Country Court Care Homes Limited

Neale Court

Inspection report

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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 5 April and was unannounced.

Neale Court is registered to provide accommodation and personal care for up to 23 older people or people living with dementia. There were 21 people living at the service on the day of our inspection.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Five people at the time of our inspection were in the process of having a DoLS authorisation granted.

Staff undertook appropriate risk assessments for all aspects of a person's care to keep them safe from harm. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were supported to have a healthy and nutritious diet and hot and cold drinks and snacks were available throughout the day. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. Relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and advance their skills to enable them to perform their roles and responsibilities effectively.

People were supported to have an active life and were encouraged to take part in hobbies and interests of their choice. Relatives commented that their loved ones were well looked after.

People where able, were supported to make decisions about their care and treatment and maintain their independence. People and their relatives had access to information about how to make a complaint.

Relatives told us that they could approach staff with concerns and knew how to make a formal complaint to the provider.

The registered provider had introduced robust systems to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

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.

The provider ensured that were enough staff on duty to meet people's needs.

People had their risk of harm assessed for all aspects of their care. Staff knew how to keep people safe.

Staff were aware of safeguarding issues, knew how to recognise signs of abuse and how to raise concerns.

Medicines were ordered, stored, administered and disposed of safely. Staff were assessed as competent to administer medicines.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced diet.

People had their healthcare needs met by appropriate healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were involved in making decisions about their care.

People were treated with dignity and staff members respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

People were encouraged to maintain their hobbies and interests including accessing external resources.

Is the service well-led?

Good

The service was well-led.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care.

There was an open and positive culture which focussed on people and staff.

People who lived in the service and their relatives found the registered manager approachable.

Neale Court

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 took place on 5 April 2017 and was unannounced. The inspection team was made up of one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the registered manager from another service owned by the same provider, the deputy manager, three members of care staff, the chef manager, kitchen assistant, an activity coordinator and seven people who lived at the service and two visiting relatives. We also observed staff interacting with people in communal areas, providing care and support. In addition we spoke with three visiting health professionals. Following our inspection we spoke with the registered manager by telephone.

We looked at a range of records related to the running of and the quality of the service. These included three staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for six people and medicine administration records for eight people.

Good

Is the service safe?

Our findings

People and their relatives told us that the service was a safe and secure place to live. We noted that there were handrails throughout the service. One person's relative told us, "It's safe for [name of relative]. There are handrails all the way down the corridor. She loves them. It means she doesn't need a frame."

People were provided with a lockable safe in their accommodation and we found that some people took advantage of this to keep some of their personal belonging safe.

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and how to recognise signs of abuse

There were systems in place to support staff when the registered manager and unit managers were not on duty. Staff had access to an emergency folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. Staff had also had access to on-call senior staff out of hours for support and guidance. Furthermore, people had an up to date individual emergency evacuation plan to be used to help them leave the premises safely in an emergency situation, such as a fire.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as mobility and nutrition. Care plans were in place to enable staff to reduce the risk and maintain a person's safety. A senior member of care staff told us that the risk assessments informed care staff of a person's care needs and what training staff needed to deliver that care safely. For example, all care staff were trained to safely assist a person to transfer using an electrical hoist.

We looked at three staff files to check that there were robust recruitment processes in place and all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. However, references from previous employers were not present in two staff files. Following our inspection the registered manager located these missing references in the organisations archives. As a result of this all locations within the provider organisation have checked their staff personal files to ensure all relevant recruitment documentation is accounted for.

The provider had a system for calculating the care dependency levels for the people who lived at the service. These dependency levels then informed the registered manager of how many staff with different skill levels were needed on each shift.

We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly. People and their relatives told us that there were enough staff to look after their care needs. We saw that people had access to a range of call buzzers, pull cords and pendants to suit their need and activity. One person's relative told us that staff were attentive to their loved ones needs and said, "[Name of relative] has a buzzer in her room, but she has no need to use it." Another relative told us, "There is always

somebody around [member of staff], she uses her buzzer and they are there instantly." Staff told us that they staffing levels had recently improved and one said, "The daily staffing levels have increased by 12 hours. We now have more time to spend with them [people who lived in the service] and get to know them. They've also introduced two activity coordinators and a full time maintenance person."

To ensure that essential tasks were carried out, care staff were given responsibility at the start of their shift key tasks, such as emptying the clinical bins and ensuring people had a drink and a snack from the tea trolley in the afternoon.

