London Residential Healthcare Limited

Oaklands House Care Centre

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

This inspection took place on 23rd and 25th April 2018 and was unannounced.

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

Oakland's House Care Centre provides accommodation and nursing care for up to 54 people who are living with dementia and related health conditions. The building is bright, modern and designed for the provision of care in a homely environment.

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

People were cared for in a safe way. Risk assessments and care plans were completed and staff provided care according to these plans.

The provider had a robust recruitment process and only people that had been checked as suitable to be employed in caring roles were recruited by the service.

Medicines were stored and administered safely. Clear and accurate medicines records were maintained.

The provider had systems in place to respond and manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. Staff understood they had a duty to report any concerns they had about people in their care.

The service had a new, online training system giving them access to training and policies.

We recommend that policies provided by St Cloud are updated to reflect the Oakland's location.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

People's nutritional needs were met, information was shared with the chef who produced meals that were pureed, fortified and to the individual requirements of people living in the home.

There was an activities programme that provided group and individual activity sessions. In addition, external entertainers visited the service on a regular basis.

The home had an end of life care pathway and people and their relatives were supported to plan for the future.

There was a clear and freely available complaints procedure. People knew who to talk to if they had a complaint.
Compliments about the care people received were also recorded.

The registered manager had systems in place to monitor the service and drive improvement

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 understood safeguarding and would take suitable actions if they had concerns

The service had a safe recruitment procedure

Is the service effective?

Good

The service was effective

Staff had access to online training and information about social care

Staff understood and worked to the principles of the Mental Capacity Act 2005

People were assessed before moving into the home and received regular reassessments to monitor their ongoing needs

Time was taken to support people with their meals and ensure that people could eat at their own pace with person centred support

Is the service caring?

Good

The service was caring

Staff regularly checked people, particularly those who were not able to use the call bell system

Care was delivered to people in a manner that maintained their dignity

Staff communicated with people in a person-centred way

Is the service responsive?

Good

The service was responsive

Activities were provided to groups and individuals to ensure there was sufficient mental stimulation for people

People had end of life plans and were supported with their relatives at the end of their life

Is the service well-led?

Good

The service was well-led

We received positive feedback about senior staff at the service and their commitment to improvements

Audits were in place and monitored the service and informed actions for improvements

A recent survey had provided positive responses about service quality

Oaklands House Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23rd and 25th April 2018 and was unannounced.

The inspection team consisted of two social care inspectors, a nurse specialist advisor and two experts-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service.

Before our inspection we reviewed previous inspection reports and notifications we had received from the service. A notification tells us information about important events in the service that the registered manager is required to tell us about.

We used information the provider sent us in the Provider Information Return in August 2017. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 13 people that lived in the home and five relatives, three visitors, five staff members, the registered manager and the regional clinical lead. We looked at eight care records, risk assessments, records about the premises and sought feedback from the local authority, health care professionals and commissioners.

We observed people receiving care and support and interacting with staff. Some people were not able to verbally communicate their views with us or answer our direct questions. 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 pathway tracked four people using the service. This is when we follow a person's experience through the service and get their views on the care they receive. This allows us to gather and evaluate detailed information about the quality of care.

We looked at staff files, training records, recruitment files, duty rotas, supervision records and reviewed the services policies and procedures.

We gave verbal feedback to the Registered Manager at the end of each day and received information from the registered manager to support the inspection after we had completed our work on site.

The service was last inspected by us in October 2016 when we rated it as Requires Improvement.

Good

Is the service safe?

Our findings

When we inspected in October 2016 we found the service to be in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed. We found that Disclosure and Barring Services (DBS) checks had not been completed for all staff members before commencing in post. At this inspection we found that recruitment processes had been improved and the service was no longer in breach of this regulation. Staff were thoroughly vetted prior to starting work. At least two references were obtained, DBS checks were completed, employment histories taken and gaps in employment accounted for.

People told us they felt safe living at Oakland's Care Centre, one person said, "Yes I feel safe here. Other people here are alright but they don't bother me. I sit and talk to the staff sometimes. This is a lovely place. The nurses here are very good to me". Another told us, "I think we are very lucky in this country to have places like this. I feel comfortable here. It's a very comfortable place to be".

