Avon Lee Lodge Limited

Avon Lee Lodge

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

An unannounced inspection took place on the 9 December 2015. The inspection continued on the 11 December 2015 and was announced. The inspection was a planned comprehensive inspection carried out by one inspector.

The service is registered to provide accommodation and personal care for up to 24 people. At the time of our inspection there were 20 people living at the service.

The service provides accommodation over three floors. There are 23 bedrooms, six of which are suitable for two people. At the time of our inspection all the rooms were being used as single occupancy. Each room has an en-suite toilet and wash basin. There was a call bell system fitted in each room. There are two bathrooms with specialist bathing facilities on the first floor. We found that one bath had been out of action for several weeks due to a safety issue. We were told by the Director that they were in regular communication with the manufacturer to get the issue resolved. The first and second floors can be accessed by either a lift or staircase. On the ground floor there is a large dining room which

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also has cinema equipment installed for film shows. There is a conservatory that people used to spend time together which looks onto secure gardens that have level access from the building. There is a kitchen that produces all the meals for the service and an on-site laundry service.

The service has a registered manager. 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.

We found that the service was safe. People living at the service and their families told us that they felt safe. Staff had received safeguarding training and had a good knowledge of how to identify potential abuse and who to contact if they had concerns. Records showed us that the service report safeguarding concerns promptly and appropriately.

People's risks were assessed prior to admission and then reviewed regularly. They included malnutrition, skin integrity and moving and handling. When a risk had been identified a care plan had been put in place. This explained what actions needed to be taken to minimise risk and keep the person safe. Other general risk assessments included slips and trips, infection control, accessing the staircase and staff related risks.

People did not have personal evacuation plans in place. These are needed to ensure each person's individual risks are understood in the event of an emergency. Staff had completed fire safety and the correct use of fire extinguishers training. Fire equipment was regularly tested. The service did not have an emergency contingency plan in place. An emergency contingency plan needs to contain information on how the service would keep people safe in the event of a major incident which affected the running of the service. We raised this with the registered manager who agreed to complete personal fire evacuation plans and an emergency contingency plan.

Staff were recruited safely. Files contained evidence of criminal record checks, references and eligibility to work in the UK. Processes were in place to manage any unsafe practice and we found evidence in supervision records of them being used appropriately. People told us they felt there were enough staff to support them safely. We activated a call bell in a room and after 15 minutes no staff had come to answer the call. We discussed this with the Director who told us that staff had responded but the call had shown in the wrong location. The issue was immediately investigated and actions put in place to rectify the problem. Call bell records showed us that staff responded usually within one to three minutes.

Medicines were managed safely. People's Medicine Administration Records (MAR) were maintained and medicine audits regularly carried out by the manager. Controlled medicines require additional security and recording processes. The records were well maintained and accurate. However creams were stored in people's rooms and there was no consistent recording of their application. The deputy manager was in the process of introducing a new recording system. Records would include a body map showing where the cream needed to be applied and an administration recording sheet where staff signed to confirm application. Staff were aware of the process for reporting medicine errors.

We found the service was not always effective. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service were not working within the principles of the MCA. We were told that some people were living with a dementia. People's files did not contain any evidence that their capacity had been assessed when care plans had initially been developed or reviewed.

Summary of findings

People had not had their mental capacity assessed to determine whether they were able to consent to restrictions on their liberty or if a DoLs application was required in line with the MCA legislation. One person had a DoLs in place which their social worker had completed on admission to the service. Staff were aware of the conditions of the authorisation and when it needed to be reviewed. We discussed our findings with the registered manager who had completed MCA training but recognised her knowledge was out of date. During our inspection training was booked for January for herself and the deputy on the implementation of the MCA and DoLs legislation. We observed staff seeking verbal consent and giving people time to ask questions and consider the information before giving their consent.

Staff received an induction that enabled them to effectively carry out their roles. This included a four day introduction to the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Records were kept of the training staff had undertaken and dates for when it needed to be reviewed. Staff received regular supervision which included checking competencies after training.

