SHC Clemsfold Group Limited

Norfolk Lodge

Inspection report

9 Norfolk Road
Horsham
West Sussex
RH12 1BZ

Tel: 01403218876
Website: www.sussexhealthcare.co.uk

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 19 September 2016 and was unannounced.

Norfolk Lodge is a residential care home, which provides care and support for up to eight people with a learning disability and other complex needs, including autism and mental health. At the time of our inspection there were six people living at the home.

Norfolk Lodge is a town house with communal areas over two floors (ground and first floor). The second floor of the house accommodated the manager's office and the laundry room but there were no bedrooms on this floor. There was a kitchen and shared dining area which was open and accessible to people. There was a back garden and we were told that people helped with the gardening. There were two lounges (one on each floor) that were used both for down time (watching television/movies) and for activities. There was a small sitting area between two parts of the building with games and puzzles.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager was appointed in April 2016; they had submitted an application to CQC to register as the manager of the service.

Although staff understood how to support people and we were confident they received consistent support, some people's individual care records did not accurately reflect their needs or were incomplete. This meant that it was not always possible to be clear if a person was supported in the right way. We have made a recommendation that the provider ensures agreed support is documented to ensure a consistent approach.

The complaints procedure was clearly displayed within the service; however was not in a suitable format for all of the people who used the service to understand and make use of. The manager recognised this needed further revision to meet the needs of people in this service.

People told us they felt safe with the home's staff. There were policies and procedures regarding the safeguarding of adults and staff knew what action to take if they thought anyone was at risk of potential harm.

People's risks were identified, assessed and managed appropriately. There were also risk assessments in place to help keep people safe in the event of an unforeseen emergency such as fire or flood.

Thorough recruitment processes were in place for newly appointed staff to check they were suitable to work with people. There were sufficient numbers of staff to meet people's needs safely. People told us there were enough staff on duty and records and staff confirmed this.

People were supported to take their medicines as directed by their GP. Records showed that medicines were obtained, stored, administered and disposed of safely.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to DoLS, the manager understood when an application should be made and how to submit one. The provider was meeting the requirements of DoLS. There were no restrictions imposed on people and they were able to make individual decisions for themselves. The manager and staff were guided by the principles of the Mental Capacity Act 2005 (MCA) regarding best interests decisions should anyone be deemed to lack capacity.

Staff received training to help them meet people's needs. Staff received an induction and regular supervision including monitoring of their performance. Staff were supported to develop their skills through additional training such as National Vocational Qualification (NVQ) or care diplomas. All staff completed an induction before working unsupervised. People were well supported and said staff were knowledgeable about their care needs.

People told us the food at the home was good and they were offered a choice at mealtimes. Staff monitored people's health to ensure they had access to other health professionals when needed.

People's privacy and dignity were respected. Staff had a caring attitude towards people. We saw staff smiling and laughing with people and offering support. There was a good rapport between people and staff.

People were involved as much as possible in planning their care. People had monthly meetings with their keyworkers to discuss all aspects of their care. The manager and staff were flexible and responsive to people's individual preferences and ensured people were supported in accordance with their needs and abilities. People were encouraged to maintain their independence and to participate in activities that interested them.

The manager told us they operated an open door policy and welcomed feedback on any aspect of the service. The manager monitored the delivery of care.

There was a stable staff team who said that communication in the home was good and they always felt able to make suggestions. They confirmed management were open and approachable.

A system of audits was in place to measure and monitor the quality of the service provided and this helped to ensure care was delivered consistently. Suggestions on improvements to the service were welcomed and people's feedback was encouraged.

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 told us they felt safe. There were enough staff to support people and staff received training to help keep people safe.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

People's risks had been identified and assessed and were managed appropriately by staff.

Medicines were stored and administered safely by staff that had received training and had been assessed as competent.

Is the service effective?

Good

The service was effective.

People told us staff were skilled and knew how they wanted to be supported.

Staff were provided with the training and support they needed to carry out their work effectively.

People had access to health and social care professionals to make sure they received effective care and treatment.

