Cumbria County Council

Petteril House

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 was an unannounced comprehensive inspection which we carried out on 27 February 2017.

We last inspected Petteril House on the 16 and 24 of November 2015. At that inspection we found the service was not meeting the legal requirements in force at the time relating to staffing and to person centred care planning. We found staffing levels were insufficient to meet people's needs and person centred care was not always being delivered. On this inspection the home was now meeting these regulations.

Petteril House is a care home registered to provide accommodation for up to 37 people requiring personal care. The property is a two storey building with a passenger lift to assist people to access the accommodation on the first floor. People live in small units, each with a sitting and dining area. One unit specialises in providing care for people living with dementia. At the time of our inspection there were 21 people living in the home.

The service had a registered manager in post. 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 and associated Regulations about how the service is run.

Appropriate training was provided and staff were supervised and supported. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People told us they felt safe and well cared for. They appeared content and relaxed with the staff who supported them. People and relatives said staff were very kind and caring.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People who used the service had been assessed to determine if a DoLS application was required. When people were unable to make decisions themselves then best interest meetings were held. People were supported to make choices where they were able, about aspects of their daily lives.

We recommend that the service reviews how it records people's capacity and ability to give consent to make this more clear within care plans.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Records had been updated and they were regularly reviewed to reflect people's care and support requirements.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people.

Staff and people who used the service said the registered manager was supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

People had the opportunity to give their views about the service. The registered manager acted on feedback in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided.

A complaints procedure was available. People told us they felt confident to speak to staff about any concerns if they needed to. Staff and people who used the service said the registered manager was supportive and 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.

Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regards to safeguarding. Measures were in place to protect people from abuse and avoidable harm.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was safe and good infection control measures were in place.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals. Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and

patient as they provided care and support. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Advocates were made available to represent the views of people who are not able to express their wishes.

People received end of life care at the home in line with best practice guidance. They were treated with dignity, kept peaceful, and pain free and staff supported families to spend quality time with them.

Is the service responsive?

Good

The service was responsive.

People's care, treatment and support needs plans contained more detail so that support was personalised. The plans reflected people's current needs, wishes and preferences and possible risks that needed to be managed.

People were provided with activities and entertainment of their choosing.

People had information to help them complain. Complaints were investigated and any action taken was recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff told us the management team were supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good and the home was well run.

The home provider had a quality assurance programme in place to check monitor on the quality of care provided.

Petteril House

Detailed findings

Background to this inspection

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

This inspection took place on 27 February 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one 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 for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales.

During the inspection we spoke with eight people who lived at Petteril House and three relatives. We also spoke to the registered manager, the provider's operations manager, the senior supervisor, and five care workers, one domestic, one member of catering staff and a visiting care professional.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. However we observed care and support in communal areas and saw how staff interacted with people.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

We contacted commissioners from the local authorities who contracted people's care.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe. Comments included; "I definitely feel safe, the staff check on me regularly", "I feel safe", "Yes, I do feel safe, there's always carers (staff) on hand" and "I feel comfortable that I could go and speak to the manager or any of the staff if I had any worries or concerns."

Relatives we spoke with also felt their family members were safe and that staff were proactive in informing them if they had any concerns about their family member's health or well-being. All of the people we spoke with told us there were enough staff to safely meet their needs and that they came quickly when they needed assistance. For example one person told us; "I've got my call bell and they always come straight away."

Since the last inspection the provider had increased staffing levels. We considered staffing levels were now sufficient to provide safe and individual care to people. The registered manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely.

At the time of inspection in November 2015 we had been concerned about people's needs not being met during the night shift as there was mostly only two staff on duty. The registered manager told us that this had increased to three care staff on night shift at all times. One staff member was based on the unit where people were living with dementia and the other two were flexible according to people's needs. During the day shift there were six to seven care staff, one supervisor and the registered manager on duty, with further ancillary staff to support. The staff rotas we looked at confirmed these levels were adhered to. Staff reported that the staffing levels were "good" and this gave them time to give people care that was paced according to people's needs. We observed unhurried and safe care being delivered, for example when a person was being hoisted staff took their time and ensured the person felt comfortable and safe.

The registered manager reported in the provider information return (PIR) that, "As well as new starters, all staff attend Safeguarding Passport as part of their competency and understanding of their role and responsibilities." This was revisited during supervisions and rechecked on an annual basis. Clear information was displayed in the staff room and was accessible to the public. All staff were able to give clear examples of different types of abuse that they may come across and signs and symptoms that people could display.

We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. Since 2015 four safeguarding alerts had been raised and shared appropriately with other agencies for example, the local authority safeguarding team.

