Pine View Care Homes Ltd

Groby Lodge

Inspection report

452 Groby Road
Leicester
Leicestershire
LE3 9QB

Tel: 01162871970

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13 July 2016

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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

The inspection took place on 12 and 13 July 2016. The visit was unannounced on 12 July 2016 and we informed the care manager we would return on 13 July 2016.

Groby lodge is a residential home which provides care to older people including some people who are living with dementia. Groby lodge is registered to provide care for up to 12 people. At the time of our inspection there were 12 people living at the home, however one person was in hospital.

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

At the last two inspections of the service in October 2013 and June 2014 we asked the provider to take action. We asked the provider to make improvements in the storage of and administration of people's medicines. We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to be compliant by October 2014. We found that the provider had taken the appropriate action. Medicines were ordered and stored safely, and staff were trained to administer the medicines people required. There is still some action needed where PRN or as required medicines were not administered consistently. Staff sought medical advice and support from health care professionals.

At the last inspection of the service in June 2014 we asked the provider to take action. We asked the provider to make improvements and provide accessible personal evacuation plans. We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to be compliant by October 2014. At this inspection we found that improvements had been made. We looked at the personal evacuation plans (PEEP's) which were kept securely along with other documents and were placed near the fire board and main exit from the home. Copies of the PEEP's were also kept in each person's file and reviewed regularly.

At the last inspection of the service in June 2014 we asked the provider to take action. We asked the provider to make improvements to the audits, checks and governance in the home. We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to be compliant by October 2014. At this inspection we found that improvements had been made. A series of checks had been introduced that were overseen by the care manager and then checked by the provider.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Relatives we spoke with were also complimentary about the staff and the care offered to their relatives. People were involved in the review of their care plan, and when appropriate were happy for their relatives to be involved. We observed staff offered people everyday choices and respected

their decisions. People's care and support needs had been assessed and people were involved in the development of their plan of care. Staff had access to people's care plans and received regular updates about people's care needs. Care plans included changes to peoples care and treatment, and people attended routine health checks.

People were provided with a choice of meals that met their dietary needs. The catering staff were provided with up to date information about people's dietary needs, and sought people's opinions to meet their individual meal choices. There were sufficient person centred activities provided on a regular basis. Staff had a good understanding of people's care needs, and people were able to maintain contact with family and friends as visitors were welcome without undue restrictions.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.
There were sufficient staff available to meet people's personal care needs most of the time and we saw staff worked in a co-ordinated manner.

Staff told us they had access to information about people's care and support needs and what was important to people. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew these would be acted on.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. The provider undertook quality monitoring in the home supported by the care manager and their deputy. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals. We received positive feedback from a visiting professional and the contracting staff from the local authority with regard to the care and service offered to people. Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs.

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 consistently safe.

Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff understood their responsibility to report any observed or suspected abuse. Staff were employed in numbers to protect people however there were times in an evening when the staffing numbers left potential for putting people at risk. Medicines were ordered and stored safely. However people that were prescribed medicines on an as required basis did not receive these consistently.

Is the service effective?

Good

The service was effective.

Staff had completed essential training to meet people's needs safely and to an appropriate standard. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005 and asked for people's consent to care before it was provided. People received appropriate food choices that provided a well-balanced diet and met their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and treated people as unique individuals, recognising their privacy and dignity at all times. People were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes

and dislikes and how they wanted to spend their time. People told us they would have no hesitation in raising concerns or making a formal complaint if or when necessary.

Is the service well-led?

Good

The service was well led.

The registered manager used audits to check people were being provided with good care and to make sure records were in place to demonstrate this. People using the service, their relatives and visiting professionals had opportunities to share their views on the service.

Groby Lodge

Detailed findings

Background to this inspection

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

The inspection visit took place on 12 and 13 July 2016 by one inspector and was unannounced.
Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Groby Lodge. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home. We spoke with commissioning staff from the local authority who told us they had undertaken a quality monitoring visit, and found the provider was operating effectively.

The provider is required to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This inspection was a follow up visit to check improvements had been made following a previous inspection visit, so the provider did not have an opportunity to complete this.

During this inspection, we asked the provider and care home manager to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our previous visit. We also asked the provider to forward more information following our visit, as some documents were not available on the day.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported. We used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

To gain people's experiences of living at Groby Lodge, we spoke with two people and three relatives. We also spoke with the provider who was also the registered manager, the care manager, the deputy care

manager, three care staff, a maintenance person and the cook. We also spoke with a visiting healthcare professional.
We looked at four people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records.