People told us that the food was good. The kitchen had a good knowledge of the dietary requirements of people. We saw that one person had been losing weight. Risk assessments were in place and reviewed regularly. The kitchen and care workers had a good understanding of what they needed to do to support this person. The service had responded quickly in getting support from a GP and dietician. Staff supported people with their meals in a relaxed and discreet manner. Specialist equipment was used to support people to maintain their independence at mealtimes. People were regularly offered drinks throughout the day.

People had good access to healthcare. This included opticians, audiologists, chiropodists and specialist health professionals at the hospital, GP's and district nurses.

We found that the service was caring. We spoke with people, their families and other professionals who told us that staff were caring, kind and compassionate. People were supported in a professional and unhurried way. Staff had a good understanding of people's care needs. They knew people's likes and dislikes and how they liked to receive their care and support. People were regularly checked upon when in their rooms. People felt involved in decisions about their care. Staff involved people in choices about how they wanted to spend their time. They were supported and encouraged to maintain their independence. People felt that their dignity and privacy was respected. Rooms had been personalised with photographs and personal belongings. People felt their rooms were their own personal space. Relative's told us they were kept informed of any changes or concerns.

People had not been provided with information about advocacy services. We spoke with the registered manager who told us that they would source a local advocacy service and share the information with people including a poster with contact details.

We found that the service was responsive. People had their care needs assessed and reviewed regularly. Care files and reviews included involvement of staff, the person and their family. Changes in people's care needs were identified quickly and when necessary other professionals were involved in supporting. Staff had a good understanding of people's care plans and felt well informed about people.

People were supported to follow their interests which included bird watching and listening to music. Activities and entertainment were organised for most days in December. This included children from a local school visiting, musical entertainers, quizzes and games. People were supported to maintain contact with friends and family. The service had worked with health professionals to support a person with complex health issues regain the ability to sit in a chair so that they were able to engage more with activities.

People were aware of the complaints process and they felt staff listened. Complaints were recorded, investigated and responded to with findings and actions. Responses included information about the Local Government Ombudsman.

We found that the service was well led. The registered manager was available throughout our inspection and had a good knowledge of the people living at the service. Interaction between staff and the manager was relaxed and professional. We were made aware prior to our inspection that there had recently been a change in

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management arrangements. We asked people, their families and staff whether this had impacted on the care people received. They were aware that changes had taken place but had not felt any negative impact.

Notifications were not always sent to CQC in a timely manner. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. This had been identified by the registered manager who had accessed information on the CQC website which provides guidance for providers on their responsibilities.

Staff we spoke with felt supported and able to share their views or concerns with management.

The service bi-annually sends a quality assurance survey form to people, their families, staff and other professionals to gather their views on the service. Results from a survey in April 2015 had been analysed by the management team. We looked at the results and the feedback had been positive. The survey results had not been shared with people, their families or staff. We discussed this with the manager who told us they would introduce this into their quality assurance process.

The service carried out regular audits which included medicines, accidents and incidents, health and safety, fire, cleaning, staff training, care files, night checks, infection control , call bell and equipment maintenance checks. Audit records showed areas where issues had been identified and actions taken.

Summary of findings

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.

People living at the service and their families told us that they felt safe.

Staff had received safeguarding training and had a good knowledge of how to identify and respond to concerns of abuse. Safeguarding concerns were reported promptly.

People's health risks were assessed and where a risk had been identified actions had been put into place to minimise the risk and keep the person safe. However people did not have personal fire evacuation plans which are needed to ensure each person's individual risk is understood in the event of an emergency.

Staff were recruited safely. People felt there were enough staff to support them safely.

Medicines were managed safely. However there was no consistent recording of the application of creams.

Is the service effective?

Requires improvement

We found the service was not always effective.

The service was not working within the principles of the Mental Capacity Act 2005. People did not have their mental capacity assessed to determine whether they were able to consent to restrictions on their liberty.

Staff received training that enabled them to carry out their roles effectively.

People told us that the food was good. Staff had a good understanding of people's dietary requirements and identified and responded to issues quickly.

People had good access to healthcare.

Is the service caring?