Staff participated in safeguarding training during their induction when they commenced working at the home. They received regular safeguarding training updates and when asked could tell us the signs and symptoms that might be observed in different types of abuse. Safeguarding records showed that concerns had been referred to the local safeguarding authority, (local authority) and these were confirmed by notifications received by CQC. Concerns had been investigated and actions had been taken to minimise the possibility of future incidents.

Staffing requirements were defined using a dependency tool that calculated how many staff should be deployed to safely meet the needs of people living in the home. We checked the staffing rotas for the current week and three weeks before our inspection. During these dates there were between 16.5 and 22.5 hours more staffing than required by the dependency tool. The registered manager told us that they would always staff at a higher level than the minimum that the tool indicated. We did not see staff rushing people to transfer or to finish their meals and during the second afternoon of our inspection, care staff were able to support people during an entertainment session in addition to providing care for them.

Agency staff worked alongside care home staff. Most of the agency staff regularly worked at the home so had been able to build relationships with people living there and become familiar with care needs.
At our October 2016 inspection we recommended that staff members administering medicines should have minimal interruptions as per the provider's policy and good practice guidance. At this inspection, we saw that staff giving medicines did so without interruption.

Medicines were managed safely. Temperatures of storage rooms and fridges were monitored and recorded daily and were within safe limits. The provider completed a monthly audit of medicines and the supplying pharmacy audited annually. Policies were in place covering the use of medicines, homely remedies and PRN medicines. PRN medicines are prescribed to be taken as and when needed, for example pain relief.

Medicines were audited monthly. We looked at storage and management of controlled medicines. Some

prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments), they are closely monitored and stored in secured cabinets. The controlled drugs were audited three times per week and we found they were all accurately recorded in the controlled drugs book, all in date and all being used as prescribed.

Lotions and creams were applied by care staff and a body map was seen in the daily notes to show where to apply. Opening dates were recorded on containers of creams and all were within their safe usage period.

Fluid thickeners were stored safely in a locked cupboard in the large lounge area. There was a discreetly stored list to advise which consistency to prepare for people and a named container of thickener for each person as prescribed. General information on how to prepare the different consistencies was displayed clearly where drinks were made.

There were a wide range of risk assessments in place to manage possible hazards and prevent harm. Risks were assessed to ascertain how likely and the extent of harm a hazard could cause. Areas assessed concerning risks to people included mobility, falls, choking and skin integrity. A personal emergency evacuation plan (PEEP) was in place for people living in the home. A PEEP details the support a person may need to evacuate the home in an emergency such as a fire when they would not be able to do so independently.

Risk assessments concerning the environment were also in place in including water safety and legionella, fire safety and use of equipment. Policies and procedures about health and safety also enabled staff to keep people safe from harm. There were also regular safety checks of equipment such as the fire alarm system, hoists and passenger lift as well as temperature checks and flushing of the water system.

People were protected from the risk of infection. The home was clean and there were no unpleasant odours during our inspection. People's rooms and bathrooms were clean and their bedding fresh. The housekeeping team were at work throughout our inspection cleaning people's rooms and the communal areas. A visitor told us, "It's very clean here, you can see the girls going around with their trolleys, always cleaning". We saw staff washing their hands before and after supporting people. Personal protective equipment (PPE) including aprons and gloves was worn for care tasks and when supporting people with their meals.

Accidents and incidents were recorded and managed appropriately with detailed investigations undertaken along with learning to prevent reoccurrence. Learning was shared with the staff team through hand over and staff meetings.

Good

Is the service effective?

Our findings

At our inspection in October 2016 we found that staff did not have a suitable induction or sufficient training to enable them to perform the duties of their roles. We saw an improvement plan showing that training had been provided. Training was up to date for almost all staff in areas such as Mental Capacity Act and Deprivation of Liberties Safeguarding, Food Hygiene, Dementia Awareness and Manual Handling. Additional training sessions were booked to ensure that all staff had attended required training and received appropriate updates. Management staff members had also attended 'train the trainer' sessions in relevant areas so they could train staff in-house.

