Bupa Care Homes (ANS) Limited

Elm View Care Home

Inspection report

Moor Lane
Clevedon
Somerset
BS21 6EU

Tel: 01275872088

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22 April 2016

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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 21 and 22 April 2016 and was unannounced. The last inspection was carried out in August 2013, at that inspection the service was found to be meeting the Regulations assessed.

Elm View Care Home is registered to provide accommodation with nursing and personal care for up to 46 people. On the days of our inspection there were 38 people living in the home. The service is located in Clevedon.

There was a manager in post at the time of our inspection who had applied to be registered with the CQC. 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.

People told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns.

There were good systems in place to make sure that people were supported to take medicines safely and as prescribed.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were enough staff on duty to make sure people's needs were met. Recruitment procedures made sure staff had the required skills and were of suitable character and background. Staff told us they enjoyed working at the service and that there was good teamwork.

Staff were supported through training and team meetings to help them carry out their roles effectively. Staff were led by an open and accessible management team.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted. The registered manager had taken appropriate action for those people whom restricted movement was a concern. Where people lacked capacity to make their own decisions, the MCA had been followed appropriately.

People told us that staff were caring and that their privacy and dignity were respected. Care plans were person centred and showed that individual preferences were taken into account. Care plans gave clear directions to staff about the support people required to have their needs met.

People were supported to maintain their health and had access to health services if needed.

People's needs were regularly reviewed and, where necessary, appropriate changes were made to the

support people received. People had opportunities to make comments about the service and how it could be improved.

There were effective management arrangements in place. The manager had a good oversight of the service and was aware of areas of practice that needed to be improved. There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

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 cared for by staff who were confident of using safeguarding procedures in order to protect people from harm.

People's risks had been assessed and plans put in place to keep risks to a minimum.

People's needs were met by sufficient numbers of staff

People were supported by staff that were of suitable character and background.

There was safe management of medicines, which meant people were protected against the associated risks.

Is the service effective?

Good

The home was effective.

People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Consent was sought from people before any care or support was provided and the home worked to the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards guidelines.

People were supported to maintain good health through having sufficient to eat, drink and maintain a well-balanced diet.

People had access to relevant healthcare professionals, where required.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

People were treated with kindness and dignity by staff who took

time to speak and listen to people.

Staff respected people's privacy.

Is the service responsive?

Good

This service was responsive to people's needs.

People were included in decisions about their care.

People enjoyed a range of activities, which took account of their individual preferences.

People knew how they could make a complaint and were confident action would be taken.

The registered provider had a procedure for receiving and managing complaints about the service

Is the service well-led?

Good

The service was well led.

The registered manager had in place clear lines of responsibility and accountability.

The registered manager had a visible presence throughout the service.

People and staff felt the registered manager was supportive and approachable.

The management team had oversight of the service and acted to maintain the quality of the service provided.

The provider had sought feedback from people receiving support, relatives and staff.

Elm View Care Home

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 21 and 22 April 2016 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection was carried out by one adult social care inspector; one specialist advisor with a nursing background and one expert-by-experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, we spoke with three health and social care professionals including the local authority contracts and commissioning team, a falls team and the local safeguarding team. We also checked any previous notifications or concerns we had received about the home. Notifications are information about specific important events the service is legally required to send to us. This information was used so that we could check issues or concerns had been dealt with appropriately. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home. What the home does well and improvements they plan to make. We used this information to assist with the planning of this inspection.

During our inspection, we spoke with the registered manager, deputy manager, 12 staff members including two housekeeping staff, the cook and two maintenance staff. We also spoke with 16 people who lived at the home, five relatives, and two visiting professionals.

We looked at documents kept by the home including 12 care records and the personnel and training records of nine staff members. We also looked at records relating to the management and monitoring of the home, including any audits carried out and reviews of care documents and policies.

Good

Is the service safe?

Our findings

The service was safe.

People told us that they were safe at the home and staff treated them well. One person said, "Yes, I feel safe. I receive help with moving and handling and this is done safely".

Staff had a good understanding of the different types of abuse and how they would report it. One staff member told us, "I would report it immediately to the manager" and another explained what would make them think someone was being abused. Staff told us about the safeguarding training they had received and how they put it into practice. One staff member told us, "I would report it to manager and go higher to the Local Authority if I needed to". They were aware of the company's policies and procedures relating to safeguarding and felt that they would be supported to follow them. There were notices in the office giving information on how to raise a safeguarding concern with contact numbers for the provider, the local authority safeguarding team and the Care Quality Commission (CQC). Staff also told us they were aware of the provider's whistleblowing policy and would feel confident in using it.