Requires Improvement

Is the service safe?

Our findings

At our inspection of October 2013 and June 2014 we found that there were unsafe arrangements in place for the storage and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

The provider sent us an action plan outlining how they would be compliant by October 2014.

At this inspection we found that improvements had been made. We found that medicines were stored securely and that the temperature of the room was regularly monitored. Records showed that the temperature was within the appropriate limits for the purpose of storing medicines safely. The provider had processes in place to ensure the continued safe storage of medicines if temperatures exceeded the recommended maximum'.

We looked at the medication administration records (MARs) for six people. We found people who were prescribed medicines such as 'as required' or PRN medicines, these were not administered consistently by staff. For example, one person was prescribed paracetamol four times daily which was not being given regularly. Staff told us this was to be given 'as required'. However this was not indicated on the MAR chart. Staff were not asking if people required their pain relief medication.
Where people were prescribed pain relief patches, there was no accurate method of recording where these were placed to ensure the person's skin was not damaged by the patch being applied to the same area of skin each time. This had not resulted in any skin damage to the people prescribed this form of treatment at the time of our visit. There were protocols in place to the circumstances and regularity when these medicines should be given. There were separate charts to record where staff had to apply topical creams.

We saw where another person's pain relief was increased from twice to four times a day. There was a hand written amendment to the MAR which was signed by two staff, which followed the home's own policy. That meant staff were following the policies and procedures laid down by the provider.

A relative said to us, "When mum came in it was hectic, she was prescribed tablets to calm her down which took her balance." They explained that the GP changed the medicine and the person regained their mobility. We looked at this person's care records, and saw the staff had recognised the person was having difficulties with mobility and contacted their GP.

The medication administration records (MARs) were kept with the medicines. These had people's photographs in place to reduce the risks of medicines being given to the wrong person. The MARs were completed with signatures and countersignatures, where these were required. Information about identified allergies and people's preference on how their medicine was offered was also included.

At our inspection of June 2014 we found the provider had not ensured people's personal evacuation plans were adequate to ensure a safe environment for people. This was a breach of Regulation 12 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

The provider sent us a plan that they would be compliant by October 2014.

At this inspection we found that improvements had been made. We looked at the personal evacuation plans (PEEP's) which were kept securely along with other documents and were placed near the fire board and main exit from the home. Copies of the PEEP's were also kept in each person's file and reviewed regularly. Staff told us they took part in periodic fire drills so they knew what action to take in the event of an emergency.

The provider told us he used a staffing calculator to ascertain the numbers of staff required to care for people. This provided cover at most times during the day, but there was a period between 6.00 pm and 8.00 pm where there was only two care staff on duty. This was considered to be a busy time, when people required personal care prior to going to bed. Staff confirmed there was between five and six people who required the assistance of two staff, which meant there were times that people were not being observed in public areas. We spoke with staff who told us there were several people who required two staff to assist them with personal care. That meant at times there was not enough staff to observe people in communal areas to ensure their safety. We spoke with the provider who said the staffing numbers were adequate for the number of people in the home.

People told us they felt staff cared for them safely. One person told us, "I feel safer living here, but miss the space my flat used to have." A relative told us that their family member was safe and well cared for. They stated, "[Person] is safe here because the staff look after her."

Staff were able to tell us about individual people's needs, and the support they required to stay safe. People's care records included risk assessments, which covered areas related to people's health, safety, care and welfare. Care plans and associated risk assessments were reviewed regularly to identify any changes in risks to people's health and wellbeing. The care plans provided clear guidance to staff in respect of mitigating risk. For example, guidance on food intake in response to a choking risk and prescribed numbers of staff and what equipment should be used to mitigate moving and handling risk. People and their relatives told us they were involved in discussions and decisions about how risks were managed.

Staff told us they believed there was sufficient staff on duty to ensure people were safe. They said there was always staff present in communal rooms to ensure people were safe. A care worker told us, "There are enough staff for the people's needs most of the time." People confirmed staffing levels were sufficient to keep them safe, and were aware who to report concerns to. Another added, "I have no concerns about my mother's safety with regard to the number of staff there are."
People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff. We found that the relevant background checks had been completed before staff commenced work at the service.