The manager and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were provided with a choice of suitable and nutritious food and drink. Staff supported people to maintain a healthy diet.

Is the service caring?

Good

The service was caring.

People said kind and caring staff treated them with respect. Staff supported people to maintain regular contact with their families.

People were supported to be involved in all aspects of their care and in their care plans. They were treated with dignity and respect.

We saw people's privacy was respected. People and staff got on well together.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The support people received was not always accurately recorded. This put people at risk of receiving inconsistent care and support

The complaints procedure was clearly displayed within the service; however was not in a suitable format for people supported to understand and make use of.

People were supported to participate in activities of their choice.

Is the service well-led?

Good

The service was well-led.

The manager was approachable and communicated well with people, staff and outside professionals.

There was an open culture in the service. Staff focused on the people who used the service. People and staff felt comfortable to raise concerns if necessary.

Staff were aware of their roles and responsibilities.

There were quality assurance systems in place to measure the quality of the service delivered and to drive improvement.

Norfolk 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 checked 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 19 September 2016 and was unannounced. One inspector and an inspection manager carried out the inspection.

Before the inspection, the provider completed 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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the Manager about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection, we observed how staff interacted with people who used the service and supported them in the communal areas of the home. We looked at plans of care, risk assessments, incident records and medicines records for two people. We looked at training and recruitment records for three members of staff. We also looked at a range of records relating to the management of the service such as complaints, records, quality audits, policies and procedures.

We spoke with two people on the day of our visit to ask them their views of the service provided. We also spoke to the manager, area manager, the provider's quality lead and two members of staff. Following the visit, we also contacted a social worker to seek their views, which we have included in this report. They consented to share their views in this report.

This was the first inspection of Norfolk lodge since a change to the provider's legal entity in November 2014.

Good

Is the service safe?

Our findings

People felt safe at the home. They confirmed there were enough staff to provide support. Comments from people included, "I do feel safe", and, "The staff look after me".

A social worker told us they felt the service was safe. Comments included, 'Obviously I am reliant on others to report any issues but I have no reason to believe the service is not safe.'

The service had policies and procedures regarding the safeguarding of people, which included details about the definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was a copy of the local authority safeguarding procedures on a notice board in the office so staff had details of how to report any safeguarding concerns. Staff had received training in safeguarding procedures. They had a good knowledge of what abuse was and knew what action to take. Staff were able to identify a range of types of abuse including physical, institutional, sexual, racial, financial and verbal. Without exception, staff told us they would keep the person safe, observe the person, offer the person 1:1 support if required, talk to their manager and if needed report their concerns to the local authority safeguarding team and/or the Care Quality Commission.

Staff said they felt comfortable referring any concerns they had to the manager if needed. The manager was able to explain the process, which would be followed if a concern were raised.

Before people moved to the home an assessment was completed. This looked at the person's support needs and any potential risks to their health, safety or welfare. Where risks were identified, these had been assessed and actions were in place to mitigate them. Staff were aware of how to manage the risks associated with people's care needs and how to support them safely. For example, a person was assessed as having diabetes. The individual had specific care plans and risk assessments on how to manage their diabetes. This included a completed nutritional assessment, documented monthly monitoring of the person's weight and regular appointments at the persons G.P (General Practitioner). The G.P appointments arranged were to check blood sugar levels and followed up on where needed.

People's risks were identified, assessed and managed appropriately. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. In two people's care records, we saw a comprehensive range of risk assessments were in place including for administering medication, communication, diet and nutrition and daily living skills.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. For example, the gas heating, electrical wiring, fire safety equipment and alarms, water supply and electrical appliances had been checked to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff, on how to support people to evacuate the premises in an emergency.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicant's conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. Prospective staff underwent a practical assessment and role related interview before being appointed.

