Complete Care Homes Limited

St Bernadettes Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 31 July 2017 and was unannounced.

At our last inspection in August 2016 we identified two breaches of regulation. We had asked the provider to take action to improve infection prevention and control practices and carry out robust audits of the service and working practices.

During this inspection we found that the provider had taken action to improve practices within the service. We found these improvements were sufficient to meet the requirements of Regulation 15: Premises and equipment and Regulation 17: Good governance. This meant the provider had met the breaches of regulation identified at the previous inspection.

St Bernadettes is a care home providing nursing and residential care and support for up to a maximum of 27 people. At the time of our inspection there were 24 people who used the service.

The provider is required to have a registered manager in post and at the point of reporting the manager's application to register had been approved by the Care Quality Commission (CQC). 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicine management practices were being reviewed by the manager and action was taken during our inspection to ensure medicines were given safely and as prescribed by people's GPs. We have made a recommendation in the report about this.

Infection prevention and control practices within the service ensured the environment was clean and hygienic, but the manager was aware that further work was needed to ensure best practice was always followed. We have made a recommendation in the report about this.

People told us they felt safe and were well cared for. There were sufficient staff employed to assist people in a timely way and recruitment of staff was carried out safely.

People that used the service were supported by qualified and competent staff that were regularly supervised regarding their personal performance. Appraisals for staff were planned for the forthcoming months. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes.

People who used the service received additional care and treatment from health professionals based in the community. People had risk assessments in their care files to help minimise risks whilst still supporting people to make choices and decisions.

Staff were knowledgeable about people's individual care needs and care plans were person centred and detailed. There was a range of social activities available and people's spiritual needs were met.

People told us that the service was well managed and organised. The manager assessed and monitored the quality of care provided to people. People and staff were asked for their views and their suggestions were used to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicine management practices did not always follow best practice and were being reviewed by the manager. Action was taken by the manager at our inspection to ensure medicines were administered safely.

The communal spaces and living accommodation were clean and hygienic, but the manager was aware that further work was needed to ensure best practice was always followed.

People were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures. There were sufficient numbers of staff on duty to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people. Staff were aware of the requirements of the Mental Capacity Act 2005.

We saw people were provided with appropriate assistance and support and with their nutritional needs.

People received appropriate healthcare support from specialists and health care professionals where needed.

Is the service caring?

Good

The service was caring.

People who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals with their daily routines.

We saw that people's privacy and dignity was respected by the staff.

People who used the service were included in making decisions

about their care whenever this was possible and we saw that they were consulted about their day-to-day needs.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and staff were knowledgeable about each person's support needs. Some clinical aspects of the care plans would benefit from further detail.

There were activities taking place and people were encouraged to join in, but their wishes were respected if they did not want to participate.

There was a complaints policy and procedure in place and people were able to discuss their concerns with the manager.

Is the service well-led?

Good

The service was well-led.

The service had a manager who supported the staff team. There was open communication within the staff team and they felt comfortable discussing any concerns with the manager.

People told us that the service was well managed and organised. People and staff were asked for their views and their suggestions were used to continuously improve the service.

St Bernadettes Nursing 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 checked whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 31 July 2017 and it was unannounced. The inspection was carried out by one adult social care 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 service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people and people living with dementia.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams. We asked the provider to submit a provider information return (PIR) and this was returned within the agreed timescale. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the manager, two members of staff and seven people who used the service. We observed staff interacting with people who used the service and the level of support provided to people throughout the day.

We looked at three people's care records, including their initial assessments, care plans, reviews, risk assessments and medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty,

actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for three members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment.

Requires Improvement

Is the service safe?

Our findings

At the last inspection carried out in August 2016 we found there was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to premises and equipment. We found infection prevention and control practices within the service were not being maintained appropriately. Two of the bathrooms at the service were in a poor state of repair, with cracked tiles and flooring that was not sealed. This made it difficult to clean thoroughly. The ground floor shower room had a malodorous drain.