Records showed that any incidents or accidents were logged and appropriate action had been taken. Accident reports were reviewed by the manager to assess if further action needed to be taken. The manager also completed a monthly summary of incidents, which helped to identify whether there were any themes or patterns. Accident forms included Information on the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 (RIDDOR) to make sure the appropriate authorities were informed.

People's care plans included details of risks and there was clear information for staff about how to minimise risks and safely support people. Up to date risk assessments were in place regarding areas such as physical, psychological and environmental risks. Risks related to moving and handling and nutrition were clearly written and reviewed on a regular basis. The outcomes of these risk assessments were translated into a comprehensive plan of nursing care for people. We noted that risk assessments showed evidence of the involvement of people or their relatives. This meant that where possible people were made aware of risks and had an opportunity to discuss how they were managed.

All parts of the building were well maintained and the environment was warm, clean and clutter free. They were systems in place to make sure the environment was safe for people that used the service. A workplace risk assessment and fire risk assessment had been completed recently and they reflected current risks at the service. There were also regular safety checks carried out by a maintenance person. These included regular checks of bedrails, room temperatures, water temperatures, window restrictors and call bells. There were Personal Emergency Evacuation Plans (PEEP) for each person, which detailed the level of risk and how to support them in the event of an emergency.

There were sufficient numbers of staff to keep people safe and meet their needs. During the morning, there were nine care staff, dropping to six care staff in the afternoons and two registered nurses and at night four care staff and one registered nurse. A staffing dependency tool was used to assess the number of staff

required to meet people's needs. This was updated every three months or when there were any changes, for example, new admissions. The last dependency
tool was completed in January 2016. The manager explained that there had been a high level of agency staff used due to difficulties with the recruitment of care staff. The manager told us their recent recruitment campaign had enabled them to have their own bank staff cover but they were still using agency nurses for weekend shifts. The manager showed us the profiles of the agency nurses that they used on a regular basis to try to ensure consistency for people living in the home. We identified no concerns regarding the answering of call bells, which were answered in a timely manner throughout our visit. One person commented, "Staff come promptly if I ring the bell".

The provider employed a number of ancillary staff such as cooks, housekeeping staff, a dedicated maintenance person and an activities coordinator who had staff to support them deliver activities to people. Staff told us that they felt staffing levels were acceptable. One staff member said, "I feel there are sufficient numbers. Staffing is improving".

People were support by staff who had undergone a safe recruitment procedure. We saw staff had appropriate checks such as evidence of Disclosure and Barring Service (DBS) checks, references from previous employers and they had provided full employment histories. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. These measures helped to ensure that only suitable staff were employed to support people who used the service. All staff were issued with a statement of terms and conditions, which made clear their role and responsibilities. The service also monitored the dates of nurse's registration with the Nursing Midwifery Council (NMC) to make sure it was up to date and current.

People told us they were happy with the way their medicines were administered. One person told us, "Yes, I get my medicines on time". Other comments included, "I get my medicines OK". Staff told us, "I would know if drugs were being stolen and I am confident that medicines here are safe" and "I am confident that medicines are managed well". Most people who used the service were unable to take their own medicines and relied on staff to make sure they took their medicines as prescribed. We observed a medicines round carried out by a registered nurse. The nurse correctly identified the medicine and dosage to be given to each person. Where support was required to take medicines this was provided without rushing and MAR charts were not completed until the medicine had been swallowed. One person was considered self-medicating with a dietary additive that was kept in a drawer in their room, which we saw, had been risk assessed.

The home had a medicine policy dated August 2015. We saw a staff signature list; this means that all staff that dispensed medication can be easily identified in the event of a query. Medicines were administered by registered nurses only. The nurses received annual competency assessments. Consent from people had been obtained for their photographs to be on the medicine record.

We saw that there had been three medicine errors in the previous six months The manager had taken prompt action to ensure these errors did not recur and that staff had learnt from them. For example, one incident of mis recording occurred during a night shift. The manager had convened a meeting the following night with night staff to discuss the importance of thorough and rigorous checks and we viewed the notes from this meeting.

We saw that ordering, storage, dispensing and disposal of medicines were all in accordance with the provider's medicine policy. Fridge and room temperatures had been recorded daily; this ensured that medicines were kept at optimal temperatures to ensure they remained effective.