One person's relative told us that they were very impressed by the way staff managed their loved one's medicines and said, "They are on the ball with her medicines. They had them reviewed by the frailty team and they lowered the dose of [name of a sedating medicine]. The staff and family noticed the change in her straight away. She has improved." Another person's relative said that their loved one did not have to worry about remembering to take medicine and added, "They [members of staff] look after her medicines."

People received their medicine from staff that had received training in medicines management and had been assessed as competent to administer them. At lunchtime we observed medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed. Measures were in place to ensure that staff administering medicines were not disturbed. The member of staff wore a red tabard to alert other staff, people who lived at the service and their visitors that the medicines round was in progress and not to disturb them. We saw that this alert was respected. The staff member spent time with each person, told them what their medicine was for and waited with the person until they had taken their medicines safely. We saw where a person had an inhaler to help relieve breathing difficulties, that the member of staff assisted them to use their inhaler through a special "easy breath" adaptor.

We looked at medicine administration records (MAR) for eight people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person was offered pain relief, but had declined. When a person was prescribed medicine through a skin patch, a body map was in place and identified the areas where the patch was to be applied, to minimise the risk of damage to the person's skin.

When a person was prescribed as required medicines, such as pain relief, staff had protocols to enable them to administer the medicine safely and the protocols had been agreed by the person's GP.

All medicines were stored in accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. We saw evidence that senior members of staff undertook a daily stock check. Staff had access to guidance on the safe use of medicines and the medicines policy.

Good

Is the service effective?

Our findings

People told us that staff had the knowledge and skills to carry out their roles and responsibilities. One person said, "You can't beat these girls."

Staff were provided with mandatory training such as safe infection control practices and fire safety. Staff also, received training specific to people's individual needs. For example, several people living at the service had a dementia type illness. In order to support people as best they could staff had undertaken training in dementia care and had signed up to an Alzheimer Society initiative called "dementia friends". Dementia friends learn what it is like to live with dementia and are therefore more able to understand and meet the needs of people in their care. Furthermore, one of the activity coordinators was the dementia champion for the provider organisation.

A member of care staff who had previous experience of caring for people in other care settings told us about their induction. They said, "I spent the first two weeks shadowing other staff and learning about the resident's needs, how they liked to live and about the layout of the building. Even although I had experience of caring I still attended all the mandatory training." Another member of care staff who had worked for the previous provider for the service told us that their training had prepared them to look after people and said, "The new owners are really investing in training. I now know how to look after people. I understand more about the needs of a person with dementia."

Staff received regular supervision and appraisals and said that they were a positive experience and they welcomed feedback on their performance. We saw that supervision sessions not only involved face to face meetings, but also included the registered manager observing staff when they provided care to people.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have bed rails insitu. The rationale for their use was recorded in their care file. Furthermore, we saw that people's wishes were respected. One person with a neurological condition that impacted on their ability to mobilise and speak effectively had signed their consent to be resuscitated in the event that their heart would suddenly stop beating.

Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA). A member of staff said, "We are here for them [people who lived at the service] and we have to act in their best interest. A couple of people do lack capacity. We work with them. They may lack the capacity to make complex decisions but can make simple decisions, such as what to eat or what to wear. Every day is different. We take each day as it comes." We looked at the care files for six people and saw that capacity assessments were person centred. For example we saw that one person had capacity to make day to day decisions about what clothes to wear or how to spend their time. However, staff had recorded that this person became more confused and forgetful in the early evening and to avoid making complex decisions at this time.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the

mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves.

We spoke with one person who had made the decision not to follow their doctors' advice on the amount of fluids they should have each day. They told us, "I know the risks if I drink too much, but I enjoy my cups of tea." We noted that this person had been assessed to have the capacity to make their decision.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and five applications had been submitted to the local authority and were waiting on the authorisations to be approved. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

People told us that the food was good, well cooked and they were provided with a nutritious and well-balanced diet. We found that people were provided with a varied breakfast menu that offered a choice of hot or cold cereals and a cooked breakfast. The four week lunchtime menu plan and the weekly tea time menu were on display at the main entrance to the service and in the dining room. We saw an alternative lunchtime menu on display offering a choice of salads, toasted sandwiches, baked potatoes and omelettes.

We noted that hot and cold drinks were provided by care staff throughout the day. People were enabled to help themselves to fruit and a selection of cold drinks from a trolley in the activity room. When a person was at risk of weight loss we saw that a record was kept of the amount of food they were offered and what they actually had to eat. This provided an accurate record of their daily intake.

