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Omega Oak Barn

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3 June 2016 and was unannounced.

Omega Oak Barn provides personal care for up to 28 older people. On the day of the inspection there were 23 people living in the home. The home is located in the village of Beadlam close to the market towns of Helmsley and Kirbymoorside. The home does not provide nursing care.

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

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home has sufficient suitable staff to care for people safely and they were safely recruited.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date in areas the registered provider considered mandatory, such as infection control, health and safety, food hygiene and medicine handling and also in specialist areas of health care appropriate for the people being cared for.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and that they should assume that a person had capacity to make decisions. They understood what needed to happen to protect the best interests of people who did not have capacity to make certain decisions.

People's nutrition and hydration needs were met. People enjoyed the meals and they were of a good quality. Clinical care needs were met in consultation with health care professionals.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity. Staff had a good knowledge and understanding of people's needs and worked together well as a team. The atmosphere within the home was one of care and respect. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided

evidence that people were supported to feel cared for and listened to.

People were supported to engage in daily activities they enjoyed and which were in line with their preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were kept up to date when people's needs changed. People were encouraged to take part in their reviews and to give their views, which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. People we spoke with told us if they had concerns they were always addressed directly with the registered manager who responded quickly and with politeness.

The service was well managed. The registered manager ensured the quality of the service through a system of audits and checks. They sought feedback from people who lived at the home, relatives, visitors and professionals with an interest in the service and acted on this to improve the quality of care.

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 were protected from the risks of acquiring infection because the service had infection control policies and procedures and staff acted on these.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by sufficient staff who were safely recruited. Staff had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring and we observed staff were kind and compassionate.

Staff respected people's privacy and treated them with regard to

their dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported them to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

Omega Oak Barn

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 03 June 2016 and was carried out by two adult social care inspectors. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We received a Provider Information Return (PIR) from the service. 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 used the information on the completed PIR and also gathered information we required during the inspection visit.

During the inspection visit we spoke with six people who lived at the home, three visitors, four members of staff and the registered manager. After the inspection visit we spoke with two health and social care professionals. We spent time observing care in the communal areas of the home.

We looked at all areas of the home, including people's bedrooms, with their permission where this was possible. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at the home.

Good

Our findings

People indicated either by speaking or through their body language that they were comfortable at the service. People smiled and appeared to feel secure in their conversations with staff and each other. One person told us, "Medication comes at the right time. Not…missed at all." And, "I feel safe when staff are moving me." Visitors told us that they were confident that people were safe. One person told us, "Yes, [my relative] is safe here." Another visitor told us, "I have seen staff moving [my relative] and it was all done safely."

Safeguarding policies and procedures were in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us they used a dependency tool and the levels were set according to the number and dependency levels of the people living at the home at any time. The registered manager told us they considered skill mix and experience when drawing up the rota. Care staff were enabled to focus on their caring role as the service employed domestic staff and also staff who engaged people in activities. We spoke with staff about this and they confirmed what the registered manager told us. They told us there were enough staff on duty at all times to meet people's needs and not feel rushed. Our observations on the day of inspection confirmed there were sufficient staff to care for people safely.

Risk assessments were in place for each person who lived at the home. The service operated a traffic light system for risk assessments. Red was for the level of highest risk and was reviewed every month, amber was reviewed every three months and green was reviewed on an as needed basis. The registered manager told us how they monitored triggers for people's behaviour. Care plans included instructions for staff around recognising changes in behaviour which may, for example, be due to changes in physical or mental health needs.

Risk assessments covered such areas as falls, mental health, infections, pressure care and nutrition. Records showed that the plans often achieved positive results leading to safer care. For example, the registered manager told us about a person who had been referred to the falls team and had been fitted with hip protectors which reduced the risk of injury. Hip protectors are devices that use padded material to absorb the shock of a fall. An updated risk assessment about behaviour for one person had resulted in a referral made to the community mental health team. This had led to more detailed instructions for staff around how to support the person when they became distressed.

We looked at the recruitment records for four staff which showed that generally safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff. The DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. This meant that the home had taken steps to reduce the risk of employing unsuitable staff.

However, in two records the service had only one reference on file for each member of staff. The registered manager told us that it was sometimes difficult to gain references for new staff, particularly when they had little work experience. They explained that they always checked personal references when people did not have sufficient work experience to give two work references and that they now would record all phone contact with referees to provider evidence that staff had been recruited according to the service's policy on recruitment.