At this inspection on 31 July 2017 we found that sufficient improvement had taken place and the provider was now meeting legal requirements with regard to the premises and equipment. The provider had taken action to refurbish/repair the flooring in the two bathrooms and the drain in the shower room. All areas in the service that we observed were clean and had a pleasant odour. We saw that personal protective equipment (PPE) was available around the service and staff could explain to us when they needed to use protective equipment. Ample stocks of cleaning materials were available. We saw that the domestic staff had access to all the necessary control of substances hazardous to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

There remained work to do to move infection prevention and control (IPC) practices further and the manager was aware of this. The manager had carried out IPC audits in May and July 2017, which identified where things could improve. The action plan produced by the manager documented that staff training was to be arranged and cleaning schedules were to be more detailed and in-depth.

Walking around the service with the manager we saw that visitors to the service were not protected against cross infection. For example, two bedrooms were set up with personal protective equipment (gloves and aprons) and staff were aware that people in the rooms had infections, but there was no identification for other visiting professionals or visitors. This meant they could walk into the rooms and be exposed to the infection risk. The manager acted by writing notices simply asking visitors to, "Please speak to a member of staff before entering the room." This helped maintain the dignity of the people concerned but protected the visitors.

We saw that additional shelving storage for commode pans was required in the sluices so once cleaned these could be stored appropriately until needed. There was no eye protection for staff whilst cleaning the commode pans and wheelchair cleaning was not being evidenced. Following our inspection we were notified by the manager that shelving had been ordered, protective glasses for staff purchased and wheelchair cleaning sheets were now in place and being completed by staff. There was no annual statement about infection prevention and control practices in the service and the manager said this would be developed.

We recommend that the service consider current best practice guidance, in relation to infection prevention and control, and take action to update their practice accordingly.

People we spoke with said they got their medicines on time and when needed. However, we noted that the nurse was still giving out medicines at 11:35am for the morning round. This was not timely practice as people who took the same medicines three or four times a day would not have sufficient spacing between the doses. The manager assured us that in these cases the nurse would make sure that the next dose of medicines was given later on in the day and not at lunch time.

We looked at a selection of medication administration records (MARs) and carried out checks of medicine stock including controlled drugs (CDs). CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. We found that the controlled drugs (CDs) were regularly assessed and stocks recorded accurately, although the entries in the register were difficult to read. We found some areas of medicine practices that could be improved. For instance, we found a tablet on one bedroom floor and gave it to the manager to dispose of. This indicated that staff did not always check that medicines had been swallowed before leaving a person's bedroom.

Information on the MARs and balance sheets was not always clear and did not always give staff the full information they needed to administer medicines. For example, information on one medicine balance sheet said 'Paracetamol 250mg/5ml' but no further information of how much to give or how often. We asked the staff and they said they were giving 20mls at a time up to four times a day. However, there were no instructions on the MAR chart or in the care file. The pharmacy label on the medicine confirmed that what the staff were giving was the correct dose. The lack of written instructions on the MAR could potentially lead to errors being made by the staff.

We saw that room temperatures in the medicine room were sometimes reaching the maximum optimal level of 25 degrees centigrade. Staff had a fan in place, but the room was still hot. This meant we could not be assured that medicines stored in the room remained fit for use. Following our inspection we were notified by the manager that a new ventilation system had been installed.

We recommend that the service consider current best practice guidance on administering medicines in a care home and update their practice accordingly.

The health and safety file contained information showing work was required to ensure the premises met fire safety regulations. The manager said work was in progress and we were provided with a list of work completed and work that was underway. During our inspection we saw electrical contractors were on site fitting new electrical circuit boards as part of this work. Following our inspection we received confirmation that all the work had been completed by the end of August 2017. The fire risk assessment was renewed following the completion of the works.

Only 51% of staff had completed fire training, which included the fire evacuation procedure. Following our inspection the manager confirmed they had booked the remaining staff onto two additional training sessions in September 2017.

We looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the staff and nominated contractors. These environmental checks helped to ensure the safety of people who used the service.

People who used the service told us they felt safe and well looked after. Five people said there were enough staff in the service, but two others said they sometimes had to wait for assistance. All the bedrooms had a

nurse call buzzer and extension cords for easy access. We did not hear the nurse call sound during the inspection, but that may have been due to the electrical work that was on-going. Staff were seen to be checking on people in bedrooms throughout the day. One person said, "If I need anything I just ring my buzzer and the staff are always popping their heads around the door to see if I am okay and need anything."