Daily staffing needs were analysed by the manager. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. Each day (Monday to Sunday) there was two support staff on duty from 8am to 8pm. At night, there was one waking member of staff 8pm to 8am and a staff member who slept at the service to offer additional support if needed from 8pm to 8am. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice. The manager worked Monday to Friday between 8am and 4pm. The service also had a 24 hour on call system in case additional staff were needed. Rotas we reviewed confirmed there were sufficient staff to meet people's needs safely. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the prescription instructions. Medication Administration Records (MAR) were in place and had been correctly completed to demonstrate medicines had been given as prescribed. Medicines were locked away as appropriate. The manager told us, there was enough staff trained to administer medicines. The manager completed an observation of staff to ensure they were competent in the administration of medicines. We checked a sample of the medicines against the recorded stock levels and found these matched.

Good

Is the service effective?

Our findings

People got on well with staff and the care they received met their individual needs. People told us the food provided was good and that they were offered choice at meal times.

A social worker told us, 'The service is effectively meeting the needs of my customer who requires respite on an adhoc basis'.

Each person had an individual plan of care. These gave staff the information they needed to provide effective care and support to people and guided staff on how to ensure people were involved and supported. Each person had signed a 'consent to care' document giving staff permission to provide them with the support they needed.

A training and development plan enabled staff and management to identify their training needs and skills development and monitor their progress. Following the successful completion of a training course a certificate was awarded to evidence staff had achieved the required standard. The manager told us they worked alongside staff to enable them to observe staff practice. This was documented and discussed with staff in supervision sessions and at annual appraisals. The manager told us she was confident that staff had the skills and knowledge to support people effectively.

All staff were required to complete essential training; this was over a four-day period when they first started and then refreshed. Training records showed staff had completed training in the following areas: fire, first aid, manual handling, food hygiene, safe handling of medicines, infection control, health and safety, safeguarding, the Mental Capacity Act & Deprivation of Liberty Safeguards, equality and diversity. This training helped staff to develop their skills and staff confirmed the training provided was good and helped them to give people the support they needed. Staff knew how people liked to be supported and were aware of people's care needs. Training was refreshed as needed and certificates in staff files confirmed the training staff had completed. In addition to training from the provider, staff were also supported to study for additional qualifications, for example, a National Vocational Qualification (NVQ) in Health and Social Care. The manager told us they always tried to encourage staff to develop.

New staff were required to complete the Care Certificate, a nationally recognised set of standards that health and social care workers adhere to in their daily working life. This covered 15 standards of health and social care topics. A new staff member had written in their induction feedback form that they had found the induction informative. They wrote, 'everything was explained well and it seems very professional . . . everyone being so welcoming.'

The provider encouraged and supported staff to obtain further qualifications to help ensure they had the skills and knowledge to look after people effectively. This included specialised training in 'managing challenging behaviour' and 'learning disability'. This training provided staff with the knowledge they needed to support people effectively. One person communicated with staff using Makaton. Makaton uses speech with signs (gestures) and symbols (pictures) to help people communicate. The area manager told us, that

basic Makaton was covered as part of the corporate induction but we did not observe that this had adequately prepared staff to communicate with a person the staff supported. Following our feedback to the manager, Makaton training was booked for October 2016 to address this shortfall.

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. We checked whether the service was working within the principles of the MCA. The manager and staff understood their responsibilities under the MCA. They knew that, if a person lacked capacity, relevant people needed to be involved to ensure decisions were made in the person's best interest. The manager told us all people at the home had capacity to make their own decisions and staff respected these decisions. Staff confirmed they received training in this area, which helped them to ensure they acted in accordance with the legal requirements.

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). No applications had been made but the manager and staff understood their responsibilities in the case that a person lacked capacity to consent to living at the home.

Staff received regular supervision for example, for two staff records sampled showed they had received four recorded support and supervisions over the past nine months. Both staff had had an annual appraisal. Supervision/appraisals discussed topics such as training needs, employee job satisfaction, competencies, achievements, attitudes/behaviours and any work issues. No performance issues had been addressed; both staff had were very positive in their feedback and indicated they were happy with their work. Staff told us, they did not have to wait for supervision to come round if they needed to talk with the manager. Staff said communication was good and that everyone worked together as a team.