We conducted a small medication stock check and all the prescribed medicines checked had been administered in accordance with the guidance. We observed good hand hygiene and a lack of interruptions during the medicine round. In care files, we saw 'body maps' indicating where topical creams should be applied. Four people needed to have blood tests prior to the administration of a certain drug to ensure the correct dosage and we saw that these blood tests had been done and the results recorded. Some people required 'as required' medicines to help with pain relief or anxiety. These medicines were only given when necessary and had been appropriately recorded.

Good

Is the service effective?

Our findings

The service was effective.

People we spoke with told us they received their care and support in the way they wanted it and that they could make choices about their day-to-day living. One person we spoke with told us; "When it was the nice weather last week, I went out in the garden in the morning. But just wanted to go to bed in the afternoon because I was completely wrung out. I told the carers and they said that was fine. I got up for tea and felt a lot better for the rest". Another person told us; "I spend most of my time in bed, so I don't get very dirty. Having a shower is very exhausting for me, so the carers usually just help me with a good wash and that is all I want most days. They do ask every day if I want a shower, but I usually don't".

We asked people about the food and drinks available at the home. One comment made by someone who lived at the home was; "I've never had a meal I didn't like. It's all good food here and well-cooked too". Another person said; "If you don't want what is on the menu, you can have something different. I love the puddings". Two people did comment on the quality of the meat and when we asked the cook, they said that on occasions, the meat from the suppliers had been tough, but they reported it to the manager and the manager was dealing with it. We saw that, when people asked for drinks, staff supplied these.

We spoke with people who lived at the home and their relatives about accessing healthcare services, such as GP's and dentists. One relative told us; "I know I don't have to worry about any sudden deterioration because I know the carers will pick it up and get a doctor in straight away". Another relative said; "It's such a relief to know [family member] is in good hands. I've got no worries about the standard of care here. Staff have called the doctor to [family member] a few times to give antibiotics".

People and their relatives were involved in regular reviews in monitoring their health and, where required, referrals were made to, and assistance sought from appropriate healthcare professionals. Care records contained details of any visiting healthcare professionals that the person had seen and details of each visit. The relative of one person told us; "I am very satisfied with the care [family member] receives. I have very good communication with the home and we regularly discuss her care plans. I'm really happy with how she's looked after". Care plans contained a record of all external professionals' visits along with recommended treatments and plans. These records help ensure that all staff involved with a people's care are aware of the latest recommendations.

We checked staff personnel files to see if staff had received adequate induction at the beginning of their employment at the home and ongoing training. Records demonstrate that staff had completed an induction at the start of their employment at the home, which included core skills training. We looked at the training matrix held by the home and staff had received regular training updates in areas including safeguarding, health and safety, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Recent additions to the training courses available for staff to undertake included 'palliative care' and 'dementia' training. These courses had been attended by some staff and other staff were awaiting course dates. One staff member

said; "The dementia training has been really good, it's amazing what you learn and it all helps us do better". This demonstrated staff were up to date with their training requirements.

Staff told us, "I get monthly supervision, we look at concerns and dignity awareness, the manager is approachable, I feel supported"; "We have supervision regularly and the training is good, we have group training and I have asked for dementia care and palliative care" and "I have had supervision and I had a whole weeks induction, it helped me to do the job". Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. The registered manager told us they carried out supervisions with senior members of staff and senior members of staff carried out supervisions with other staff i.e. care staff.

All staff files we looked at contained records of supervisions that had taken place, in line with the provider's policy. Supervisions covered a range of areas including professionalism, time keeping, attendance, behaviour, attitude, people in the home and documents. Supervision documents had comments boxes for the manager and staff member to write in, as well as a space to write information about training needs and actions required. In all the staff files we looked at, we saw that staff who had worked at the home for over 12 months had an annual appraisal document in their files, with details of any training requirements or areas for improvement. This demonstrated staff were adequately supported to identify areas for improvements, concerns, training requirements and to effectively carry out their roles and responsibilities.

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. Care records showed the service recorded whether people had the capacity to make decisions about their care. In care records we looked at, there were details about the person's mental capacity. For example, in one care plan we read that the person lacked mental capacity and that consent to provide the person's care and support had been given by an advocate; the person's son who had lasting power of attorney. An advocate is a person who speaks or writes on someone's behalf when they are unable to do so for themselves.