The manager told us that a dependency tool was used to assess the levels of staffing needed to meet the dependency levels of people who used the service. We were given a copy to look at, which had last been reviewed in June 2017. The staff to people ratios were appropriate to enable people to receive care in a safe and person centred way and take part in activities. The duty rosters we looked at showed that there was always someone in charge of the service; either the manager or lead nurse. Staff told us, "There are enough staff most days to get our work done to a good standard" and additional ancillary staff were employed to cover maintenance, domestic, kitchen and laundry duties.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. These included application forms, interviews, references and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. The manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

Staff received training on making a safeguarding alert so that they would know how to follow local safeguarding protocols. Staff told us they would have no problem discussing any concerns with the managers and were confident any issues they raised would be dealt with immediately. There was written information around the home about safeguarding and how people could report any safeguarding concerns.

There were care notes and risk assessments in place that recorded how identified risks should be managed by staff. These had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks.

The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents. These showed what action had been taken and any investigations completed by the manager. Where necessary the manager had notified CQC of any serious injuries. There had only been one in the last year.

Good

Is the service effective?

Our findings

The majority of people we spoke with told us they thought the staff were well trained and able to meet their needs. However, one person said, "Some more training would not do them any harm." This person did not wish to say anything more on the subject.

Observations showed that people got on well with the staff and there were some very positive interactions with a lot of laughter and good humour. People who used the service were interested in what we were doing in the service and we saw staff communicate effectively with them. However, one person said, "It is difficult sometimes to understand what they are trying to say or get them to understand what I am saying to them. There are quite a few staff who are from overseas." This was discussed with the manager during the inspection.

People were cared for and supported by friendly staff who knew what care and support each person required. The induction programme for new starters consisted of them completing three days and three night shifts shadowing more experienced staff before working as a member of the team. The manager said there was a new induction and training process being introduced in September 2017 which would include three days basic training.

A training programme was in place for new staff and there was continuing training and development for established staff. Our observations showed that staff had the appropriate skills and knowledge to care for people effectively. They had access to a range of training deemed by the provider as 'essential' as well as subjects specific to meet people's needs. Staff told us they completed essential training such as basic food hygiene, first aid, infection control, health and safety, safeguarding and medicine management. Records showed staff had participated in additional training including topics Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

The nurses received support from the provider and manager to complete their registration requirements (revalidation) for the Nursing and Midwifery Council (NMC). Each nurse had their own portfolio for training, reflection and feedback. When the time came for them to renew their registration their portfolio of work was discussed with the manager who then signed it off.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Staff told us they received supervision every two or three months. They said, "We can ask questions and make suggestions during our meetings and we are given the opportunity to speak up if and when we have any issues to raise. The manager always listens to us and takes action to resolve any problems." Minutes of the supervision meetings were made available to us during the inspection. The manager had only been in post for 10 weeks, but was aware of the need to ensure staff appraisals were booked in and completed.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that people had been assessed for their capacity to make specific decisions, and DoLS referrals were being made to the supervisory body. Where authorised DoLS were due to expire, further requests for renewal had been sent. An overview sheet showed that the manager was monitoring and updating these as needed. We saw there was recording of Best Interests decisions and the manager told us they were working on ensuring that families provided copies of Lasting Powers of Attorney's (LPA) where they had been registered with the Office of the Public Guardian (OPG).

Staff showed awareness of people's rights and MCA. In discussions staff were clear about how they gained consent prior to delivering care and treatment. For example, one member of staff knew to ask people for consent before giving care, but was also aware there were people who were cognitively impaired so followed their care plans, which were all individual and detailed about the support people needed.

The staff we spoke with displayed an in-depth knowledge about each person's care needs, choices and decisions. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans. The cook told us, "The heads of each department have a daily meeting at 11 in a morning to catch up and see how people are feeling and if anyone is ill."

Information in the care files indicated people who used the service received input from health care professionals such as their GP, dentist, optician and podiatrist. People received regular check-ups and staff provided people with support to attend their appointments. We asked people who used the service what happened if they did not feel well and they told us, "If I need a doctor I just ask" and "The staff are very good at getting a doctor if I need one."