One person's relative spoke with us about the quality and choice of meals and said, "They have a well-balanced diet, meat potatoes and two veg. I've seen it. [Name of loved one] is always raving about it. And they have drinks on tap all day." However, some people told us that the menu was not varied and said, "The food is good, but very repetitive." We looked at the menus and found that people were offered the same evening meal each week. For example, it was always a teacake and fruit whip for tea on a Monday and cold meat and pickles and strawberry mousse on a Tuesday.

We spoke with the chef manager who explained that the provider had recently adopted a menu and recipe system produced by a development chef from an external catering agency. The rationale behind this was that a four week seasonal menu was in place that ensured that people received a balanced and nutritious diet and that any allergies and special dietary needs were catered for. The catering team were provided with nutritional information about the menus and any food allergens. We discussed with the chef the rigidity of the tea time menu. They explained that until recently people were offered soup at lunchtime and tea time, but as a result of discussions at resident's meetings the tea time menu at been changed to light snacks rather than soup. We also spoke with the apprentice chef who was attending a chef school provided by the external catering company. They told us that in response to people's feedback, they had put on an Italian themed day the previous week and had planned an American themed day for June 2017. The chef manager reassured us that any concerns raised about the menu plans were shared with the area operations manager

who was in discussion with the external catering company.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, dentist and physiotherapist. For example, during our inspection two people were visited by their GP at the request of care staff.

We saw that if a person presented with signs of fever, such as a high temperature or a urine infection that staff had a screening tool to detect early signs of sepsis. This meant that people received timely and appropriate treatment from their GP. This tool was also used as part of the admission assessment process. When a person required their fluid intake to be restricted for medical reasons we saw that staff monitored their fluid intake and output and reported any concerns to the person's GP.

We spoke with three visiting healthcare professionals who informed us that staff made appropriate and timely referrals to them and always followed up on any advice and prescribed treatment. Furthermore, they told us that care staff were competent caring professionals and knew the needs of the people who lived at the service.

Good

Is the service caring?

Our findings

People told us that they were looked after by kind, caring and compassionate staff. One person said, "The staff are very caring." We spoke with the relative of person who was admitted as an emergency. They told us that their loved one was well cared for and said, "[Name of loved one] loves this place. The staff are amazing, always popping in and out. Always asking if she would like her hair washed or have a bath. She has come on leaps and bounds. She is really happy and settled here and we have peace of mind." We met with the person in their accommodation and saw that they were happy and content with the care they received and with their surroundings.

One visiting healthcare professional spoke highly of the care people received and told us that care staff were very caring and their patients were incredibly well looked after. Another healthcare professional that was supporting a person to improve their mobility said, "The staff are following through her care. They are actively promoting [Name of person] recovery. They are helping them become more independent. They have left me with a good impression of the service."

Before a person made their decision to move into the service they were encouraged to visit and have a look around. We spoke with the relative of one person who had recently moved into the service who said, "Mum wasn't so happy in her last home. She had moved away from the area she had lived in for over 50 years. I brought her to see Neale Court and within the week she had been assessed [by Neale Court staff] and had moved in."

People had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. We saw that staff made reference to people's likes and dislikes and past life events to provide person centred care.

We found where a person was unable to verbally communicate effectively that staff supported them to use hand gestures and facial expressions to communicate their needs. Staff had recorded in their care file that there was a risk of misinterpretation as the person would at times say "no" when they meant "yes". Staff had taken action to help orientate people to their surroundings, the time of day and the staff caring for them. For example, there was a list of the names of staff on duty clearly on display in the dining room. This helped people remember the names of staff caring for them.

Staff had access to a policy on advocacy. However, this policy provided contact details for national advocacy services but did not provide contact details for the local advocacy service. We brought this to the attention of the visiting registered manager from another service who said that they would share this with the provider. People were provided with information on how to access an advocate to support them through complex decision making, such as moving into the service. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

People were enabled to maintain contact with their family and friends and people could receive visitors at any time. On the morning of our inspection one person went out for breakfast with a relative. On their return

they were full of enthusiasm about their trip out and recalled their story several times throughout the day to staff and other people who lived at the service. We spoke with another person whose spouse was cared for in a nursing home. They were supported to visit their spouse every day. The deputy manager informed us that they were working with other agencies to try to accommodate the couple in the same care home.

People were proud of their achievements and we saw photographs of their participation in arts and crafts groups and other activities on display at the reception area.