One staff member told us, "I've done safeguarding training with the local authority and we talk about it in the home. We wouldn't tolerate anything like that." Staff were able to describe various types of abuse and tell us how they would respond to any suspicions or allegations of abuse. They told us they would report any concerns to the registered manager or the supervisor in charge. Staff were aware of the lines of reporting within the organisation. They were aware of the provider's whistle blowing procedure and knew how to

report any worries they had. Any concerns that were raised were taken seriously and treated in confidence.

People received their medicines in a safe way. Up-to-date policies and procedures were in place to support staff and to ensure medicines were managed in accordance with current guidance. We observed a medicines round that were always carried out by trained senior supervisors. We saw the supervisor remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. We found that there were no gaps in signatures and all medicines were signed for after administration. All medicines were appropriately stored and secured.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as for moving and assisting, mobility, nutrition and pressure care. For example, we observed staff moving residents in wheelchairs and using hoists. These were all used appropriately and safely with the correct equipment.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

We saw that recruitment procedures were in place and were being followed in practice to help ensure staff were suitable for their roles. This process included making sure that new staff had all the required employment background checks, security checks and references taken up. For example, application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Copies of interview questions and notes were also available to show how each staff member had been appointed.

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used in the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

We found the home to be clean, tidy and fresh smelling throughout. Sufficient domestic cleaning staff were employed at the home and cleaning schedules were in place. Staff wore protective clothing such as gloves and aprons while carrying out personal care. Staff told us that infection control was part of their induction training. This helped to ensure that people were cared for by staff who were knowledgeable about the spread and causes of infection.

Good

Is the service effective?

Our findings

People who could speak with us told us that the staff in the home knew the support they needed and provided this at the time they needed it. Relatives told us the staff were very good and met the needs of people who used the service. Relatives praised the staff team and spoke very highly of the support provided. One relative said, "Staff are always well informed and helpful." One person told us, "I see my Doctor if I need to, the girls just send for him".

The staff training records showed staff were kept up-to-date with safe working practices. The registered manager told us in the provider's PIR, "All staff complete a minimum of 15 hours continuous professional development to ensure that their skills and knowledge are kept up to date with the ever changing nature of the job role. In house training is also carried out specific to the needs of the service delivered at Petteril House." The provider's PIR stated 30 out of 40 staff had achieved a National Vocational Qualification (NVQ), at level two, now known as the Diploma in Health and Social Care.

The staff training records showed and staff told us they had received arrange of training opportunities to meet peoples' needs as well as training in safe working practices. We saw an on-going training programme that helped to ensure all staff had the skills and knowledge to support people.

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work.

Staff had opportunities for training to understand people's care and support needs. Staff comments included, "We get loads of training", "There are training opportunities all the time", "There's a lot of training face to face". The staff training records showed staff were kept up-to-date with safe working practices. The registered manager told us there was an ongoing training programme in place to make sure staff had the skills and knowledge to support people. Training courses included dementia care, nutrition, catheterisation, tissue viability, end of life care, epilepsy, Parkinson's disease, dignity awareness, equality and diversity, pressure ulcer prevention and diabetes awareness.

We saw that some staff had received more specialist training in caring for people living with dementia and this had included how to support people who may become agitated, upset or challenge the service. The provider did not advocate the use of restraint and instead trained staff in diversion and distraction techniques to help calm people. The registered manager said, "We have been very effective in settling people into the unit that cares for people living with dementia. We have regular training and support from the community mental health team and staff have also linked into Stirling University dementia training courses." We observed skilled and sensitive interactions by staff.

Staff said they received regular supervision from the registered manager or one of the supervisors. One staff member said, "We have supervision every two-three months." Staff also received an annual appraisal to

evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually." This showed staff were supported in their role as well as assisted to identify their individual training needs.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the 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 the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a good understanding and knowledge of this subject, and people who used the service had been assessed to determine if a DoLS application was required. We looked at the care files of people who had an authorised DoLS. We saw this was detailed in a care plan, which clearly described any imposed conditions and how these were being met. This ensured the person's needs were being met in the least restrictive way.

Staff were clear about their roles and responsibilities to ensure people's human rights were protected. They knew people well and were aware of their communication needs and how best to enable them to make decisions for themselves. They were also knowledgeable about the process that needed to be followed when people were unable to make certain decisions themselves. For instance, staff described how they would make sure decisions made were in people's best interest. They involved the person using the most effective means of communication, and involved relatives and relevant health professionals as required.

However, we found that people's capacity was mentioned in a number of different places within the care plans and the details were very brief. We found it difficult to tell what level of capacity people had and the support they needed to make day to day or more complex decisions. People's ability to make decision and to have capacity was not set out in a way that care staff would know which decisions people were capable of making and which required more support.