Input from specialists such as the Speech and Language Therapy (SALT) team, dieticians, district nurses, continence nurses and physiotherapists was used to develop the person's care plans and any changes to care were updated immediately. Staff completed risk assessments relating to nutrition, choking and swallowing and where appropriate referrals had been made to the dietician or SALT team. Specialist diets were supervised by the nurses.

We observed lunchtime in the dining room, which a minority of people who used the service attended. The majority of people chose to be served individually in their bedrooms. We observed diets being served that reflected the dietary advice of dieticians as documented in people's care files. The quality and variety of meals were well received by people and clearly enjoyed. One person said, "Excellent menu and lovely food." We spoke with the cook who was knowledgeable about people's nutritional needs, and strongly committed to providing good quality food that reflected the choice of people who used the service.

Good

Is the service caring?

Our findings

Even though there were a lot of workmen in the building carrying out repairs to the electrics, we found the service to be calm and relaxed as we walked around. We saw that people were well presented and dressed appropriately for the weather. People said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. One person told us, "I really like it here. Lovely care staff and I can talk with them."

Staff told us they enjoyed working in the home. They had a good range of equipment to help them meet people's needs including specialist beds and mattresses, hoists and slings and safe bed rails. Staff interactions with people were positive and cheerful. Staff were focused equally on providing a safe environment and creating a welcoming, comfortable and stimulating home life for people.

People were able to move freely around the service; some required assistance and others were able to mobilise independently. We saw that people were able to spend time where they wished either in the communal spaces or in their own bedrooms. The bedrooms we saw were individually decorated and furnished to meet people's own tastes.

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. Staff gave us examples of how they had provided support to meet the diverse needs of people using the service. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in their care files.

We saw staff explain to people what was going to happen during the day, using appropriate language and giving time for people to process what was being said. People we observed were watching television, chatting or reading their newspapers and magazines. They told us, "Nothing is too much trouble for the staff."

We were told by staff that people could have a bath or shower whenever they wished and information in the care files and bathing records showed that these usually took place on a regular basis. One person we spoke with said they had had a shower yesterday. They told us they hated showers and would prefer a bath, but this facility had been taken out so they had to have a shower now. We saw that there were both baths and showers available in the service so this was fed back to the manager to look into and action.

The manager understood the role of advocates and had contact details available if anyone who used the service required the support of an advocate. An advocate is someone who supports people, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them. At the time of our visit no one who used the service was receiving input from an independent advocacy service, although some had family or friends as their power of attorney.

People were treated with dignity and respect. The staffs' approach was professional, but friendly and caring. Staff spoke with people in a polite and respectful way, showed an interest in what people wanted to say to them, called them by their preferred name, knocked on people's doors before entering and ensured they had privacy whilst they carried out their personal care. One person told us, "You can talk with the staff and they do listen to what you have to say" and another person said, "There has been a lot of changes in the service. Some staff have left and new ones have started, but everything seems okay. I am waiting to see what happens when everything settles down again."

Good

Is the service responsive?

Our findings

The staff were knowledgeable about the people who used the service and we found that they provided people with personalised care which was based upon their individual assessed needs and personal preferences.

The nurses carried out a variety of clinical interventions as part of their role of caring for people who used the service. They used nationally recognised risk assessment tools to assess people's level of need and reduce the risk of harm. We saw they had completed nutritional risk assessments using the Malnutrition Universal Screening Tool (MUST) and assessed people for risk of developing pressure ulcers by using a Waterlow tool.

A needs assessment had been carried out to identify each person's support needs, and care plans had been developed outlining how these needs were to be met. People who used the service told us there were few or no restrictions on their daily life, although risk assessments had been completed and care plans were in place to make sure people stayed safe and well. Evidence in the care files showed us that people's views were sought and listened to, and that families were also involved in reviews of people's care.

People's care plans were person-centred. Families were encouraged to input to the care files where people were unable to contribute. Each of the care plans included details of the person's care needs, their wishes and choices around support and any risks related to the need. This meant that people's care profiles included a wide range of information designed to assist staff to support them effectively. When people's needs changed this was clearly recorded.