We saw that people's right to their privacy and personal space was respected. People's private accommodation was entered by a front door [from an internal corridor] and comprised of a bed sitting room, kitchen and an ensuite toilet with shower. We found that each front door had a door bell and staff always rang this before entering a person's accommodation. People were able to lock their front door from the inside, although staff could access their accommodation in an emergency. This provided a sense of security and ensured that other people could not enter a person's accommodation without their permission.

We observed that care staff respected a person's wish to be alone. For example, we observed one person who did not like to join in with activities was sat on their own in the dining room prior to lunch. We spoke with the person who told us that they were looking forward to their lunch and the food was good and they were comfortable.
Several people invited us to visit their accommodation. We saw that people had furnished their accommodation with items of furniture and ornaments from home and photographs of family and friends. For example, one person had a double bed, because that was what they were used to sleeping in and another person had a leather sofa as they liked to lounge on it when watching television. One person's relative spoke positively about the lay out of the service and said, "The home is clean. It's small, nice and compact. [Name of relative] knows its home." To help people maintain their sense of identity and purpose, they were supported to undertake small household tasks if they wished. For example, we saw one person living with short term memory difficulties had a duster and sweeping brush. There relative told us that their loved one was used to being independent and added, "Staff respect her for who she is."

We saw that some people used their kitchens when family and friends visited to make hot drinks and a snack. Most people had a fridge for drinks and desserts and a kettle. People shared with us the benefits of their accommodation. One person said, "It's very homely. It's lovely. I have my kitchen, I can have a tea or coffee when I want and I keep plenty of snacks." Relatives spoke positively about the kitchen facilities that people were provided with and said it helped ease the transition from their loved one's own home into the service.

Good

Is the service responsive?

Our findings

We found that people were encouraged to spend their time how and where they wished. We saw that some people chose to sit in the lounge or conservatory whereas others preferred to return to their private accommodation between meals. Before lunchtime we spoke with six people taking part in an arts and craft activity. We observed them make table decorations for Easter Sunday with the support of two activity coordinators. There were other people sat in the activity room either watching their peers or reading. The atmosphere was social. People had a cup of tea or coffee and most were singing along to music popular with their generation. After lunch we observed several people participating in a music quiz. Most people sang along to the songs and the activity coordinator and a member of care staff praised people for their efforts. We visited several people in their rooms and found that they were there through their own choice. One person showed the jewellery they were making and another person talked about the crafts they were knitting.

People were encouraged to have pets and we saw that one person had a budgerigar in a cage in the activity room. When we asked the person about their pet, the conversation with the arts and craft group quickly changed to people sharing stories about pets they used to have. Several people had bird feeders outside their window, even those accommodated on the first floor.

The activity coordinators focussed activities and events on people's preferred interest's and pastimes. There was a full and varied activity programme that focussed on individual and group activities. For example, some people were supported to maintain their interests in gardening. We saw pots of herbs in the conservatory that people had planted and were caring for until they could be transferred to the garden. Furthermore, the service was taking part in a garden competition organised by the provider. We saw that people had been involved in the design of the garden and flower and vegetable beds and a pond and rockery were raised and suitable for a person dependent on a wheelchair to access. After lunch we watched one person who was dependent on their wheelchair go into the garden with a member of staff. We saw that they were in deep discussion about the progress made with the garden and the work that still had to be done.

One of the activity coordinators spoke with us about the positive impact their role had on people. They said, "I initially got to know people on a one to one level. I worked with [Name of registered manager] to identify people's needs and build the activities on their personal needs and focus on them as individuals. Each person has an activity plan and we focus on their physical, emotional, social, cognitive and sensory needs. It has helped people to build and develop new skills." We looked at individual activity plans and saw that one person edited a newspaper for the service, several people living with dementia got a chance to play with a visiting ukulele band and some people now kept contact with family through social media. The activity coordinator was building links with a local day nursery and scout group to introduce activities to bridge the generation gap.

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and people and their relatives were involved in planning their care. We

saw that individual care plans focussed on supporting a person to live well with their frailty and maintain their independence as much as possible. The provider operated a system where two members of care staff were allocated to three people who lived at the service and took on the role of their key worker. This maintained continuity of care and strengthened communication between care staff, people who lived at the service and their relatives. One key worker explained their role and said, "We assist the person with bathing and we sew name labels into their clothing if they haven't done so and we also take them shopping. We feedback what we have done to the senior [senior member of care staff] who also reviews their care plans."

People were also supported to maintain interests within the community. For example some people maintained contact with or attended services at their local church. Where people were unable to attend church they received a visit from a local clergyman or church visitor of their religious faith. Other people attended a "Dementia Activity Hub" in a local church hall where they took part in singing, music and exercise events. The day before our inspection five people visited a local garden centre to look at plants for the garden and had morning coffee.