District nursing staff provided a service for people with wound care and other nursing needs. We reviewed the records of one person that required specialist treatment because they were at risk of skin damage. We found staff were effective at following advice from the district nursing team to minimise the risks of skin damage. Pressure relieving equipment was in place and turning regimes to relieve pressure had been implemented. Position changes were recorded and in accordance with the person's individual care plan. Any marks or changes in people's skin were recorded on body maps, and corroborating reference made in the daily records. We spoke with a visiting healthcare professional who told us the staff were on hand to

answer any questions they had, and provided a good service between their visits. They said, "The staff are excellent, I've never had a problem, they are always available."

The provider had a safeguarding policy and procedure that informed staff of the action to take if they suspected people may have been abused or were at risk of abuse. Staff we spoke with had received training in safeguarding people from harm. They had a good understanding of what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff knew the different types of abuse and how to identify them. Staff were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on. They also knew which authorities outside the service to report any concerns to if required, which supported and protected people. The provider and care home manager were aware of their responsibilities and ensured safeguarding situations were reported to us appropriately.

Good

Is the service effective?

Our findings

People were pleased with the staff that supported them and felt staff understood their needs and how they liked to be cared for. One person said, "I like the staff, they are very good staff." However, one relative told us, "Staff don't make time to sit and talk."

Staff said there was enough training and they did not feel they had any gaps in their knowledge. There was evidence staff had received induction training on commencing their employment. That was followed by training in safeguarding, moving and handling, food and hygiene, fire awareness, health and safety and mental health awareness. Some staff received additional training in infection control, medicine administration and working with people living with dementia.

Our observations confirmed that staff put their training into practice. Staff used hoisting equipment correctly whilst they kept the person informed as to what they were about to do, guided them and provided reassurance throughout the process.

Staff felt communication and support amongst the staff team was good. There were daily handover meetings which provided staff with information about people's health and wellbeing. Staff also told us they felt supported through regular staff meetings and supervision meetings with the care manager. Staff supervision is used to advance staffs' knowledge, training and development by regular meetings between the management and staff group. That benefits the service user group with staff being more knowledgeable to care and support people effectively.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 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.

A relative said to us, "Mum has capacity and signs her care plan, but she likes us to have a look now and again." We found evidence of mental capacity assessments for individuals and best interest assessments. Where people were unable to make decisions themselves, the correct procedure had been followed to protect their rights under the Act. There was a form in place for assessing people's mental capacity. We found that the provider had ensured that people were protected by the DoLS. Records showed that they had applied for the necessary authorisation from the relevant local authority when any deprivations on people's liberty had been identified.

The care manager had a 'quick reference guide' in the office, which detailed who had been granted a DoLS, and any conditions on the authorisation. Staff confirmed they were aware of the list and told us this

provided an instant reminder of any restrictions on people and the conditions under which they were allowed.

Throughout our visit we saw that staff offered people choices and sought consent before they helped them. We overheard one member of staff asking a person, "Is it alright if I help you with your slipper back on."

We looked at the home's meal provision and how staff assessed that people received a nutritious and healthy diet and maintained their weight. People told us they were happy with the meals provided. One person said, "The food's good and we get a choice." Another person said to us, "The meals are good, home cooked, if you want anything not on the menu you just order it in the morning." Menu preference questionnaires were in care plans and included people's likes and dislikes. There was information in the kitchen about people's dietary requirements which included their individual dislikes. Meals were plated when the lunch time meal was served. The care manager agreed to look at offering vegetables in dishes to promote people's choice and independence.

People living with dementia were supported to choose a meal to suit their taste. We saw that some people were offered the choice of two plated meals when they had difficulties choosing from the written menu. One relative told us about the food preferences for their relation. They said, "Mum is offered extra food, but she won't touch baked beans or tomatoes." Staff were aware of the person's individual preferences.

People had the choice to eat in the dining room, lounge or their bedroom. We observed staff helped people who required assistance to eat their meal. This was done at a pace to suit the person, and staff were positioned to enable good eye contact. The atmosphere at lunchtime was relaxed and staff supported people to eat without rushing them. Staff were attentive and responded to requests when people wanted second helpings or assistance with cutting their food into smaller pieces. We saw all staff maintained friendly conversations with people throughout the meal. Fluids such as water and cordial were freely available in communal areas which were in addition to regular hot beverage rounds provided by care staff. Staff were observed to give choices to people including prompting to maintain the ability to eat and drink independently.