The home was on one level and was safe and easy for people to walk around. Environmental risk assessments were in place and each person had a Personal Emergency Evacuation Plan (PEEP) to protect them in the event of fire. We saw that entry to the home was controlled and there were keypads on the exit and internal doors for people's safety. Health and safety checks were regularly carried out as part of the quality monitoring system and any required actions were acted upon. Door and pressure sensors were in use when appropriate to protect people.

Staff told us that they had received training in the control of infection and training records confirmed this. They correctly described how to minimise the risk of infection, such as through using the correct aprons and gloves and washing their hands between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry were kept separate to minimise the risk of cross infection.

Medicines were stored safely in a trolley attached to the wall. Controlled drugs were stored separately and administered according to policy and procedure. Medicines were supplied to the home in a Monitored Dosing System (MDS). MDS is a medication storage device designed to simplify the administration of solid oral dose medication. We found appropriate arrangements were in place for the ordering and disposal of all medicines. We observed a member of staff while they were dispensing medicines. They did so safely and according to policy and procedure. This ensured that the correct medicine was administered and signed for at the right time. The registered manager told us they made regular checks on stocks and recording to ensure people received their medicines safely and at the time they needed them. We saw the results of these medicines audits. These had highlighted areas for improvement with action points in place and a timescale for completion. This oversight of medicines reduced the risk of error.

We looked at the Medication Administration Records (MAR) for two people. The MARs were accurately completed and medicines were signed for, however we noted a small number of missed signatures, though

stocks tallied so that it appeared that the medicines had been given as prescribed. The registered manager told us these errors would be highlighted during the medicines audit and the members of staff responsible would be spoken with to improve safe practice in this area.

The registered manager told us that the local GPs were very supportive and that one GP would regularly visit the home to support them to risk assess medicines and to review prescriptions to ensure that prescribed medicines remained appropriate for people's current needs.

Staff told us that they received regular medicine training updates and records confirmed this. This meant that people benefitted from being cared for by staff who were trained in best practice around medicine handling.

Good

Our findings

People told us that they enjoyed the meals. One person said, "The food is great, I really love it." A visitor said, "The food is excellent, all home made." One person told us how the staff understood their food likes and dislikes. Another person said, "If I want an alternative [lunch] staff will provide one." A visitor said, "They always bring us drinks when we want them and visitors are offered tea or coffee." In surveys sent out by the service, people had written that they were kept up to date with health concerns, and a visitor told us that the home was quick to inform and involve them if they felt health care professional support was needed. One person said, "The doctor comes to visit, and staff will call the GP quickly if I feel unwell." Another visitor told us, "The staff always involve [my relative]. They ask what they want to wear, and generally make them feel part of everything that is going on."

Staff had received induction and training in all areas the registered provider considered mandatory (core training). Staff told us this was thorough. They told us they shadowed other more experienced staff when they were first recruited and only began working with people unsupervised when they were confident and the registered manager felt they were competent. Training was provided through a range of provision. Some was online, some was off site and face to face in a classroom setting and some was through meetings and informal learning. All core training was completed with a plan in place for when this needed to be renewed. In addition, the registered manager had sourced training in areas such as behaviour which may be challenging, care for people who were living with dementia, palliative care, diabetes care, visual impairment and continence. Staff told us that this supported them to offer personalised and safe care for people.

Staff told us they received regular supervision and appraisal which they told us supported them to offer safe and personalised care. Records confirmed that supervision and appraisal regularly took place.

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. We checked whether the service was working within the principles of the MCA.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions. The service also had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should always assume capacity and support people to make their own decisions. They were able to tell us about when a Best Interests Decision may be made and who might be involved in this to protect people. A Best Interest Decision is made when a person does not have the capacity to make a decision for themselves and involves a multidisciplinary team. We saw records of Best Interests Decisions which had been carried out involving the person concerned and other relevant people which formed a multidisciplinary team. A number of DoLS had been applied for and granted which were subject to review. Records confirmed that these had been applied for and put into place appropriately and that the decisions had been made in the person's best interests.

People's consent to care and treatment was recorded along with their capacity to make decisions about their care. Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures. Information about advocacy services was available to people and advocates were appointed, when needed.

Needs relating to nutrition and hydration were recorded in people's care plans, and risk assessments were available. One person's risk assessment had not been updated in line with their care plan, however staff were able to tell us what this person's up to date nutritional needs were and the risks associated with food and drink. The care plan had been updated and gave current guidance to staff on the care needed in this area.