Looking at a selection of care files we found that some information needed review and updating. We saw that although wound care was documented by the nurses it was not clinically detailed enough, for example with regard to the size of wounds, depths and location on the person's body. One care plan we looked at was not clear regarding the person being dysphasic (speech problems) or dysphagic (swallowing problems). Another care plan relating to end of life wishes for one person was noted to have a different name used in mistake. Following the inspection the manager informed us the specific care plans had been updated and rewritten by the nurses. We were also told that the service would be consulting with the tissue viability nurse to assess the documentation used and ensure it met best practice guidance.

Activities were on offer daily and these were facilitated by an activities coordinator. People had the choice of joining in the planned activities, although some people preferred not to join in and chose to spend time in their room or in the other communal areas within the service. The activities coordinator had plans in place to spend time with people who chose to stay in their rooms if they wished. Each person who used the service had their own sheet for activities and this included information on their interests and hobbies as well as their medical history, needs and abilities.

The activity plan for the service indicated that visiting entertainers came into the service to sing and sometimes the activity coordinator took people out for walks, weather permitting. Time was spent each day

doing one-to-one activities with people in their rooms and the hairdresser visited every fortnight. One person said "We are all well looked after. Very good girls."

Some families arranged activities for their relatives who used the service. For example, one person enjoyed going out to a social club and their family had ensured arrangements were in place for them to be picked up and then dropped off back at the service following their activity.

We saw that people's cultural and spiritual needs were accommodated at times of their choosing. For example, staff told us about one person who did not wish to attend church services, but every night took time to say prayers before going to bed. Staff respected this time and ensured they were not disturbed.

People had access to a copy of the provider's complaint policy and procedure in a format suitable for them to read and understand. We looked at the complaints folder and saw that none had been made in the last year. People who we spoke with said they were confident of speaking with the manager should they have need to.

We saw evidence during our inspection that the manager was in daily contact with people who used the service and was available to discuss their care and any concerns they might have. This meant people were consulted about their care and treatment and were able to make their own choices and decisions.

Good

Is the service well-led?

Our findings

At the last inspection carried out in August 2016 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in regard to good governance. We found that audits had been carried out to monitor and review any areas for improvement, but the results of the audits were not consistently acted upon to improve the quality of the service.

At this inspection on 31 July 2017 we found that sufficient improvement had taken place that the provider was now meeting requirements. The manager had carried out audits and produced action plans and timescales so we could see where improvements had been made and where further work was on-going. Where issues were identified at this inspection the manager took immediate action to resolve the issues.

We saw regular checks were completed by the manager and the staff team to ensure they provided a quality and safe service. For example, checks on medicines, care plans and health and safety. The provider also completed regular checks to confirm the manager's findings. Some of the issues we found during the inspection with regard to infection prevention and control and medicine management had already been identified. We saw the manager had an overall development plan and they monitored progress against the plan to ensure improvements were made. This meant the quality assurance system was effective.

There was a manager in post who was supported by qualified nursing staff. Our observation of the service was that it was well run and that people who used the service were treated with respect and in a professional manner. During this inspection we received positive feedback about staffing, the environment and positive comments about the manager. One person told us, "The manager seems nice, open and honest when speaking with me" and another said, "The place is running much smoother now." Staff told us about the introduction of daily meetings where updates on changes to people's needs and day-to-day practices were discussed. This meant the service was more responsive to change and staff were aware of any actions they needed to take.

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open and transparent and the manager sought ideas and suggestions on how care and practice could be improved. The manager was described as being approachable and there was an open door policy.

Feedback from people who used the service, relatives, health care professionals and staff was usually obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. This information was analysed by the manager and where necessary action was taken to make changes or improvements to the service. People told us, "Yes we have meetings. I go if I feel like it" and "The girls tell me when they are going to have a meeting, but I don't go due to my medical condition. The girls tell me if I have missed anything important."

We found an engaged, friendly and experienced staff team in place. All staff were encouraged to share ideas and reflect on their performance through team meetings and supervisions. The manager said the

information would be used to inform the annual appraisals.

We asked for a variety of records and documents during our inspection. We found these were easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.