We saw that staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of person centred care. In addition, staff maintained a handover sheet that record key information, such as when a person was had gone out with family or when a person wanted a "lie in" in the morning. Senior care staff had a diary where the noted on-off tasks to fulfil, such as booking an optician appointment and requests for district nurse visits.

We saw a notice on display near the main entrance inviting people who lived at the service, their relatives and friends to give their feedback on the service. Each month there was a different topic. We saw that eleven people had taken part in a survey in cleanliness in March 2017. We saw that their feedback on the cleanliness of the service was consistently positive. There was also information on how to raise or share a concern about the quality of the service. People had access to information on how to make a complaint, and told us that they had no reason to complain and could talk with staff at any time. After lunch we noted that a member of kitchen staff took time to sit with each person and asked them for feedback on their meal. We saw that comments were recorded in a feedback book provided by the catering company. We read comments such as, "Dinner was delicious" and "Enjoyed, but portion size too large." A senior member of care staff told us that staff were good at escalating concerns to them or the register manager. We saw a copy of email correspondence between the registered manager and the external catering company about the concerns raised regarding choice and in particular for choice for people who received a textured diet.

The registered manager maintained a record of compliments and complaints received from people and their relatives. We saw that these were shared with staff. The provider and registered manager followed a robust process to formally respond to complaints in a timely manner and take action as required. For example, the registered manager had received a complaint that their office was upstairs, in response to the complaint they moved their office to the ground floor, where they were now more accessible to people and their visitors.

Good

Is the service well-led?

Our findings

People who lived at the service were invited to regular meetings and could input to the agenda. One member of staff spoke positively about a residents meeting that they had recently chaired and said that people's ideas and comments were taken seriously. They said, "People put their ideas across for activities. They discussed kitchen issues with [Name of chef manager]."

The registered manager held regular meetings with individual staff groups and general staff meetings. A member of staff told us that they had a say and contributed to the agenda and discussions. We found that if a member if staff was unable to attend that any topics they had for discussion were included on the agenda.

Staff told us that they enjoyed their work and found the registered manager approachable and supportive and that they felt valued. One member of care staff said, "We are a good team with a good team leader. She listens and supports our development. Her door is always open." Another member of staff told us, "[Name of registered manager] is a brilliant manager. Is approachable, best boss I have ever had, thanked me by text message for working an extra shift." In addition, the registered manager was supported by the area operations manager who visited the service at least once a month.

Relatives of people who lived at the service were invited to attend regular quarterly meetings. We saw that the last meeting was held on 23 January 2017. Relatives were also kept up to date with events in the service through an up to date information board. The registered manager sent us a copy of the provider's newsletter that was circulated throughout the provider organisation to all staff, and people and their relatives. The newsletter covered good news stories and updates about all the services in the provider organisation.

The registered manager was not on duty on the day of our inspection. However, we found the service ran like clockwork in their absence. Staff were aware of their roles and responsibilities and carried them out in an exemplary manner.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on delivering personal care. We noted that the policies were cross referenced to each other and to national guidelines. Staff were expected to read any new or amended policies and sign to say they had done so. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. One member of staff told us that had confidence that the registered manager listened to their concerns and said, "I blew the whistle on a colleague, sometimes you've got to be a grass. [Name of registered manager] took me seriously and [Name of staff member] left their job."

The registered manager followed a strategic quality monitoring system that involved a rolling programme of audits. For example, we found robust processes around the monitoring of medicines. The registered manager carried out a weekly medicines audit and the area manager carried out a medicines audit as part of their monthly quality visit. Each audit undertaken had an action plan with realistic timescales that were

signed on completion. The registered manager also submitted a monthly audit report to the provider. This report identified quality indicators for key areas such as tissue viability, infection control, falls and notifications to CQC. The underlying cause for each incident was reported, including other professionals involved and any treatment given. For example, if a person was prescribed an antibiotic for a chest infection, the underlying cause may be recorded as long standing breathing problems and other professionals involved may be the person's GP and a respiratory nurse specialist.

The provider had a system were the registered manager reported all incidents and accidents to their health and safety team directly. We looked at the recent falls records and accident forms and saw that they had been fully investigated and the registered managers had taken appropriate action to reduce the risk of further incidents. For example, a person who had a fall was advised to wear their call pendant at all times and another person who had experienced recurrent falls was referred to the community falls team.