Team meetings were held regularly, most recently on 23 August and 14 September. Minutes reviewed from August included discussions of people's changing needs, recruitment of staff, training refreshers planned, and review of safeguarding procedures, cleaning schedules, activities and staff values/behaviours.

People were supported to eat and drink enough and to maintain a balanced diet. We saw drinks were freely available throughout the day. Care plans clearly documented people's food likes and dislikes and there was a list in the kitchen detailing people's preferences. Weekly meal plans were done in advance and people informed of the choices on the white board in the dining room. Alternatives were encouraged if people did not like the main meal. 'Meal check' forms had been completed for some dishes to gauge people's opinion of the food, which informed the menus.

We asked people for their views on the food provided and everyone said the food was good and they always had enough to eat and drink. People had jacket potatoes for lunch during our visit and said they enjoyed it. We asked people if they had sufficient choice and they said if the meal on offer was not to their liking then they could always have something else. People were provided with suitable and nutritious food and drink.

People's healthcare needs were met. The home had links with healthcare professionals, including the chiropodist, dentist, psychiatrist, speech and language therapist and community learning disability team. These professionals were contacted for advice and support about specific medical and health conditions affecting people to ensure staff were providing effective support. A record was made of all health care

appointments including why the person needed the healthcare visit and the outcome and any recommendations. People's weights were recorded monthly so that prompt action could be taken to address any significant weight fluctuations. In addition each person had a 'Hospital Passport'. This provided the hospital with important information about the person and their health if they should need to be admitted.

Good

Is the service caring?

Our findings

People were happy with the care and support they received. They told us they were well looked after and said all the staff were kind and caring. A person who was unable to communicate verbally but was able to indicate "yes" and "no" and used Makaton and written communication, indicated they were happy living at Norfolk Lodge. The same person indicated "yes" when asked if staff were nice to him. Another person told us, the staff were kind to them and they liked them. Comments included, "[staff member] is nice, she jokes, she smiles, she's happy." The person described the manager as, "very very nice."

A social worker told us, 'the manager and staff who I have met are attentive and skilled, able to meet the challenges of supporting my customer who has a severe learning disability and exhibits some behaviours that challenge.'

People were supported to maintain relationships with their families. Details of contact numbers and key dates such as birthdays for relatives and important people in each individual's life were kept in their care plan file. People told us staff helped them to keep in contact with their friends and relatives. Family and friends were able to visit without restriction.

People and their relatives were involved in the care, which people received. Minutes of reviews sampled showed relatives in attendance at meetings. Keyworkers updated people's needs and risk assessments monthly after spending time with the person to understand their views and seek their involvement. A key worker is a named member of staff that was responsible for ensuring people's care needs were met.

We spent time observing care practices in the communal area of the home. We observed staff maintain people's privacy and they knocked before entering people's bedrooms. People's care plans contained guidance for staff on how to maintain people's dignity while supporting them with personal care tasks. When staff approached people, staff would say "hello" and check if they needed any support. Staff chatted and engaged with people and took time to listen to them. Staff showed kindness, patience and respect to people. This approach helped ensure people were supported in a way, which respected their decisions, protected their rights and met their needs. There was a good rapport between staff and people.

Throughout our visit, there were frequent, positive interactions between staff and people and there was a relaxed atmosphere. People were confident to approach staff and any requests for support were responded to quickly and appropriately. Everyone was well groomed and dressed appropriately for the time of year. We observed that staff spent time listening to people and responding to their questions. They explained what they were doing and offered reassurance when anyone appeared anxious. Staff used people's preferred form of address, chatted and engaged with people in a warm and friendly manner. Staff said they enjoyed supporting the people who lived in the home.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was passed verbally in private, at staff handovers, put in each individual's care notes or

recorded in the communication book. This helped to ensure only people who had a need to know were aware of people's personal information.

At the time of inspection, one person received a visit from their advocate. The advocate helped to promote the involvement and ensure the persons views were known, to the service. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. Staff were aware of the process and action to take should an advocate be needed and leaflets on advocacy were available for people to read.