The 'Training, Development and Qualification' policy devised by the provider in October 2016 states clearly that staff will have robust inductions and complete all Care Certificate units within the first 12 weeks of their employment. The Care Certificate is a set of standards that all health and social care staff work ensuring a consistent approach to care. We found the provider to be working in line with their policy to achieve this.

The provider had recently updated training to online courses. This was reflected in the registered manager having two training record overviews for staff as the new system showed that training had not been completed when in fact staff had completed it on the old system. Once the training on the old system had all been updated there will be one, online system. The online system provided mandatory training and a wide range of supplementary courses that staff could complete if they wanted. The providers policies and procedures were also available through the online system.

Staff told us they received regular supervision. The registered manager confirmed this was completed at least six times per year. Staff told us that their supervisions were useful and included information sharing from their supervisor as well as an opportunity to discuss their own agenda items. Staff also participated in an annual appraisal meeting and discussed their priorities in terms of role and development.

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.

Staff members had a clear understanding of the Mental Capacity Act 2005. They spoke to us about the five principles of the act and told us they would respect people's decisions even if they appeared to be making unwise choices. Assessments of people capacity had been completed in people's care files and when needed, appropriate people had been consulted when making best interest decisions. Some people had been allocated Independent Mental Capacity Advocates (IMCA) IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who can represent the person.

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).

The provider made DoLS applications as required and notified CQC as and when they were authorised. Many applications had not yet been authorised, by the supervisory body (local authority), some of which had been submitted over a year ago. The Registered Manager regularly followed up on the outstanding applications and we saw a recently submitted an email to express concern at delays in the progress of applications.

People who had specific nutrition and hydration needs were monitored as were their weights. The service used the Malnutrition Universal Screening Tool (MUST). 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. People who had been assessed as 'at risk' received additional nutrition as needed either using supplements or fortified foods with added butter, cream or syrups. Specialist diets were also catered for, meals were pureed and alternative foods were offered both at meal times and in between. People who didn't want the main meals of the day were offered alternatives such as cheese on toast. One staff member said, 'crispy with lots of butter, just as you like it', an indicator they were aware of the persons preferences.

At mealtimes we saw sufficient staff deployed to support people with their food. People were able to spend quality time with the staff that supported them. People were discreetly offered clothes protectors and staff sat to the side of them while they assisted, holding relevant conversations. People were offered two choices of main course and, rather than pre-ordering meals, people were shown both meals on sample plates so they could make an informed choice at the time about what to have for lunch. Staff had good knowledge of people so if they were not able to make choices about meals they had recorded information to indicate their preferred options.

Menus were displayed daily in picture or photo form for people. The reverse of the meal photos had a note of allergens present in each meal to inform staff, people or their relatives if it were safe for them to have.

Relevant information in relation to the previous 24 hours in the service was passed on to staff at a handover session. Information from these meetings was made available for staff not present in printed form to ensure that all staff were informed about specific events and requirements. Regular staff meetings took place and were used as a venue for information sharing, updates and discussions about the service.

The Registered Manager told us that they would refer to other services or professional bodies if needed. There was a close link with social care professionals and regular contact with health teams. Notifications received from the service before we inspected included arrangements for reviews by health professionals and an awareness of staff in the service to perform basic medical tests such as establishing whether someone had an infection before requesting support from the GP. The GP also visited the service every week and when requested.

A medical professional gave us feedback about the service. They told us that the registered manager was receptive to their input and had requested that they attend to advise about infection control and to do a 'fresh eyes visit' to see if there were areas to be improved that had not been considered by the provider.

Some areas of the home were not in use and parts of the older building were also vacant, some areas being refurbished. The main part of the building was clean, bright and had signage appropriate to people living

with dementia. The registered manager told us about plans to upgrade the large lounge area with more modern décor, furnishings and floor coverings and develop a small private dining area for people and their visitors. This had been agreed by the provider and was due to go ahead.