We recommend that the service reviews how it records people's capacity and ability to give consent; to include any support needs people may need to communicate their wishes. Reference should also be made to people's legal status, such as any Mental Health Act section or whether a Lasting Power of Attorney is in place.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as General Practitioners (GPs), district nurses, the behavioural team, psychiatrists and a speech and language therapists (SALT). We spoke with a visiting health care professional. They told us, "People are appropriately referred." Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Staff assessed people's risks of not

eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietitian when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely. For example, where people had difficulty in swallowing, staff followed the health professional's advice to provide food that had been pureed. We observed people were provided with food that was suitable for their needs, for example thickened fluids or soft foods. People's care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies.

People received the support that they needed to eat and drink enough to help maintain their health and well-being. Staff were knowledgeable about people's food preferences. We observed lunch being served; people were provided with a choice of meals and alternatives if they did not like what was on the menu. People said that they enjoyed the food; one person said, "The food is very good, we get two choices every day." Another person said, "The food is excellent, you have a choice." Staff serving lunch engaged with people in a positive way; asking if people had had enough to eat and drink, and checking that they had enjoyed their meal and second helpings were offered. The food looked appetising and we observed people finishing their meals, clearing their plates and appreciating the food.

Good

Is the service caring?

Our findings

People who could comment were all positive about the care and support provided by staff. Their comments included, "It's very nice, very nice indeed, they look after us very well" and "I am loving it. I have been in six weeks for rehabilitation and they could not have been kinder, I'm not looking forward to going home, I always dreaded coming into a place like this but I couldn't be better looked after." Another person said, "It is very good, the girls are great, they can't do enough for you." Everyone we spoke with told us that this was a good home and said they would recommend it to other people.

We observed the atmosphere was calm and relaxed. Throughout the home staff interacted well with people. They were kind and caring and they spent time engaging with people and not only carrying out care tasks. Some people had complex needs and we saw staff interacted well with people who we saw were relaxed with them. We saw staff engaged with people in a quiet and compassionate way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They asked the person's permission before they carried out any intervention. For example asking, "Can I help you to the table" and "Do you want to have some drink."

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. We saw people who lived with dementia were encouraged to make choices and be involved in decision making. For example, with regards to drinks and other activities of daily living. Staff gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. People told us they were offered choices and were involved in daily decision making about other aspects of their care, for example in activities and when to bathe. Care records detailed people's preferences and how they could be enabled to make a choice. Examples included, '[Name] can choose their own outfits' and '[Name] prefers to have a shower.'

We observed the lunch time meals on both floors of the home. The meal time was relaxed and unhurried. People sat at tables that were set with tablecloths and condiments. Specialist equipment such as cutlery and coloured dishes were available. Staff remained in the dining areas to provide help and support to people. Some people remained in their bedrooms to eat. Meals were taken out on a tray with a cover and a napkin. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served. They also checked that people had enjoyed their meal.

We saw that staff had gone to considerable lengths to redesign the dining area in the unit for people living with dementia. This was set out like a café with checked table clothes, bunting and flowers on each table and a piano in the corner. There were bistro style net curtains at the window. Staff said, that all people in the home were encouraged to pop in for a coffee and it was also used for larger social events.

People's privacy was respected. Staff treated people with dignity and respect. Staff received training to remind them about aspects of dignity in care to promote dignity within the home. We saw staff observed and offered any prompts and words of encouragement to people at meal times to provide assistance. Staff knocked on people's doors before entering their rooms. Most people sat in communal areas but some preferred to stay in their own rooms. People looked clean and well presented. Care plans provided information for staff about people's preferences for personal care.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate where there was no relative involvement. An advocate is an independent worker who can help speak up for people and ensure their rights are promoted.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed when a 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive was in place. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

The home worked with hospice nurses and the GP's to ensure people had comfortable, peaceful, pain free, end of life care. We saw the home had good communication with the GPs about a person's condition and avoided delays in receiving end of life anticipatory medicines which meant the person was kept comfortable. One relative had written to the home to say, in a thank you letter, 'You put our minds at rest. Thank you for the care you give our mother during her long and happy stay at Petteril House. I know she just loved living there and breathed in the warm atmosphere you created.' This person was cared for in the home and passed away in accordance with their wishes. A GP had also written to the home to comment on a person's end of life care, 'Congratulations is not a fitting enough compliment to describe the outstanding care given.'

Good

Is the service responsive?

Our findings

People told us activities were available if they wanted to take part. One person told us, "I am walking a bit better now so I can go down for the coffee mornings but I like my jigsaws." This person said they had an iPad connected to the homes wi-fi. A staff member said, "We have a nun come in on a Sunday to give communion and we have a bible stories group that comes in on a Wednesday, they are very good, those that want to, enjoy that."