People who were deprived of their liberty had appropriate DoLS authorisations in place or had DoLS applications submitted to the local authority for authorisation. We saw the service was acting within the conditions of the authorisations. Staff we spoke with were able to explain the main principles behind the MCA 2005 and DoLS and what this meant for people who lived at the home. This demonstrated the home acted in line with the MCA 2005 and DoLS.

Care records demonstrated nutritional assessments were completed to assess whether the person was at risk of losing weight by not eating sufficient amounts of food and these were reviewed with appropriate frequency. Care records we looked at demonstrated people were encouraged to maintain a well-balanced diet that promoted healthy eating and gave the person choice over what foods and drinks they consumed. Plans reflected peoples' food and fluid preferences. Referrals to specialist external professionals from the speech and language team (SALT) had been made when people exhibited swallowing difficulties and the recommended treatment had been recorded. Where people had lost weight we saw that nutritional supplements had been requested and the registered manager had increased the frequency the person was weighed.

We saw mealtimes were relaxed and not rushed and the dining areas were bright, airy and well decorated. Some people ate their meals in their bedrooms, which was their choice. Staff spoke sensitively with people whilst supporting them with their lunches and all food was homemade, including pies and a hotpot. Plate guards and adapted cutlery were provided for people who required extra support with their meal to enable them to eat independently.

Throughout the home, we saw there was fresh fruit and snacks available for people to eat. We saw people being offered hot and cold drinks throughout the day. This demonstrated people were supported to have sufficient amounts to eat and drink to maintain a balanced diet.

People's bedrooms were well decorated and personalised. We saw bedrooms were bright, airy, clean and fresh smelling. Televisions were present and some people had photographs, pictures, music systems and CD's.

Good

Is the service caring?

Our findings

The service was caring.

People told us, "I'm quite ill at the moment but they are really kind and caring when dealing with my problems", "Carers are very good, very kind", "they are excellent. You can't fault them". More comments included "I'm very comfortable, they're good girls", "They are very kind and patient, [staff name] is lovely." Relatives told us, "Nothing is too much trouble" and, "I can come and visit whenever I want."

We observed staff, being kind and supportive to people and we saw people's privacy and dignity was respected. For example, we saw a member of staff preserve a person's dignity, the person had quite a cold and their nose was running; staff gently guided the person to the nearest toilet and were able to support the person to become more comfortable. The staff member then supported the person back to their chair and gave them a supply of tissue. The staff member asked if the person was warm enough and could they get them a blanket. The person did want a blanket and thanked the staff member for their time.

We observed staff knocking on doors prior to entering and signs on doors were used when people were having personal care. The use of these signs helped maintain privacy and prevent unnecessary interruptions during personal care. We asked people if they felt staff treated them respectfully and they told us, "They are very respectful."

People and relatives told us they felt involved in making decisions and planned their own or their family member's care. One relative told us, "Staff always tell me about how [person] is and discuss her needs with me." Staff we spoke to told us how important it was that they involved people in making decisions about how they wanted to receive their care. One staff member told us, "People have the right to say no and we have to respect that decision, it's all about their own choices." Another told us, "People who use the service always come first". It was evident in people's care files that people and their relative's involvement in pre-admission assessment, subsequent decisions and during reviews was encouraged and in place. People and their relatives told us they were involved in care planning, where possible. One relative said; "I couldn't wish for anything better when it comes to knowing what's going on. We have regular reviews, but I can raise anything anytime and I know the carers will do something about it".

We asked people whether they were given choices about how they received their care. One person told us, "I think I do have a choice", another told us, and "Here you can do what you want. I have breakfast, read the paper, go for a walk, listen to music". People told us they could go to bed and get up when they wanted; this was reflected in care plans reference to what time people preferred. We observed a person go to the dining room after 9am for breakfast, they were sitting on their own, when we asked if the person was ok, and they told us they liked their breakfast whilst listening to their choice of music.

We saw staff promoted people's independence by encouraging them, where possible, to do things for themselves. This included eating and drinking, and encouraging people to move as much as they could without the use of hoists or aids. We observed a person who had an electric wheelchair and a walking frame.

We were told the person can become tired quite quickly and the wheelchair could be used on those occasions. During our visit, we observed staff encourage the person to use their walking frame throughout the day to maintain their independence.

Staff told us they enjoyed working at the service because of the interaction they had with people who lived there. We asked one staff member what they thought was the best part of their job and they told us they loved working with the people and being able to spend time talking and engaging with them. We observed staff through the day working in a non-hurried way, sitting with people chatting and giving each person time they needed. One person told us they received specialist support from palliative care professionals and we saw some people at the service had been consulted about their wishes at the end of their life. We reviewed care records, which documented their preferences. One person told us they had discussed with staff that they wished to end their life at the service.