Good

We found the service was caring.

People, their families and visiting professionals told us they found staff caring, kind and compassionate. Staff had a good understanding of peoples care needs and how to support them.

People felt their dignity and privacy were respected.

People and their families felt involved in decisions about their care. However, people had not been provided with information about advocacy services.

Is the service responsive?

Good

We found that the service was responsive.

Summary of findings

People had their care needs assessed and reviewed regularly.

Changes to peoples care needs were identified and responded to quickly including informing other health professionals when appropriate.

People were supported to follow their interests and maintain contact with families and friends.

People were aware of the complaints process and felt able to make a complaint. Complaints were recorded, investigated and responded to with findings and any actions.

Is the service well-led?

Good

We found the service was well led.

Staff felt supported and able to share their views or concerns with the manager.

Notifications were not always sent to CQC in a timely manner. The registered manager had identified this and taken appropriate action.

Bi annual quality assurance surveys are carried out to gather views from people, their families, other professionals and staff on the service. Results had been analysed and actions identified.

Regular audits of the service were carried out and any shortfalls identified and actioned.

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Detailed findings

Background to this inspection

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

The inspection took place on the 9 December 2015 and was unannounced. The inspection continued on the 11 December and was announced.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. Before the inspection we did not request 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. We gathered this information from the provider during the inspection.'

During our inspection we spoke with six people who use the service and five people who were visiting. We spoke with the Director, Registered Manager, five care staff, the Kitchen Manager and chef. We spoke with two health professionals who had experience of the service.

We reviewed three peoples care files and discussed with them and care workers their accuracy. We checked two staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.

We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

We found that the service was safe. People living at the service and their families told us that they felt safe. One person said "The staff are lovely, nobody is ever nasty".

Staff had received safeguarding training and completed competency checks. They had a good knowledge of how to identify potential abuse. One care worker told us, "There could be clear physical signs such as bruising or seeing somebody upset or withdrawn. To be on the safe side I would always report anything to a senior member of staff. We also have a poster in the staff room with information and telephone numbers of who to call if concerned". Staff told us that they felt able to report any concerns about poor practice or bullying to the manager.

Records showed us that the service reported safeguarding concerns promptly and appropriately. Any accidents and incidents were recorded and included actions taken to keep the person safe and minimise the risk of further harm.

People's risks were assessed prior to admission and then reviewed regularly. They included malnutrition, skin integrity and moving and handling. Risk assessments had been signed by staff and the person or their representative. When a risk had been identified a care plan had been put in place. This explained what actions needed to be taken to minimise risk and keep the person safe.

The home had open staircases. A risk assessment was in place and detailed how people needed to be supported. A visitor told us "Mum had been found a few times attempting the stairs and it was felt she wasn't safe. It was decided it would be safer for her to move to a downstairs room".

A risk assessment was in place for a person who smoked. To reduce risk the person was able to independently access an outside smoking area. For safety the person had agreed for staff to keep the lighter when not being used.

Risk assessments had been completed for work stress and control measures included a policy on equal opportunities and bullying. Other general risk assessments included slips and trips and infection control.

People did not have personal evacuation plans in place. These are needed to ensure each person's individual risks are understood in the event of an emergency. Staff had completed fire safety and the correct use of fire extinguishers training. Fire equipment was regularly tested. The service did not have an emergency contingency plan in place. An emergency contingency plan needs to contain information on how the service would keep people safe in the event of a major incident which affected the running of the service. We raised this with the registered manager who agreed to complete personal fire evacuation plans and an emergency contingency plan.

People told us they felt there were enough staff to support them safely. One person said, "I feel there are enough staff through the day and at night". We activated a call bell in a room and after 15 minutes no staff had come to answer the call. We discussed this with the Director who told us that staff had responded but the call had shown in the wrong location. The issue was immediately investigated and actions put in place to rectify the problem. We checked call bell records for a Sunday and it showed us that staff responded, other than on one occasion, within one to three minutes.

Staff were recruited safely. Files contained evidence of criminal record checks, references and eligibility to work in the UK. Processes were in place to manage any unsafe practice and we found evidence in supervision records of them being used appropriately.

