordinator helped to support people with their lunch.

People were supported to live healthier lives by receiving on-going healthcare support. One person living at the home said, "If you need the doctor they get one for you, or else the nurse comes." Another person told us, "You've only got to tell them you don't feel 100% and they're checking up on you." A relative also told us that staff were good at raising concerns with the doctors if they were worried about people's health. A person living at the home and their relative told us how supportive the home had been in helping them access healthcare. They told us how the registered manager had arranged for an optician to visit the home and how the home had organised the transport they needed for a hospital visit.

Care plans showed that healthcare professionals had been involved in people's care when needed. For example, we saw one person's care plan noted that they had been seen by the doctor and an optician. In addition, records showed that people were supported to access healthcare as they would have done if they lived at home. For example, we saw that people had been offered the opportunity to have a flu immunisation to reduce the risk of them being poorly over the winter.

We found that the accommodation was designed, adapted and decorated to meet people's needs and expectations.

There was good dementia signage around the home which helped people to find their way to the bathrooms and their bedrooms. We saw that corridors had been given names of former and much loved residents. For example, one corridor had been renamedMasons Way. The registered manager told us that they had discussed using the names with the people's relatives who had been happy that they would be remembered in this way.

The upstairs and downstairs corridors had been decorated and were painted a pleasant cream colour with a contrasting green for handrails this ensure that people living with dementia were able to see and identify the handrail. Memory boxes were in place to help people identify their bedrooms and each door had the person's name on it to assist them in identifying their own bedroom. Important areas like toilet doors also had large clear signage with both pictures and words. This supported people to be able to retain their independence.

There were several smaller sitting rooms and people were able to use them if they wanted quiet time with their family. The registered manager told us one person had recently used one of the rooms to have a small family party for their birthday. The registered manager was developing a small room into a reminiscence room. They had decorated the room in a retro fashion and had provided objects such as an early electric iron to prompt discussion. The registered manager had plans to invite small groups in the room for coffee and cake mornings. The hairdressers room had been redecorated and provided a pleasant environment for people to spend time getting individual care and attention.

We found that there were no window restrictors in place. We raised this as a concern with the registered manager. They told us they would ensure they were put in place immediately and contacted us following the inspection to confirm that this had been done.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that where people were unable to make a positive choice about living in the home, the registered manager had completed applications for their assessment under the DoLS. Two people living at the home had DoLS in place on the day we inspected. There were no conditions on these DoLS.

Staff had received training on the mental capacity act and knew that they should assume that people had the ability to make decisions unless there was some indication that they may be struggling. Where people had legally appointed family of friends to make decisions on their behalf this was recorded in their care plans.

Some people living at the home were taking their medicines covertly. This was when staff hid the medicine in the person's food so that they do not know that they are taking it. Medicine can only be administered this way if the person does not understand the impact of not taking their medicines. We saw that the person's lack of ability to understand had been confirmed by a mental capacity assessment and a best interest decision involving the views of family and healthcare professionals was undertaken.

Some people living at the home needed bed rails to keep them safe. We saw that people's views of the use of bedrails was sought and consent obtained before they were put in place. Where people were unable to

make a decision about the use of such equipment a mental capacity assessment had been completed and a decision made in their best interest.

Good

Is the service caring?

Our findings

We saw that the staff ensured that people were treated with kindness and that they were given emotional support when needed. People told us that they liked living at the home. One person said, "I would advise anyone needing care to come here. It's a good group of staff they are caring and jovial."

People told us that they had built relationships with the staff and trusted them. They told us that staff had time to care for them. One person told us, "It's homely here. I can talk to the staff and tell them things, especially if I'm worried about something. They are very good." Another person said, "I ring my bell if I need help. If they're seeing to someone else they let me know and then come back when they've finished. I like to keep independent, they encourage you here. I think the staff are very sympathetic, they deal with what you want straight away."