People had access to advocacy services if they required them. An advocate is a designated person who works as an independent advisor in another's best interest. Advocacy services support people in making decisions, for example, about their finances, which could help people maintain their independence.

Good

Is the service responsive?

Our findings

The service was responsive.

People who used the service told us that they were able to say how they would like to be supported. We saw people telling staff what they wanted and staff responded in a timely manner to accommodate them. Staff told us that they were aware of people's preferences but appreciated that people often changed their minds. They worked in a way that responded to individual needs and preferences.

People were assessed prior to, and at the time of their admission to ensure that the service would be able to meet their needs. One relative said their loved one had come for a day visit and lunch before they had moved in, so they were happy and knew the home. One social care professional told us that they had recently worked with the registered manager and the staff team and that they had managed admissions "Well". Reviews of care and support took place after admission to
ensure that the staff team continued to meet people's needs.

The care plans were responsive to the changes in individual needs. In each care plan, we saw a letter that had been sent to the family members offering a choice of dates for a meeting to discuss their loved ones care. This ensured that family members are offered the opportunity of involvement and participation in care planning. In each care plan, there was a letter detailing the names of the person's named registered nurse and care staff, this meant people and their relatives had specific staff to talk to if they had any problems.

We looked at twelve care plans in detail. The care plans were comprehensive and detailed. Information was up to date and had been regularly recorded and reviewed. Where people required support with repositioning or turning or had fluid and nutrition charts, these all had been accurately recorded. For example, where a care plan recorded a person required four or two hourly turning to prevent pressure sore development we observed that this had been done and duly recorded.

Where people had mobility needs we observed detailed descriptions of support aids that should be used when transferring the person from bed to chair, what size slings to be used with the hoists so that staff were fully aware of the equipment that should be used for each individual. We saw inflated mattresses that were used to prevent the development of pressure sores had been set at the correct setting in accordance with the weight of the individual. Where a person had a wound or a pressure sore we saw that photographs had been taken. This enabled progress in healing to be recorded properly.

People's personal preferences had also been identified and we saw evidence that this was acted on. For example, one person wanted an alarm pendant around their neck when in the lounge areas. When we spoke to this person we saw that they were wearing the alarm they had requested. Another person liked to listen to classical music and we heard that classical music was playing when we visited them in their room.

When people and family members had requested the person's care plan be kept in a drawer or at the nurses' station, rather than in the person's room, we saw that this had been done. Care plans were formally

reviewed on an annual basis and ten percent of care plans are reviewed monthly in a care plan audit. The home also operates a 'resident of the day' this involves catering, housekeeping and care staff spending time with a resident and identifying any changing needs or preferences. As part of this the care plan is reviewed.

Throughout our inspection we saw that the activities staff made sure that people were interacting, talking and taking part in activities. One person said, "I love things we do [name] knows exactly what we want to do. I love the tea and birthday parties we have". We observed staff consulting people about how they would like to be supported, where they would like to sit and if they would like to join in with group activities. People's decisions were respected and supported. When people were seen to change their minds staff accommodated this without question. For example, one person wanted to do an activity and then they decided they wanted to go to their room.

We spoke with the registered manager about those people who chose to stay in their rooms or were unable to come downstairs. They said activities staff went to them and spent time doing activities of their choice, we asked people and they confirmed that someone came to see them every day either to do an activity or just to chat. This meant people were not socially isolated. The registered manager also explained they had activities staff in the home seven days a week.

People told us that they would speak with the registered manager or the nurse on duty if they had any complaints. People who used the service were happy to approach the manager and the staff to discuss all aspects of their care and support. Relatives also told us they had regular opportunities to speak with the registered manager and would be confident to raise any concerns that they might have with them. People told us that they were confident that resolutions would be found informally without having to use the formal processes. The complaints procedure was displayed in the entrance hall making it readily accessible. Staff told us that they were aware of the complaints procedure and they would share it with people who used the service if necessary. The service had received one complaint in the previous six months. The manager had followed the provider's complaints policy. Records clearly identified what had happened in response to the complaint, the lessons learnt and the action taken to prevent recurrence. Team supervision following the event had taken place to make sure all staff were aware of the actions needed to prevent it happening again. We also saw in the induction files for newly appointed staff a workbook on complaints handling was included. This ensured that all new staff were aware of what to do in the event of a person or family member making a complaint. One person told us, "You only have to speak to the manager and she will put it right".