People's likes and dislikes were recorded and staff were aware of what these were. Charts were used, when necessary to monitor people's food and drink and these were accurately recorded with no gaps. Information from charts was used to ensure care plans were up to date and relevant to people's changing needs. The registered manager referred people for specialist support when this was needed. For example, one person's care plan included evidence of the involvement of the Speech and Language Therapy service (SALT). Another person had been referred to the diabetic nurse for their specialist guidance.

We observed a meal time. People received food which was served in good portions and looked appetising. People told us that if there was a meal they did not like the cook would ask whether they would prefer an alternative. Lunch time was a sociable occasion with people having the opportunity to chat with each other. We noted that drinks and snacks were available throughout the morning and afternoon and people told us that they could choose what they liked at breakfast and tea time.

The registered manager told us how they monitored triggers for people's behaviour. Care plans included instructions for staff around recognising changes in behaviour which may for example, be due to changes in physical or mental health needs. The service used ABC charts when necessary, these were charts which supported staff to monitor people's behaviour and identify what may cause distress. Information from these charts was used by mental health professionals when deciding on guidance for staff around individual people's care.

The registered manager told us that medical conditions which required monitoring were managed in consultation with health care professionals and that risk assessments were in place. They told us that staff handover between shifts was a useful way of ensuring staff understood any changes in people's care needs and whether there was any involvement or advice to pass on to them from health care professionals. GP and other health care professional visits were recorded separately on a 'medical matters' form which meant that communications around people's health were easy to find and monitor.

Staff routinely supported people to attend GP and hospital appointments. Care plans showed that people had been seen by a range of health care professionals including GPs, dentists and district nurses. Care workers had involved GPs and other health care professionals in a timely way and kept clear notes about consultations. The support guidelines for this were written into care plans with people's involvement and consent where relevant.

A health care professional confirmed that the staff at the home were quick to refer to them and that they consulted them appropriately. They told us, "They contact us if they need advice. They work with us to support people when their needs change."

We were present when staff discussed the care of a person with the registered manager and decided to call the emergency services rather than wait for a routine ambulance. The decision was made in a timely way and the ambulance called promptly so that the person could receive the care they required when they needed it.

The environment was well adapted to the needs of people who were living with dementia. There were signs to support people to recognise key rooms and areas of the home. The service had a sensory room, which staff told us was used by people to relax in. Shower rooms had suitable non slip flooring. The garden was secure and attractive, and the registered manager told us about plans to improve accessibility in the courtyard, which was only partly available for people to use, due to unmarked steps and uneven ground.

Good

Our findings

People told us that the staff were kind and caring. One person said, "They are very caring staff, they speak to me respectfully and they are kind." Another person said, "They pop in for a chat and I really like that. They give me time." A visitor said, "They make a fuss of [the person] and [their] face lights up when staff talk with [them]." Surveys sent out by the home to relatives and friends of people who lived at the home had been returned with the following responses; "All staff appear to be very caring." "Very pleasant and caring." "All staff are very kind and helpful." "I think the care given is excellent." "Very open, friendly, honest, caring and compassionate." "Always greeted in a professional friendly manner when visiting." "Magnificent care and affection from your dedicated team." People told us that staff responded quickly when they asked for help and that they did so cheerfully.

The staff and people we spoke with told us that the home encouraged visitors at any reasonable hour and we observed that a number of visitors were greeted by staff in a friendly way. Visitors told us that the staff always offered them refreshment, involved them in all aspects of their relative's care, when this was appropriate, and that they were made to feel very welcome.

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. Staff gave the impression that they had plenty of time and spoke with people who were sitting so that they were on eye level with them. They reassured people with a touch on the arm or hand where this was appropriate. We observed that staff were talking with people about their lives, who and what mattered to them and significant events. Staff were good at communicating with people, anticipating needs and making people aware of what their choices were. Staff interacted well with people who were observed to be more withdrawn and included them in conversations. People who were spoken with when they were sitting quietly became more animated and smiled when staff were speaking with them and appeared to enjoy the interaction.

Staff understood the importance of respecting people's privacy and dignity and we observed a number of examples where this happened during the day of inspection. People were approached discretely with regard to their personal care needs. They were encouraged and reassured in situations which may be otherwise upsetting. For example, staff supported people when they were unsure how to find their room or the dining area. They gave people time and responded to them in a way which respected their view of what was happening.

In the PIR the registered provider told us that they were planning to appoint dignity and wellbeing

champions which they felt would support them to place people at the heart of their care. Staff were aware of this planned initiative and told us that they regularly discussed the principles of compassionate care in team meetings and handovers.