Medicines were managed safely. People's Medicine Administration Records (MAR) were maintained and medicine audits regularly carried out by the manager. Controlled medicines require additional security and recording processes. The records were well maintained and accurate. However creams were stored in people's rooms and there was no consistent recording of their application. The deputy manager was in the process of introducing a new recording system. Records would include a body map showing where the cream needed to be applied and an administration recording sheet where staff signed to confirm application. Senior staff knew the process for dealing with a medication error. One said "If I made a medication error I would ring the manager straight away. It would be a safeguarding".

Requires improvement

Is the service effective?

Our findings

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service were not working within the principles of the MCA. We were told that some people were living with a dementia. People's files did not contain any evidence that their capacity had been assessed when care plans had initially been developed or reviewed. One person had a sensor mat and it was put next to them wherever they were sitting. If the person stood on the mat staff were alerted and needed to respond quickly to check they were safe. One person was in bed and bed rails were up on both sides of their bed. They understood they were to keep people from falling out of bed. They said "I wasn't asked if I was happy about it and I'm not". People had not had their mental capacity assessed to determine whether they were able to consent to restrictions on their liberty or if a DoLs application was required in line with the MCA legislation. One person had a DoLs in place which their social worker had completed on admission to the service. Staff were aware of the conditions of the authorisation and when it needed to be reviewed. We discussed our findings with the registered manager who had completed MCA training but recognised her knowledge was out of date. During our inspection training was booked for January for herself and the deputy on the implementation of the MCA and DoLs legislation.

We observed staff seeking verbal consent. Staff asked people how they would like to be supported and waited for them to consent before providing care. We observed a care worker explaining a safety situation with a person. They gave the person all the information needed to help them understand the full implications of their actions. The person was given time to ask questions and consider the information before giving their consent.

Staff received an induction that enabled them to effectively carry out their roles. This included a four day introduction to the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. One care worker said "We get so much information, but this is good as it makes me feel safe and trained properly. When I had my moving and handling training we tried all the equipment so that we knew what it would feel like for people". Training records were kept for each member of staff and included dates it needed to be reviewed. Training included health and safety, diabetes awareness, dementia awareness, basics in catheter care and person centred care. Staff told us that they had supervision every six to eight weeks and that this would include having competencies checked after training.

People told us that the food was good. One relative told us "If I ask the chef for something different for my husband it's never a problem. They automatically find something else he fancies". We spoke with the chef who told us that they have a board in the kitchen with people's likes and dislikes. He said "One person today doesn't like the desert so we had made them a fruit salad". One person had been losing weight. The kitchen staff had a good understanding of what was needed to support this person to gain weight. They told us "We provide a snack between meals at 10am, 3pm and 7pm. They like chocolate and jam sandwiches so this is what we give them". We spoke with a senior care worker who said "Their weight is up and down. When they are with people they like to talk and forget to eat so we have to encourage them. They have lots of snacks. We weigh them every week and log in the care plan. If weight starts going down we put a food chart in place". We observed staff supporting with snacks and encouragement throughout the day.

We saw in one persons' file that they had been losing weight. A risk assessment was in place and being regularly reviewed. The service had quickly involved the support of a GP and dietician and the care plan reflected their input. Kitchen and care staff were aware of the content of the

Requires improvement

Is the service effective?

persons care plan. The person and their family had been involved in decisions about significant changes to their diet. We spoke with a dietician who was visiting a person at the service. They had received an urgent referral from the GP which had been initiated by the care staff. They told us, "Staff are clued up on food textures. Good at sharing information with kitchen staff. They were quick to get back in touch when a persons' health deteriorated. They already had a plan in place but needed support. When I visit the staff give me a really detailed history of what's been happening. They always ensure a care worker is with me who can answer questions and offer practical support"

During lunch we observed staff supporting people in a relaxed and discreet manner. One person was worrying they had too much food on their plate and the care worker said "You don't have to eat everything, just what you fancy". One person had a plate guard and was using a spoon so that they could eat independently. We observed people being regularly offered drinks and jugs of squash being replaced in rooms throughout the day.