Some areas of the older building were less suited to the people living there. Thresholds on floors were raised and corridors were narrow however people were placed in suitable areas in the home to minimise risks. Potential trip hazards had been identified and had been highlighted with yellow and black hazard tape. There were memory boxes containing photos of people and items connected to their life or interests displayed outside people's rooms and items to promote reminiscence were placed around the building. People could also visit the onsite hair and beauty salon and a coffee bar was available for people and their visitors. There was an accessible courtyard garden with plenty of seating and tables for people to use as they wished.

Good

Is the service caring?

Our findings

People told us staff were caring. A medical professional told us 'I have not seen the care at point of delivery, however the residents appear to be well looked after, and any interactions I have seen are kind and dignified'. A relative also told us they had 'no complaints', and 'the care here is exceptionally good'.

Through observation and talking with relatives and staff it was evident that positive caring relationships were developed with people living at the home. Two visiting relatives said the care was "Fantastic" and they had "No complaints". They told us staff were understanding of their family members current needs and provided appropriate emotional support.

During the morning we observed staff chatting to people in the communal areas and offering them drinks. The atmosphere was friendly, unhurried and inclusive. Staff approached people in a reassuring and supportive manner. If a person wanted to be left alone then the staff respected their wishes. The registered manager told us that staff were encouraged to spend quality time with people outside of providing care. Staff were able to sit with people and enjoy a drink and a snack providing them with company and conversation and for some people encouragement to eat and drink.

During an entertainment session, one person became distressed as the music started. We saw a staff member quietly approach them and sit holding their hand for a few moments speaking to them softly. This calmed the person and soon after the person began to clap and rock to the music.

We saw staff transferring a person from a wheelchair to a lounge chair. The staff members spoke calmly to the person throughout the transfer, keeping the person informed as to what was happening and used a blanket to maintain the person's dignity when being transferred.

We asked staff members how they would maintain a person's dignity during care giving and they told us they would ensure that the area was private, doors were closed and curtains if needed and they would speak to the person and ask if they could proceed. They would always ask if a person was OK whether they had capacity or ability to respond or not

We heard very few call bells during our inspection. The registered manager told us that very few people could operate the call bell system. The service provided care for people with differing stages of dementia and those with more advanced dementias were unable to operate the bells. Staff checked people regularly throughout the day and night to ensure they were safe, if they wanted food or drinks and to ensure their wellbeing was maintained.

People were supported to maintain their independence. Electronic monitoring aids such as pressure mats were used when a person was at risk of falling to alert staff that support was needed, these were also in use if someone was unable to use the call bell. People accessed the building freely and relatives could take people out when they wished.

We saw different methods of communication throughout our inspection. We noted that staff would get down to people's levels and make eye contact when speaking to them, they would use gestures and touches to the hands and arms to make connections. There was evidence that photos and symbols were in use in the home, menus and items on noticeboards were visually eye catching and specialist signs were in use to direct people about the home. Other signage used for example was a picture of an ice lolly image on the freezer door which acted as a prompt to remind people they could get a lolly from the freezer when they wanted one.

Care plans were detailed and held information about people's preferences. In the homes statement of purpose, it states that people have 'the right to receive an anti-discriminatory service which is responsive to your race, religion, culture, language, gender, sexuality, disability and age'. Care plans reflected these rights and sensitively addressed areas such as disability.
Social histories in people's care files detailed friends and relatives of people and contact details were held where appropriate. People's current and previous views and beliefs were reflected and staff worked to enable people to maintain interests, friendships and faiths. There were no time limits for visiting, people told us they had been there very early and very late at times and there were opportunities for families to be involved in meetings about the service. Visiting ministers saw people individually and conducted services. If someone had a faith need that was not being met, the service would endeavour to support them with their requirements.

A quiet room, named the 'Namaste Room' has been developed and people use it for relaxation and reflection. Staff felt it to be beneficial to some people, it has soft light, sounds and music and comfortable seats and promotes a feeling of calm. The room was developed by staff in the home who wanted to provide a place for people to go if they felt distressed.

Good

Is the service responsive?