When we asked the registered manager how people were placed in the centre of importance they told us that the staff were observant, and that they had regular meetings to discuss whether people's needs had changed. Small adjustments in approach were often needed to reduce anxiety or to increase people's comfort. For example staff gave the example of making sure they always used the correct mug for a person as they found this comforting. This was also recorded in the person's care plan. The registered manager explained a number of examples where staff had noticed signs which concerned them. Staff told us they observed people for signs of pain or distress and acted quickly to alleviate this. Our observations confirmed that staff were kind and responsive to people's emotional needs.

Some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, and these were correctly completed and regularly reviewed to ensure they were in line with people's current wishes.

Staff told us about the way people were cared for in their final days. Staff had received training in palliative care and the registered manager told us that they liaised with the district nurses at the surgery around ensuring they had anticipatory pain relief medicines in place for people who may require these at short notice. They emphasised the need for close liaison with palliative care professionals and attentive monitoring to ensure people did not suffer pain. They also spoke about the importance of supporting relatives, the people who lived at the home and each other when that difficult time arrived.

Good

Our findings

People told us that the service was responsive to their needs. One person told us they were involved in their relative's care, "I am involved and asked what I think about care for my [relative]. I know reviews are due soon." Another person said, "They come in to encourage me to get involved in the things they do. Sometimes I go and I really enjoy it. We play scrabble and draughts, and we do quizzes which are good. It does me good to take part in it." Another person said, "I [like to] watch TV in the top lounge in the evenings." Another person told us, "I sit in the garden when it is nice." A visitor said, "I see that [my relative] is dressed well and staff have thought about her outfits." They went on to explain that their relative enjoyed having a matching outfit and that staff supported them to dress in the way they preferred.

Staff told us they focused on promoting people independence and on what people could do for themselves. One member of staff said, "We don't take over and do tasks for [each person] just because it is quicker." Our observations confirmed that people were supported at a pace which was comfortable for them and that staff encouraged people to carry out tasks which they were able to do for themselves.

The communal areas contained jigsaws, hand/eye coordination games, magazines, textured mitts, soft toys, a large white board with markers, books and other objects for people to engage with and to provide interest. These were particularly supportive for those people who were living with dementia. We observed staff accompanying people on walks around the building, which people appeared to enjoy. The service had a sensory room which people used for relaxation or as a room to meet with visitors. We also observed a quiz taking place and people were clearly enjoying this. The quiz was delivered in a way which emphasised fun, and there was lots of positive encouragement when people offered answers, with a prize for all participants.

The registered manager told us about 'The Daily Chat' which was a free daily news sheet containing material for discussion and reminiscence. For example, on the day of the inspection visit staff had been discussing with people a news item from 1972 about Ireland, they had read out a poem, and were talking about what it was like for children during the second world war. The chat sheet ended with a crossword puzzle for people to enjoy.

Some people had signed their care plans and we saw that written care plans were regularly reviewed. It was clear from the records that efforts had been made to involve the person and those they wanted to be consulted in this process either through people signing or by staff writing records of what the person had said and preferred. Reviews focused on wellbeing and any improvements which could be made to people's

care. For example, the registered manager had identified that a walking aid needed to be adapted. The frame was redesigned to support the person's independence in moving about the home.

Relevant specialists were consulted for advice at reviews. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care.

People had identified areas of interest, likes, dislikes and preferences within their care plans. In some files people's life histories were recorded in detail with their permission, and included information such as previous occupations, hobbies, family and friendships, pets, spiritual needs, preferred clothing and ways to spend time. This was work in progress and the registered manager told us they were working with people to gather information which would support staff to offer personalised care. For example, one care plans stated, "[The person] needs to be encouraged to sing as this is especially calming for them." Another person was regularly supported to visit horses as this had always been important to them. Where people did not have the mental capacity to communicate their choices and preferences, efforts had been made to consult with those who were important to them or with Independent Mental Capacity Advocates (IMCAs).

The registered manager told us that there were specifically employed activities staff. Staff also described how they had time to take people out into the community on trips of their choosing such as for shopping or walks. Several people enjoyed a local 'Songs and Scones' group, and a 'Farmer's Breakfast' group which both met regularly to entertain people with talks, music, refreshment and to offer a chance to socialise with a wider group of people. People were also supported to attend a regular local 'Singing for the Brain' group which emphasised the benefits of song for people who were living with dementia.