Where people had experienced a weight loss or had a specific dietary requirement, staff completed charts to monitor their food intake and weight. Catering staff were able to show us who required fortified drinks to maintain their weight, and we saw these being offered to people. People's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) and the dietician. This ensured any meal supplements or changes to people's dietary needs was managed in line with professional guidelines. Staff described how they supported one person which showed they followed the advice recommended by the SALT team. One person had a poor appetite. Records showed how much the person should eat and drink as a minimum and staff monitored their food and fluid intake to ensure they had sufficient to maintain their health. The care manager said if they had concerns about the health of anyone monitored this way, they would seek further medical advice. Records we viewed confirmed people were subject to regular health checks by the GP, specialist nursing staff and hospital consultants.

People told us their health and medical needs were met. They told us staff would call the GP if their health was of concern. People's care records showed that people received health care support from a range of health care professionals and attended routine medical appointments.

Good

Is the service caring?

Our findings

A relative told us they believed their family member was well cared for by staff. They said they thought they were well cared for because staff knew their family member well and had encouraged them to eat. One relative said, "[Person] is always clean, they (staff) seem very organised, and they do communicate if there is a problem." Another said, "It's like a home from home, I can make my own coffee, as I don't like it wishy washy." People told us the staff contacted their relatives if they became unwell or if they required a visit from the doctor.

Most people were unable to express their views and opinions so it was difficult to see if they were involved in their care decisions. Some care records were not signed by the individuals but staff told us family members were involved when any care decisions needed to be made. The provider said care plans were reflective of people's needs and were reviewed monthly, although some of the care plans required further improvements so staff provided consistent care. They said people were not routinely involved in monthly reviews, where there were no changes to their care plan. They said relatives were always involved and updated when people's health and wellbeing changed. A relative we spoke with confirmed this.

People told us that staff checked that they were comfortable throughout the day. Individual choices, preferences and the decisions made about their care and support needs were recorded. The daily records about the care and support people received showed that staff respected people's decisions about how they were supported and their lifestyle choices.

Staff respected people's dignity and they understood people's need for privacy. We saw where staff explained discreetly to a person they required personal care, and assisted them to do so. We observed a member of care staff who assisted another person, to eat their lunch. The member of staff ensured the person's clothes were appropriately covered, and used prompting to ensure they completed eating their meal. That demonstrated staff were aware how to best assist people whilst their dignity was recognised.

One person said they sometimes preferred to spend time in their room because they liked the peace and quiet and told us staff respected their right to privacy and choice. A member of staff told us that ensuring people's privacy was paramount in their mind and explained, "I keep their dignity by covering them up (when providing personal care)." When people allowed us to look we saw people's bedrooms were individually furnished with personal items such as furniture, pictures, photographs and other personal memorabilia. A relative said, "My mother always has clean clothes on, and clean sheets too."

Staff understood the importance of caring for people and they described to us the qualities staff had at Groby Lodge. Staff said there was a good team who knew people's needs and they all helped each other. All the staff said they enjoyed working at the home and got on well with people they supported. The care manager said they had a good team and were confident staff cared for people at the home. The care manager told us, "I want [to employ] people that will care, not those that just want a job."

A visiting healthcare professional was complimentary about the staff team, and described them as a 'caring

team'. They said, "I think staff are very caring, there's always a tea trolley with biscuits [for people]. I think they (staff) have personal relationships with people and deal with them as individuals, they know them all."

Good

Is the service responsive?

Our findings

We spoke with one person who was involved in the planning process for their care. They told us they enjoyed the activities. We spoke with a visiting relative who told us, "The staff are absolutely brilliant, we visited the other day and they had just done some painting. I have also seen them having a sing a long, and their nails painted." People told us they were able to visit their relatives at times suitable to them, and was unrestricted. One person added they preferred not to visit during meal times.

People told us they were aware there was a care plan in place which detailed their care and support, and said that staff supported them in a way that they preferred.

People and when appropriate their families were invited to be part of the review process for care plans. A family visitor confirmed that they (and some family relatives) were involved in the initial care planning of their relative and said they were always consulted with regard to any changes and reviews. One person said, "The staff are fairly good, they do what they can." The person then explained their relative was becoming more frail and the staff were providing more support. They explained the person now required the support of two staff and for longer periods of time to allow their personal care to be completed. That meant the staff were responsive to people's needs and adjusted people's care plans to support those needs.

Staff had access to people's plans of care and received updates about people's care needs through daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, suggesting the care process was being well managed.