Our findings

In our two previous inspections there had been insufficient details in care plans to enable people to have suitable care delivered. Care plans we checked at this inspection had significantly improved. There was evidence of reviews being completed monthly regardless of whether people's needs had changed and were detailed sufficiently for staff to be able to provide appropriate care.

Before people moved to the service an initial assessment of their needs took place to help ensure the service was suitable for them. Following the initial assessment, a care and support plan was developed that was tailored to the individual. It reflected their personal preferences and provided staff with information about how to meet the person's needs. Care plans were written in a personalised way, including what and who was important to the person.

Staff monitored people's changing needs through reviews and observation and this was recorded in their care plans. Risks to people had been identified, assessed and actions had been taken to minimise the risks, such as the risks of people falling or becoming malnourished. This information was recorded in each person's care records and updated regularly with any changes to the level of risk or changes to health. Records showed that people were supported to have access to healthcare services and, where necessary, a range of external healthcare professionals were involved in assessing and monitoring their care.

A social care professional told us that the service had been proactive in accepting a very short notice referral for urgent respite during a period of extreme poor weather conditions recently. 'They accepted the emergency admission and agreed to assess over a few days as [person] was unsafe at home…. the staff were great and [person] stayed there for emergency respite'.

The service reacted promptly if someone needed support with their health. We saw that when a blister was noted on a person the wound was photographed and referred to the Tissue Viability Nurse for assessment and a treatment plan. The wound was monitored and treated and photographed to assess whether it had improved. The response to locating the wound was fast and actions were taken immediately to treat it. Photographs of wounds were not that clear however and could be improved. Other health conditions such as infections were tested for and GP's were called as needed in addition to their regular visits.

The service and staff responded well to a recent emergency. There was a power failure in the area and staff remained on duty after their shifts had finished to assist with changing more than 30 air mattresses for standard mattresses and to support with people who were isolated on an upper floor when the power failed. Staff supported again the following day when the power supply returned and changed the mattresses back to minimise anyone being on a standard mattress longer than necessary.

There was a programme of activities to promote mental stimulation and social inclusion, which people could choose to take part in if they wished. People had completed a questionnaire, with support if required, about what activities they were interested in. Activities included singers and entertainers, trips to local places and events, and a Shetland pony visiting the home. During our visit a bird box building activity was

being held in one area of the home. In addition to group activities, one to one activities and social interaction were provided. One of the activities staff said, "No-one gets ignored". They gave examples of how they supported individuals who did not take part in group activities, such as walks around the home and garden or reading to them in their room. Books, puzzles and other activity items that people may find interesting were placed in the lounge areas to promote people's engagement. Two people walked around the ground floor repeatedly. Staff members did not attempt to stop them but now and then tried to engage the person in an activity or offered to make them a drink. Staff kept records of the activities offered to and taken part in by individuals, as well as their levels of engagement.

The provider has a robust complaints procedure. Complaints were recorded and dealt with by staff members at the time of complaint and those more complex or those received in writing were dealt with by an allocated manager. The policy offers alternative organisations to complain to including the Local Government Ombudsman and local authority social care and complaints departments. The policy was compiled by St Clouds Care, a company that had recently joined with London Residential Healthcare Limited the provider of Oakland's House Care Centre. The policy had not been adjusted for this service as the local authority details given were for Worcester rather than Hampshire or other more local service commissioners. We recommend that policies provided by the new company should be adapted and updated to reflect the locality and provision of Oakland's House Care Centre.

The provider encouraged people to comment and feedback about the services they or their relatives received and a book of compliments was available to view in the lobby area. One of the recent comments received in March 2018 read, 'Thank you for all the care you gave to [person]. You work hard to keep people safe'. Another thanked the service and named a specific staff member for going above and beyond when caring for their relative. We also saw a suggestions box in a prominent area of the reception to encourage people's comments and ideas for improvements. In the staffroom there was a noticeboard of 'what we have done well'. The board showed compliments and praise from relatives and names staff members who have worked exceptionally well. Additionally, there was positive feedback on care review websites.