The home had an abundance of compliments from grateful family members including the following; "I would like to compliment you on your operation of Elm View. All staff with whom we came in contact with were professional, courteous and kind. Thank you for taking care of my Mother"; "A big thank you to all staff for your kind and caring support"; "It was great for us to see how much mum is respected and loved by you all at Elm View. You run a happy ship" and "I would not hesitate to put (family members name) into Elm View again".

Good

Is the service well-led?

Our findings

The service was well led.

People we spoke with who lived at the home recognised and knew the roles of each member of the management team.

The service demonstrated good management and leadership. There was a clear line of management responsibility from the area manager through to the management team and staff. People and staff felt the management team were supportive and approachable. One staff member told us about the registered manager, "They get involved and care about the people." One staff member told us, "The manager [name] does walk rounds all the time." Another told us, "I think the office are strict with spot checks which is good." This showed the management team had a visible presence within the home.

One staff member told us they had personal development meetings with the registered manager. They told us it had enabled them to enhance their role with further training. This staff member said, "They [the registered manager] pointed me in the right direction." We spoke with the registered manager about developing staff, and they commented, "It is lovely to see people develop and gain skills. It is what it's all about." This showed the registered manager valued and motivated staff.

Throughout our inspection, we observed the office door was not closed and families and friends of people called in. People who lived at the home and families both approached the management team throughout the inspection. For example, one family came to speak with the registered manager, about planning a birthday party for their relative in the dining room at the weekend. The registered manager told us they would attend, as would all the people who lived in the home if they wanted to. One staff said, "[The registered manager] has got a very open door policy, you can go and talk, she listens, she always tries to find a solution." Another said, "[The registered manager] is easy to talk to, they are passionate and so caring and approachable, she gets things done." This showed the registered manager promoted an open and inclusive culture.

We were told monthly staff meetings took place in the home and there were team meetings for the full staff team. We saw minutes of meetings, which included agenda items on teamwork, staffing and pressure care. Minutes also included information sharing on safeguarding and Mental Capacity Act implications. One set of team meeting minutes looked at infection prevention. The meetings enabled the registered manager to support and develop staff. It also gave a forum for staff to discuss any issues or concerns. The registered manager and senior staff had small meetings each morning to discuss the 'Residents of the day', issues for the day and for the presentation of certificates for good work to staff who had been nominated by people, their relatives or other staff members.

We saw minutes from a residents meeting held in March 2016 and saw that actions had been agreed and taken. One person wanted to have a varied menu to include different food from different cultures. The

registered manager had suggested a "Theme Night" which people agreed to and a Thai food night had taken place. A relatives meeting had been held on the 13th of March 2016. In the main hallway of the home, we saw that the minutes of the relatives meeting were available for family members to take a copy and read what had been discussed and actions agreed. For example, the possibility of holding the relatives meetings at the weekend in order for more people to attend. The registered manager agreed to this and the next meeting has been set for a Saturday afternoon.

Surveys were sent to people, families and staff on a yearly basis. The results were displayed on notice boards for people to see under the heading, 'You said, we did'. We saw staffing had been raised as an issue in feedback from families and people. We read minutes of discussions regarding staffing in team meetings. We spoke with the registered manager who told us they had been actively recruiting and had resolved this issue. This showed the registered manager had positively listened and acted upon issues received to improve service quality for people.

We saw evidence there was a structured schedule in place for audits. There was a full audit of the service every six months completed by the area regional manager and quality manager. These were followed by bi monthly reviews. The schedule identified who was responsible for taking the lead with these tasks. Quality checks included management and administration, personal care, staffing, mental capacity, mattress audits, nutrition, falls and medication. For example, we saw monthly infection control audits with actions identified and the timeframe they should be completed by. Nutrition and catering audits were given a red, amber and green rating (RAG) and we saw evidence of action that had been taken. The registered manager also completed care documents, care plan reviews and safeguarding information. We saw training matrix reviews, maintenance safety certificate checks and fire alarm drills had taken place. These ensured the service provided remained consistent and people were safe.

The services liability insurance was valid and in date. There was a business continuity plan in place. A business continuity plan is a response-planning document. It showed how the management team would return to 'business as normal' should an incident or accident take place. The registered manager understood their responsibilities and was proactive in introducing changes within the workplace. This included informing CQC of specific events the provider is required to notify us about and working with other agencies to maintain people's welfare.