Relatives were also complementary about the staff. One relative told us, "He seems very attached to the staff. Some of them say he reminds them of their Dad." Another relative said, "All the staff are brilliant! Including the laundry lady and cleaners. They give him a cup of tea if he's wandering in the night." One relative gave us examples of how staff had supported their father, telling us how the cook had arranged for their relative to look around a motorbike. The relative told us, "They did it especially for him because they knew he was interested. He loved it and couldn't stop talking about it." They also told us how the maintenance man spoke to her relative explaining exactly what he was doing. They told us that this had made their relative feel included in the home.

We saw that staff engaged with people using best practice techniques to get people's attention. For example, staff made sure they had eye contact with people before speaking to them. They knew and used people's preferred names. In addition staff had got to know people and were able to tell us about people's families, backgrounds and what was important to them.

During the morning one person went out with a relative to attend a hospital appointment. They returned during the midday meal. We saw that staff took the time to welcome them back and say that they had missed them during the morning. They were immediately offered a drink and when they had settled and spoken to other's sitting at their table staff offered them a choice of meal. This showed how staff were kind and caring, the person was offered what they needed but not rushed or made to feel that they had put people out by arriving late for the meal. It showed how people and staff supported each other to be part of a community.

In addition to supporting the people living at the home staff took time to ensure that their family members were happy and well. A relative told us how pleased they were with the support and reassurance they themselves had received explaining that staff would notice if they were feeling down and in need of a chat.

A relative told us how if they rang the home staff were always able to take the telephone to their relative so that they could speak with them. They told us that this meant a lot to them as they were not always able to visit. Another relative we spoke with told us how staff had encouraged their parent to communicate more

with the other people in the home to decrease their social isolation. The relative told us this had done the person, "A world of good."

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Staff told us how they supported people to make choices about their everyday lives, for example, by offering clothes choices. One member of staff told us, "It's their home, they can have whatever they want. I think about how I would want my relatives treating."

People had the opportunity to make choices about their care. For example one person was meant to wear boots which reduced their risk of pressure sores but were reluctant to do so during the day. Records showed that they were able to make this decision and while staff would provide gentle encouragement for the person to wear the boots they respected their decision not to.

Where people may not be able to make choices staff engaged with relatives to identify their preferences and these were recorded in their care plans. For example, people's preferred bed and getting up times were recorded along with their food likes and dislikes. No one living at the home currently required an advocate but information on how to obtain one was available for when needed.

People's privacy, dignity and independence were respected and promoted. Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use.

Staff told us how they respected people's privacy and dignity by encouraging people to self-care as much as possible and by ensuring doors and curtains were closed when providing care. Staff told us that they always checked if the person consented to care from a male carer. Staff told us that they had received training in equality and diversity and that it meant that they treated people with respect and did not discriminate based on people's protected characteristics.

A family member told us how the staff ensured that when they visited they had a space where they could be private. They explained that this was helpful as their relative was hard of hearing and being private made conversation easier. Another relative told us that staff ensured that there was always a wheelchair available when they wanted to take the person out of the home.

Good

Is the service responsive?

Our findings

People were happy living at the home. One person who was at the home for some respite care told us, "I have enjoyed myself and the staff have been good." We found that people received personalised care that was responsive to their needs including their right to have information presented to them in an accessible manner. The registered manager had provided information in an accessible format when needed. For example, food choices were available in picture format for people whose dementia made it hard for them to understand words. People's communication needs were recorded in their care plans. The television was on and as well as the sound the subtitles were on for those people who may have difficulty hearing.

People told us that they had been involved in planning their care. Where people had been unable to be involved in planning their care their relatives or others they had requested make decisions on their behalf had been included. A relative we spoke with told us, "The staff seem to love him and he is very settled. I helped with his care plan, its more than OK, we are really pleased with how he's looked after. To facilitate people's involvement in care planning they and their relatives or other people who supported them were invited to a review of their care needs.

People's care plan reflected their current health needs. For example, one person's care plan noted that they were prone to urinary infections. Records showed that staff had identified when they were not well and ensured that urine tests were completed as soon as possible so that medicine could be arranged if needed. Care plans also recorded how people reacted to pain and if they were able to tell staff or would need staff to monitor their needs and provide pain medicines when needed. Where people had diabetes there was clear guidance in their care plans how often their blood sugars should be checked and at what level should staff refer the person to the doctor for additional support.