End of life care was provided by the service and people's files had end of life care plans in place. We saw clear and regular reviews of prescribed medicines for end of life however one of the care plans we looked at was for a person who had been a devout Christian and there was no mention of spiritual wishes in the care plan.

At the time of our inspection there was no-one receiving end of life anticipatory medicines however there were people being reviewed daily as they appeared to be approaching this stage of their life. The registered manager told us that the end of life plan currently in use by the home was called the 'Red Rose Pathway' and had been developed by the registered manager at a previous home. The pathway focussed on the comfort of the person at the end of their life. There were no restrictions on visiting the home and relatives were supported during emotional periods.

Good

Is the service well-led?

Our findings

The service had a registered manager in post who was proactive in supporting their staff team within the home. All feedback received about the registered manager was positive. One healthcare professional told us, 'The manager has made great progress within the home …she remains committed to the home and the residents. She is always open to the visits offered and any advice or suggestions offered'.

At our last inspection in October 2016, we saw that improvements had been made to the leadership and governance of the home including the introduction of more thorough audits and use of a dependency tool to ascertain appropriate staffing levels. There were still shortfalls in auditing and the new systems had not embedded into regular practice. At the October 2016 inspection we found the service to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, we found there had been almost four months since a medicines audit had been undertaken. At this inspection there were checks of controlled medicines three times per week, a monthly medicines audit and an annual audit by the supplying pharmacy. The overall comment from the pharmacy audit completed on 7th April 2018 was 'absolutely excellent. Nurse very knowledgeable, medicines well organised, clean, paperwork up to date. Much improved. Very well managed.' Three actions were required from this audit, one for the pharmacy, one for the GP and the service were advised to obtain an additional set of keys to the clinical areas and medicine trolleys in case of damage or loss.

The newly introduced audits noted at the last inspection and the systems such as the use of a dependency tool have now become part of the everyday practice in the home. The registered manager is keen to continually improve the service and uses information from audits to inform plans, staffing requirements and future developments. The service has a file of practices and events they hope will evidence their good practice and their continuing improvement.

We reviewed policies and procedures which were informative and clear as to the expectations of staff in each situation. These were available for reference from the registered manager and online.

A member of staff said the registered manager was "Very supportive. Her door is always open". They told us the registered manager listened to staff and acted when necessary, such as when more moving and handling equipment was needed to meet people's needs. They told us the registered manager worked hard, coming in for handovers at 7am to keep up to date with people's current needs and often staying into the evening.

An agency staff member told us that the Registered Manager was also very supportive to them. If there were problems they acted upon them, for example, some agency staff members showed poor moving and assisting skills, those staff members were not booked to work at the service again. When we inspected, one of the inspection team noted a person being supported up from a chair in an unsafe manner, we spoke to the registered manager and they immediately dealt with the people concerned.

Staff also confirmed that although the use of agency staff was less than it has been previously, if there are

not sufficient staff on duty due to illness or leave, agency staff were booked to ensure that safe staffing levels are maintained and people receive the care they need.

Staff confirmed they received appropriate training and development to support them in meeting people's needs. They told us they felt the service was continuing to improve and now used less agency staff. They said they felt staff worked as a team and the good relations between staff benefited people living in the home. Several staff members told us that senior staff members such as the head of care were happy to step in and support a care situation rather than a person have to wait for carers.

There were several notice boards around the home, some for staff members, some for people living there. These contained a wide range of information such as chiropody times and charges for people, the whistleblowing policy for staff, how to make a complaint and the business continuity plan for the service. These boards held current information and were bright and clear for easy understanding. The information reflected aspects of the provider's values such as 'tips for promoting dignity'.

The provider had carried out a survey of people's views of the quality of the service. The registered manager had received a report containing the collated responses to the questionnaire, which were overall positive, and was looking to see if any follow up actions were needed.
Notifications received from the registered manager about people living in the service showed positive links with other professionals. If someone had been challenging, staff worked with health professionals to ascertain if there was a physical cause, with mental health professionals with regard to a psychological need and with social care professionals when necessary to review placements. Feedback received from both health and social care professionals was positive about the service.