The service had a calm and positive atmosphere. People's rooms were personalised with possessions such as pictures, family photographs and bedding of their choice. People were able to bring in their own furniture to make their room feel more familiar and homely. Staff had a good understanding of people's needs and individual likes and dislikes. They understood the importance of building relationships with people.

Requires Improvement

Is the service responsive?

Our findings

We looked at how the provider managed complaints. There was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. However, this was not in a format that everyone could understand. People that we spoke to about this did not always know how to access it. This meant people may not be confident in raising a complaint or knowing what to expect from the complaints process. At the time of our visit, no complaints had been recorded in recent months. The manager present at inspection recognised this would need to be revised further to meet the needs of people with variable capacity and vocabulary.

We found the quality and completeness of care records was variable. We spoke to two staff members on duty regarding the lack of detail in the care plans and without exception they were able to explain what they would do in various circumstances to support people. However, the care records did not reflect the support people always needed.

For example, some people had behaviours that could be challenging to other people and staff. However, for some of those people there was a lack of guidance to show what could trigger these behaviours or what support staff should provide. For example in one risk assessment, comments included, '[person] can be verbally / physically aggressive'. The care plan did not explain these risks and did not indicate what diversions were known to be successful for that person. The person had an incident in April 2016 where they were described as being verbally and physically abusive, which resulted in them scratching a staff member. There was no guidance for staff on how the person would prefer to be supported when/if displaying these behaviours or how staff should keep the person/others/ themselves safe.

We identified a care plan, which stated that the person should be encouraged to wear a pad at night-time due to their continence needs. It included that the person often declines. However, it did not indicate what support should then be given. Consequently, despite staffs' best efforts to clean the person's bedroom, there was a malodour present. Staff told us the person's continence was deteriorating and they were incontinent in communal areas, such as the lounge, which we observed during the inspection. The care plan did not indicate what support was being arranged or offered to manage this. We spoke to the manager about this during the inspection and we were told there were plans to replace the person's mattress and action was being taken to seek advice from West Sussex's community team about the person's continence needs.

We recommend that the provider ensure that agreed support is documented clearly to ensure a consistent approach by staff.

Other care plans were personalised and included detail of how people wished to be supported. Before people moved into the home, they had received an assessment to identify if the provider could meet their needs. This assessment included the identification of people's communication, physical and mental health, mobility and social needs. There was a 'personal profile, which contained information about people and asked questions such as: 'Who are the most important people in your life, what do you like to do during the

day/night? What makes you angry/happy/sad?' Following the assessment there were a variety of care plans, which, had been developed to describe how to meet people's needs. Care plans had been developed with the involvement of the person concerned and their relatives to ensure they reflected people's individual needs and preferences. In discussions, staff were knowledgeable about the individual preferences and needs of each of the people staying at the home at the time of this inspection.

A social worker told us the home was responsive, comments included, 'Yes, this is a real strength of the service. Norfolk Lodge always respond to whatever is needed, often at very short notice, perhaps only a few hours. This gives us all peace of mind that my customer will be cared for whenever it is required.'

Handover records sampled showed entries were completed by staff three times day between 8am and 8pm. Handover records demonstrated that when staffing teams changed shift, people's needs were discussed such as their behaviour or their mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs. At handover, a nominated staff member on each shift recorded what each person had done that day. It detailed what else was planned, a reminder for staff to read the house diary for appointments and the name of the staff member who was nominated to administer medication. It stated which staff were supporting people to cook their meals, which staff were supporting people in checking toiletry supplies and do their agreed tasks of hoovering, dusting and other general house cleaning tasks. This ensured staff provided care that reflected people's current needs. Daily records compiled by staff detailed the support people had received throughout the day and this followed the plan of care.