One person told us how they enjoyed cooking and baking sessions with one member of staff. Another person told us how they enjoyed taking part in art and craft activity, that they were particularly enjoying compiling a life history book with staff and getting involved in rug making. Another person told us they enjoyed going into the garden and planting in the raised beds. There were photographs in the corridor from when a pony and owner had recently visited the home and had visited people in their rooms to their obvious enjoyment. A person who had lived in a rural area all their life told us how the registered manager had set up an owl nesting box near their window so they could watch and share whether this was being used. These examples showed that the service responded to people's individual needs and interests.

People were consulted about their preferences on a one to one basis or in the regular residents meetings. For example, the registered manager told us how people had been involved in making decisions about the extension to the building and its decoration and that they were now being consulted about plans for a new tea room on a 1950s theme.

The home had a cat and two budgies which were brought into the home by people who lived there. The cat in particular seemed to give a number of people pleasure and was seen at several points during the day sitting near them. People told us this gave the place a homely feeling. The registered manager said this was particularly beneficial to the person who spent time with the cat in their room.

The registered manager told us that they made efforts to understand people's skills and interests and to offer them meaningful activity in line with these. The conversations we had with people confirmed this. For example, staff told us about a person whose background was outdoor maintenance work who worked alongside the handyman at times. This person told us how much they enjoyed keeping busy and working on projects at the home.

The service kept an activities log which gave details of what each person had been doing, whether they

enjoyed it and plans for further pastimes.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw that the service had a complaint procedure and staff told us this was followed. One person told us, "I could go to the manager or any of the staff if there was a problem and they would listen and help." We saw a record of complaints and the outcomes with timescales to monitor how these were managed.

Good

Our findings

People we spoke with told us they thought the home was well run and that the registered manager was regularly available for people to talk with. One person told us, "Yes, the manager pops in to see me and talk about things. I think they do a good job." They added, "They ask my opinion about things, how to make things better and they tell me what they have done." One visitor told us, "I can approach the registered manager about anything and talk about anything." Another person said, "The manager is willing to talk anything through and I feel that they listen."

The home had a registered manager. Staff told us that the team discussed each person's care and passed on any information between shifts. Staff told us that the lines of communication to and from the registered manager and registered providers were clear and they knew who to go to for support. They felt consulted and encouraged to give their views about how to improve care. They said that the registered manager valued their ideas and encouraged them to share their thoughts. This meant that staff views were sought and acted upon for people's benefit.

The registered manager held regular meetings with staff to discuss individual people's care, to consult with staff and to pass on important information. Staff meeting minutes confirmed that the agenda covered a varied range of subjects where staff were supported and encouraged to improve people's care.

Staff told us that they were well supported by the registered manager, that they were regularly consulted and had the opportunity to pass on any concerns and to discuss areas for improvement. They told us that the staff team was supportive of each other and that the ethos of quality care applied to them too in addition to the people being care for. This made them feel valued and committed to delivering good quality care. They were clear about their job roles and knew when they needed to refer to a more senior member of staff.

People who lived at the service told us the registered manager often spoke with them and asked if they would like anything to be changed. Visitors told us that the registered manager often spoke with them whenever they visited the service and that they were regularly consulted around reviews of care.

The registered manager held regular meetings for the people who lived at the home and those people who were important to them. Records confirmed this outlined how people had been involved in plans for a sensory area in the garden, the new tea room, and how the service had responded to requests for changes in the menu.

In addition to regular meetings, the registered manager regularly surveyed people who lived at the home for their views on their care. The results of surveys were analysed and plans put in place to improve in areas which people had raised. Staff told us that the results of surveys were shared with them and also that any praise from people was passed on to them.

The service produced a monthly newsletter which reported on events and activities, individual stories and updates on improvements. The registered manager told us that staff would read this newsletter to people, when necessary.

The registered manager had a clear understanding of their role and although they were involved in the day to day care of people who lived at the home they were also aware that their role was one of maintaining and improving the quality of the service and in planning for the future. They described a new computerised system of care planning and review that the service was implementing. The focus was on improving the quality of life for people who lived at the home through linking records and automatic updating via this new system. The registered manager also described how they were developing a champion role within the service, so that identified staff could take on a specialist role and be a source of expertise to the staff group.

There were systems and procedures in place to monitor and assess the quality of the service. For example we saw records of checks such as a call bell log, emergency lighting, fire equipment and water temperatures. Care plans were regularly reviewed and health and safety checks took place regularly. Medicines were regularly audited and action plans were put in place to improve practice in this area.