We looked at four care plans which were well detailed. Pre-admission assessments were included and care planning was linked to people's needs and ensured care plans were individualised. There was evidence of up to date photographs, and information on people's past life history, allergies, likes, dislikes, wishes and aspirations. These were incorporated into the care planning to support care delivery in a way people preferred. Staff were able to explain and demonstrated through the care we observed the support that people required.

One person had advance decision care plan in place and a do not attempt resuscitation (DNAR) advance decision. This had been agreed with the person at the time when they had full capacity. That meant staff were clear about the person's wishes, and could inform any other appropriate authority of this. For example if the person was admitted to hospital.

There were notices around the home that informed people about the daily activities on offer. We spoke with staff about what people preferred to do. They told us that some people liked to sit outside, and some had asked to do some gardening. We saw where raised tubs had been organised, which enabled people to participate in planting bulbs and flowers. They added that an activities plan was in place, but if people wanted to do something else, the staff would provide alternatives. We saw activities took place on the day and were recorded in people's records on an individual basis. We saw people were engaged with activities which were chair exercises, painting and colouring books. The home had a cat which frequented the

communal lounge as well as visiting people in their bedrooms. One person told us they enjoyed the cat visiting their bedroom, where they could stroke him at their leisure.

However, we saw that some practices did not support people living with dementia as information could be confusing. The meal on offer at lunch on the menu chalk board located outside the main dining room was unclear, with a mixture of breakfast and lunch time choices on it. A printed menu outside the dining room was in very small print and included the full week.

The provider had systems in place to record complaints. People and their family visitors that we spoke with said they knew how to make a complaint. Records showed the service had received four written complaints in the last 12 months. Outcomes had been provided for each, and changes were made to the service, as a result of the outcomes. Analysis by the care manager did not reveal any patterns or themes. The information was fed back to staff though staff meetings or individual supervision sessions, so that staff were aware of the issue and any changes that were required. One person said to us, "I feel we could approach the care manager or provider with any issues." A visiting relative said, "If mum didn't like anything she would tell you."

People and their relatives were invited to regular meetings to plan changes to the menus. People could make suggestions and changes to the running of the home and the meals on offer. There were minutes available for these meetings which people who were unable to attend were kept informed of any changes.

Good

Is the service well-led?

Our findings

At our inspection of June 2014 we found the provider had not ensured adequate governance or maintenance and safety checks. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 15 of the Health and Social Care Act 2008.
The provider sent us a plan that they would be compliant by October 2014. At this inspection we found that improvements had been made.

We saw the system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. There was an in house maintenance person who undertook repairs at a number of the provider's locations. Staff were aware of the process for reporting faults and repairs, and the 'business continuity plan' was available in the office if there was an interruption in the provision of service. This file included instructions where gas and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

People living in the home and their relatives told us they regularly saw the provider visiting the home. One person said, "We see the registered manager, he always comes in and says hello, and asks how we are."

We discussed the checks and audits the provider and care manager conducted in order to ensure people received the appropriate support and care. The care manager told us there were regular audits undertaken by the staff in order to ensure health and safety in the home was maintained. We saw records of the checks that had been undertaken to ensure the building was safe for people. These included checks on the medicines system, care plans, accidents and incidents and people's weight loss or gain and their nutritional and dietary requirements.

The care manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required.

We saw evidence that people who used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process. They were sent questionnaires, so were enabled to comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary staff assisted them in completing questionnaires. We saw people who lived at the home and their relatives were also invited to meetings with the provider and staff, with minutes being available to us. We saw that people requested to be able to do gardening. The staff had provided raised flowerbeds, bulbs, plants and shrubs, and assisted people into the garden to complete the planting. That meant the provider embraced the quality assurance process and also assisted in providing an open culture in the home.

The service had a provider who understood their responsibilities in terms of ensuring that we were notified of events that affected the people, staff and building. The provider had a clear understanding of what they wanted to achieve for the service and they were supported by the care manager, their deputy and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours were that necessary.

All staff had detailed job descriptions and had regular staff and supervision meetings which were used to support staff to maintain and improve their performance. Staff confirmed they had access to electronic copies of the provider's policies and procedures. Staff understood their roles and this information ensured that staff were provided with the same information which was used to provide a consistent level of safe care throughout the home. Staff told us they could make comments or raise concerns with the management team about the way the service was run. Staff had noted that after being laundered some clothes had been put in incorrect bedrooms. The care manager had developed a system of checks which had resulted in few mistakes now taking place.