Records contained evidence that people have good access to healthcare. This included opticians, audiologists, chiropodists and specialist health professionals at the hospital, GP's and district nurses.

Good

Is the service caring?

Our findings

We found that the service was caring. People, their families and visiting professionals all told us that the staff were caring. We observed staff interacting with people, their families and each other in an unhurried and professional manner. A relative said, "Staff are very cheerful and nice with me and my husband". Another person said, "A new member of staff came into the room, introduced themselves and shook my hand and was really helpful". A relative said, "All the staff know my mum. They seem nice to people, patient and considerate, they don't rush people with mobility but go at their speed, they are kind and thoughtful".

Staff had a good understanding of people's care needs. They knew what people liked and disliked and how they liked to receive their care and support. A care worker said "Everybody is different with different needs. It's important to get to know each person. I feel a bond with the residents and feel I've got to know the little things they like and dislike". Staff told us how people liked to receive care and spend their time. A care worker told us "One person likes to go to bed quite late. They like to watch DVD's until late and then like to read until 10ish". Peoples care plans confirmed what staff told us. Staff had a good knowledge of friends and family who were part of people's lives. One person regularly shared a meal together with their family. We observed staff listening to what people were saying, sharing a joke and laughing together. A relative told us "If I telephone and leave a message I know the staff pass it on".

We looked at compliments the service had received. One relative had written, 'Within a short time of arriving at Avon Lee Lodge they were back to their usual self, with a twinkle in their eye, colour in their cheeks and a smile on their face. This is attributed to the attention, care and kindness from yourselves'.

We observed staff regularly checking on people in their rooms. A relative told us, "Always staff in and out of the room, in an hour there can be two or three people".

People felt involved in decisions. A relative told us "If the staff want to talk to me because something has changed they always ring me to discuss. If there is something mum doesn't want to do it is always respected". We observed staff involving people in making choices about where they would like to eat their meal or whether they wanted to join in with a musical activity. At the time of our visit nobody was being supported by an advocate. We saw no evidence that people were being provided with information about an advocacy service. We spoke with the registered manager who told us that they would source a local advocacy service and share the information with people including a poster with contact details.

People felt their privacy and dignity was respected. One person described to us how a carer knocks on their bedroom door and always says "Sorry to disturb you". They said they felt staff were polite and respectful of their space and understood it was their home. A care worker said "When I help people with personal care I make sure the curtains and door are closed and place a towel over their lap. I encourage people to do things for themselves to help people keep their independence. Some people can wash and dress their top half and I would help with the rest". A relative said "They let mum do what she can herself, she likes to feel she is still independent".

People's rooms were personalised with ornaments, pictures and photographs of families. Some people had pieces of furniture they had brought from their homes. People told us that they felt that their rooms were lovely and their own personal space. One person said "Feels like home and that was what appealed when I decided to move here".

Good

Is the service responsive?

Our findings

We found that the service was responsive. People had their care needs assessed prior to admission and they were reviewed regularly. We looked at care files and reviews had included involvement of staff, the person and their family. Care plans were detailed and specific to each person. Instructions for care staff were clear and the records showed us that staff reported changes quickly to senior staff. We saw evidence that whenever changes were identified senior staff responded by reviewing assessments and care plans and contacting other professionals to support when it was needed. We read a care file where the person had been discharged from hospital. It recorded discussions with the person about how some of their care needs had increased and agreed how they would need to be supported. Over several months each review with the person showed improvements until they regained their initial level of independence with personal care, mobility and continence.

We spoke with staff who had a good understanding of information in care plans. One care worker told us, "You have to read all the care plans when you first start. If we have a new resident, even for a short respite stay, you have to read the care plans. When you have been off for a few days you are given time to read the handover books which gets you back up to date. If somebody had a fall or been poorly you know what has been happening".

People were supported to follow their interests. One person who was cared for in their room had bird feeders outside their window and enjoyed watching the bird activity. We read that one person liked to have music on when they were in their room. We visited the person in their room and they were enjoying listening to their radio.