People living at Norfolk Lodge did not have nursing needs and all were independently mobile. Everyone was able to go out and access the local Horsham community amenities independently. The only exception was for one person, who's confidence to go out independently was low because of his eyesight. The manager told us, "We would support [person] because he's got bad eyes." The persons records indicated that this support had been provided. People were supported to be independent where possible. This included cooking, tidying their rooms and doing their laundry. Staff told us that it was important to encourage people in order to help prepare them for independent living. This also included visiting the theatre/cinema and independently travelling to attend activities.

Records were kept of activities undertaken by people such as shopping trips and visiting relatives. We observed people going out independently, visiting the bank, going to the theatre and socialising with each other or spending time in their rooms. We saw photos of people engaged in activities of their choosing. This included activities such as, gardening, going to the pub, seeing a brass band, a 70th birthday celebration and a trip to Brighton.

A person signed to us that he liked to watch movies, and go out for coffee/cakes. During the day, we observed the person going in and out, going out for a walk and to the shops independently. We observed the person smiling and laughing with staff. They appeared relaxed and at ease with staff and staff responded appropriately to him when he approached them.

People, their representatives and staff were asked for their views about their care and treatment through regular meetings and surveys, which were sent to them. The most recent meetings were April, June and August 2016. People discussed food/menus, maintenance issues, health and safety, suggestions for trips/activities and one to one time with staff. This was a good mechanism for gaining people's feedback and addressing any required changes.

Good

Is the service well-led?

Our findings

A manager was appointed in April 2016; they had submitted an application to CQC to register as the manager of the service.

People we spoke with were positive about the care and support they received and the way in which the service was managed. Comments included, "The manager is lovely" and, "The manager listens".

A social worker told us, 'The service was set up very efficiently by the area manager and communication is now with the manager. She is very proactive and has a good relationship with myself, my customer and his mother. The customer's mother likes to correspond by text message so [manager] acquired a work mobile in order to most effectively communicate.'

Staff said they felt valued and listened to. Staff felt they received support from their colleagues and that there was an open, transparent atmosphere. Staff told us, "The manager has tried really hard since the last manager left." and, "I like the manager, we get on well. The manager listens."

Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously if needed. The manager felt confident that staff would report any concerns to them. Staff said they felt valued, that the manager was approachable and they felt able to raise any concerns, which would be acted upon. We were told there was a stable staff group at the home, that staff knew people well and that people received a good and consistent service.

The manager told us she aimed to ensure people were listened to and were treated fairly. She operated an open door policy and welcomed feedback on any aspect of the service. Open communication was encouraged and staff were able to question practice. The manager said she would welcome any suggestions and make changes if this benefited people.

Regular meetings took place with staff and people, which enabled them to influence the running of the service and make comments and suggestions about any changes. The minutes of the meetings did not reflect suggestions from people and staff, however; people and staff confirmed meetings did take place and their comments and suggestions were sought. They also told us, they could discuss issues openly with the manager.

The manager was able to demonstrate good management and leadership. The manager told us that she regularly worked alongside staff. This enabled them to identify good practice or areas that may need to be improved. Each member of staff was given a job description and this detailed their role and responsibilities so staff knew what was expected of them.

The manager showed a commitment to improving the service people received by ensuring their own personal knowledge and skills were up to date. The manager completed the same training as the rest of the staff team.

The manager acted in accordance with CQC registration requirements. We were sent notifications as required to inform us of any important events that took place in the home.

The provider had a policy and procedure for quality assurance. The quality assurance procedures carried out helped the provider and managers ensure the service they provided was of a good standard. They also helped to identify areas where the service could be improved. The manager carried out weekly and monthly checks, which included medicines, food hygiene, health and safety, fire alarm system, fire evacuation procedures and care plan monitoring. The manager also carried out regular audits to identify any trends in areas such as medicines and incidents. Any shortfalls or areas for improvement would then be discussed with staff so that appropriate action could be taken.

We asked the manager how learning took place from any accidents, incidents or complaints. She told us that any issues were discussed with staff during staff meetings.

Records were kept securely. All care records for people were held in individual files, which were locked away when not in use. Records we requested were accessed quickly, consistently maintained, accurate and fit for purpose.