At the last inspection in November 2015 we had found that people's care records did not contain enough information to ensure that care being delivered was personalised. On this inspection we found that the home was no longer in breach of this regulation and peoples needs were being recorded and met according to their wishes.

We found that care records contained more information about people's history, likes, dislikes and preferred routines. Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were detailed, provided information and guidance for staff about people's care needs and how they liked to be supported and how to maintain some independence. The service consulted with healthcare professionals about any changes in people's needs. For example, referrals were made to the dietician and speech and language therapist if a person was losing weight or there were concerns about a person's ability to swallow.

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure people's daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

A programme advertised activities that were available and these included armchair exercises, skittles, art and crafts, board games, quizzes, one to one time, pamper sessions, reminiscence, snooker, bingo, movie afternoons and baking. The home had a large and well stocked activities room and large bright daily posters were up on the wall for each day's activities. These were designed to be dementia friendly being in picture form and clear to understand. There was a 'coffee shop' downstairs, made from a converted room which accurately reproduced a high street outlet. Staff took people 'out' for coffee downstairs. One person said, "We do bingo or go to coffee mornings, the girls help me as I don't manage bingo so easily now."

The upstairs sitting room had a panoramic view of the garden and many mature trees and people told us they loved to watch the squirrels. The garden had been improved so that it could safely be used and enjoyed by people in the home.

Entertainment and concerts took place. We saw a variety of seasonal entertainment was arranged that included local school choirs and entertainers. The hairdresser visited weekly and a local member of the clergy also visited regularly. Transport was available and people had the opportunity to go out on trips. This included to garden centres and to the seaside.

We were informed arrangements were in place to carry out pre-admission assessments of people to the service. This was to ensure the compatibility of people and to check that staff had the required skills to meet people's needs before they were admitted. There was a good standard of record keeping. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations were detailed and included information about peoples' progress and well-being. For example, with regard to nutrition, communication, mobility and falls.

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. We saw how people had been supported to improve their mobility and had reduced the risk of falls through the intervention of staff working with health care professional.

People said they knew how to complain. A person commented, "I'd speak to the manager if I needed to." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure in the information pack they received when they moved into the home. A record of complaints was maintained and we saw the most recent one had been investigated and resolved appropriately. Several cards of appreciation were also available from relatives expressing thanks to staff for the care provided.

Good

Is the service well-led?

Our findings

The home had a registered manager who became registered as manager for Petteril House in May 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service. The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary.

Staff we spoke with were positive about their management and had respect for them. Staff commented, "The manager is approachable" and "There's good management, I'm well supported." Relatives also told us the registered manger was approachable. Their comments included, "There's an open door" and "If I had any problems I'd see the manager."

The atmosphere in the home was friendly. People told us the atmosphere was warm and relatives and visiting professionals said they were always made welcome. Staff said they felt well-supported. Staff comments included, "This is a lovely place to work. We work brilliantly as a team and everyone pulls together." Another staff member said, "You can go to the manager anytime about anything, you are never made to feel like you are intruding or your questions is too daft."

There was a strong focus on continually striving to improve. The registered manager and provider had carried out checks on how the service was provided and identified areas where the service could be further improved. We found there was an open, fair and transparent culture within the home. Staff told us they felt that they worked well as a team and they all helped each other. They told us they felt the management team were approachable and listened to their concerns and ideas for improvement.

Auditing and governance processes took place within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. Monthly audits included checks on health and safety, medicines management, care documentation, training, kitchen audits, accidents and incidents, hand hygiene, first aid and infection control. All audits showed the action that had been taken as a result of previous audits. The provider's operations manager carried out regular visits to the service to assess the quality of the care provided. This helped the provider to maintain oversight of the home.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. Records showed where a person had fallen more than twice they were referred to the falls clinic. Staff meeting minutes showed if an incident occurred it was discussed at a staff meeting.

Staff told us that they received regular supervision and support. They also told us they had an annual appraisal of their work which ensured they could express any views about the service in a private and formal manner. There was regular staff meetings arranged, to ensure good communication of any changes or new

systems. We saw the minutes of meetings that had been held; topics discussed were separated into areas to cover quality issues, reflective practice, culture, policies and procedural updates and person centred care. We saw how the team developed ideas and plans together so that all staff had ownership and were fully engaged in ensuing these changes were put into place.

Questionnaires were used to gain the views of people using the service, relatives and visiting professionals. We saw people had responded to the set questions in a positive way. The outcome of the surveys was available. There were also key worker meetings involving the people who used the service, which ensured people's voice was heard.

We found people's care records were fit for purpose and had been regularly reviewed to include pertinent details related to changing needs. Care records accurately reflected the daily care people received and were up to date. Records relating to staff training were also of a high standard and reflected the comprehensive training and supervision staff had received. We found that records were securely stored in the registered manager's office to ensure confidentiality of information.