One person had complex health issues that had been preventing them getting up out of bed for several months. Under the guidance of a physiotherapist and the GP the person had been supported by staff and family to use a specialist reclining chair. The person said "All the staff have been very good, they don't rush me". After our inspection we spoke with a health professional who had been involved. They said "Staff were very receptive and had a good knowledge of the person. The aim had been to help the person engage more with their family and join in the activities". Family said, "Two days ago the Salvation Army came. Staff used a hoist and they were supported into the new chair. It's the first time they have left the room since moving here some months ago. It was a great achievement; we all found it quite emotional".

On the noticeboard we saw that activities and entertainment were organised for most days in December. This included children from a local school visiting, musical entertainers, quizzes and games. We observed people, their families and staff enjoying a sing-a- long with a visiting musician. One relative told us about some incubated chicken eggs earlier in the year. "We watched the chickens hatch, it went on for weeks and we were all fascinated by it. Everybody enjoyed the experience". People were supported to maintain contact with friends and family. One person had written their Christmas cards and staff had ensured they were posted.

People were aware of the complaints process and felt able to approach staff if they needed. People told us that they felt staff listened. We looked at the complaints records. Complaints were recorded, investigated and responded to with details of any findings and actions. People were given information about what to do if they remained not satisfied which included information about the Local Government Ombudsman. We saw that in response to concerns raised about the laundry service additional social care hours had been introduced which included checking with each person that their clothes were in good order after a laundry service. This action had resulted in a better outcome for people which was reflected in the quality assurance survey.

Good

Is the service well-led?

Our findings

We found that the service was well led. A relative told us "The manager is nothing but kindness". The registered manager was available throughout our inspection and had a good knowledge of the people living at the service. Interaction between all staff with the manager was relaxed and professional. We were made aware prior to our inspection that there had recently been a change in management arrangements. We asked people, their families and staff whether this had impacted on the care people received. They were aware that changes had taken place but had not felt any negative impact. A relative said, "We are seeing more of the owner, they seem to do some things differently but nothing has changed for us, were still happy with the care". We also spoke with a health professional who told us, "There was a break in continuity which led to a delay in a care plan being implemented but this was quickly resolved".

Notifications were not always sent to CQC in a timely manner. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. This had been identified by the registered manager who had accessed information from the CQC website that provided details of the requirements.

Staff felt supported. One told us, "If you feel stressed by a situation you can ask for five minutes down time. If I have a problem I know I can have a chat with the manager". Staff had monthly staff meetings. One care worker said, "If something is happening I feel we can discuss it. I feel I have an input. At a recent meeting was able to give my view on rotas and the laundry". We looked at the results of the last staff survey carried out in April 2015 and one outcome was that staff felt they were not getting enough support. We were told by a manager that this had not been reflected in individual supervisions and had not been explored further with the staff team.

The service had sent a quality assurance survey form to people, their families, staff and other professionals in April 2015 to gather their views on the service. The results had been analysed by the management team. We looked at the results and the feedback from people, their families and visiting professionals had been positive. An area identified as requiring action had been activities and we saw that an additional member of staff had been employed to support with this. The survey results had not been shared with people and their families. We discussed this with the manager who told us they would introduce this into their quality assurance process.

Staff were aware of the grievance process and felt able to use it if necessary. The registered manager had been meeting with staff to discuss and said, "Staff are encouraged to use the grievance process if they are not happy so that issues are professionally addressed. We are keen staff understand a grievance is not a reflection on the person. Things can be difficult at work but there is a professional path that can be followed; it's OK".

The home in 2015 had been accredited with the 'Investors In People' award. This is a nationally recognised framework that helps organisations to improve their performance and realise their objectives through the effective management and development of their staff.

The service carried out regular audits which included medicines, accidents and incidents, health and safety, fire, cleaning, staff training, care files, night checks, infection control , call bell and equipment maintenance checks. Audit records showed areas where issues had been identified and actions taken. The audit findings were shared with staff and in some cases actions had been allocated to individual staff members.