People told us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. There was an activities coordinator to lead activities in the home. They told us that there was a daily plan of activities but that it was flexible and it depended on what people wanted to do.

During our visit we saw that people were engaged with activities and were happy and laughing with the activities coordinator. A relative told us how activities ensured that people were kept engaged with the seasons and celebrations. An example of this was when everyone received a rose on Valentine's Day. The activity coordinator also produced a monthly newsletter which introduced people when they moved into the home and new staff. It also celebrated people's birthdays and contained news about upcoming activities.

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. When people neared the end of their lives their wishes regarding resuscitation were sought. Where people or their relatives had made a decision not to resuscitate, appropriate information was recorded in the person's care plan to ensure their wishes were respected.

A member of staff told us how they worked with people at the end of their lives to help them have a comfortable pain free death. For example, by working with other healthcare professionals to ensure pain relief was available when needed. In addition they supported relatives to spend as much time as they wanted with the person ensuring that they were comfortable and providing food so that they did not have to leave.

There were arrangements in place to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Information was available to people on how they could raise any concerns they had. One person living at the home said, "If I had any problems I would tell the manager." Another person told us, "I know about the complaints procedure and I've been given a form but never filled it in." There had been no formal complaints received since our last inspection.

Good

Is the service well-led?

Our findings

People told us that they considered the home to be well run. One person told us, "It has altered here but for the better. I like the things [the registered manager]'s done to make it better."

We noted that the registered manager and provider had taken a number of steps to ensure the home complied with regulatory requirements. There was a registered manager in post. The last rating was on display in the home and the provider and registered manager had completed the appropriate notification to tell us about events that happened in the home.

The culture in the home was open and people were able to raise concerns with the registered manager on an ongoing basis and they were resolved. A family member told us, how following an incident the registered manager had contacted them on the telephone and explained what had happened and provided reassurance and support. All the people living at the home and their relatives were positive about the manager. They felt that she listened to their concerns and acted in their best interests. The registered manager told us they received good support from the providers who visited weekly.

The provider and registered manager had audits in place to monitor the quality of care provided. Where the audits identified areas of concern the registered manager took action to improve the quality of care people received. In addition, they took notice of external audits such as the infection control audit completed by the local authority and a pharmacist audit to improve the safety of the care they provided.

The registered manager and provider took account of national guidance when making improvements. For example, they had worked to the King's Fund guidance when updating the environment to ensure that it reflected best practice for people living with dementia. The registered manager told us that they had noticed the changes they had made had supported people to improve their independence. For example, the signage meant people were able to find the way around the home on their own.

We found that a number of systems were in place to help care staff to be clear about their responsibilities. Staff told us that they received supervision with their line manager every three months. In addition, staff had regular staff meetings and would feel confident to raise any concerns or ideas on how the home could be improved. One member of staff told us, "We are one big family both the staff and residents. I am able to raise concerns with both the registered manager and the head of care. I can talk to them and they are understanding." The provider recognised the hard work of the staff was crucial to people receiving good care. They had an employee of the month scheme where each month one member of staff was recognised for their contribution and presented with a bouquet of flowers. Staff told us they appreciated this recognition.

We found that people who lived in the home and their relatives had been engaged and involved in making improvements. The activity person spent time with people living at the home to gather their views on the care they received. For example, one person had suggested having fish and chips from the local shop. Surveys had been completed to gather the views of people living in the home and their relatives on the

quality of care they received.

We found that the registered persons had made a number of arrangements that were designed to enable the home to learn and innovate. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles.

The registered manager kept up to date with any changes in best practice by networking with other registered manager's and ensuring they were signed up to receive updates in the industry magazines, in addition they liaised with the local authority to ensure they were up to date with all their requirements.

We found that the staff worked in partnership with other agencies to enable people to receive 'joined-up' care. They ensured that they shared information with other agencies to support people's joined up care when people moved between services. In reception information was available on how to contact Healthwatch Lincolnshire. Healthwatch is a consumer champion for health and social care.