Methodist Homes

Hampton Lodge (St Basils)

Inspection report

33 Hill Lane
Southampton
Hampshire
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23 June 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 21 and 23 June 2016 and was unannounced. The home provides accommodation and care for up to 44 older people, including people living with dementia. There were 42 people living in the home when we visited. Accommodation is provided in two units with people requiring nursing care on the ground floor and people living with dementia on the first floor.

At our last inspection on 23, 26 and 27 February 2015, we found six breaches of regulations. The service was non-compliant with staffing, infection control, staff supervisions, monitoring and meeting the hydration and nutritional needs of people, reviewing people's care plans and the audit process was not effective. During this inspection we found action had been taken and improvements made.

A registered manager was not in post at the time of our inspection. 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. The service was currently in the process of registering the manager for the home.

We found people's safety was compromised in some areas. Staff were trained and assessed as competent to support people with medicines. However medicines were not always stored correctly and there was not any clear guidance about applying topical creams. Risks were managed appropriately, however a business continuity plan had been recently reviewed and details were no longer relevant and had not been updated.

Most people's care plans provided comprehensive information and were reviewed regularly. However, there was some confusion for one person's records about what stage their thickened fluids should be and people's skin integrity plans were not always adequate to support people appropriately.

Safe recruitment practices were followed and appropriate checks were undertaken, which helped make sure only suitable staff were employed to care for people. Staff received training in safeguarding adults and knew how to report concerns.

Staff received regular one to one sessions of supervision to discuss areas of development. They completed a wide range of training and felt it supported them in their job role. New staff completed an appropriate induction programme.

People received varied meals including a choice of fresh food and drinks. Staff were aware of people's likes and dislikes and offered alternatives if people did not want the menu choice of the day.

People were supported to eat and drink when needed. People felt they were treated with kindness and said their privacy and dignity was respected. Staff had an understanding of the Mental Capacity Act (MCA) and were clear that people had the right to make their own choices.

People had a choice and access to a wide range of activities. People were able to access healthcare services.

Staff were responsive to people's needs which were detailed in people's care plans. People felt listened to and a complaints procedure was in place. Regular audits of the service were carried out to asses and monitor the quality of the service. Staff felt supported by the manager and the area manager and quality business manager were supporting the home and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were trained and assessed as competent to support people with medicines. However medicines were not stored correctly and there was not any clear guidance on how many times to apply topical creams.

Risks were managed appropriately; however a business continuity plan had been recently reviewed and details were no longer relevant and had not been updated.

Staff received training in safeguarding adults and knew how to report concerns. Staffing levels had improved. The process to recruit staff was robust and helped ensure staff were suitable for their role.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and one to one supervisions. People were supported to access health professionals and treatments.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the way staff treated them with kindness and compassion.

People were treated with dignity and respect. People's privacy was respected at all times.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most people's care plans provided comprehensive information and were reviewed regularly. However, there was some confusion for one person's records on what stage their thickened fluids should be and people's skin integrity plans were not always adequate to support people appropriately.

People received personalised care from staff that understood and were able to meet their needs. People had access to a range of activities which they could choose to attend.

People's views were listened to. A complaints procedure was in place.

Is the service well-led?

Good

The service was well led.

Staff spoke highly of the manager, who was approachable and supportive.

There was an open and transparent culture within the home. People and visitors felt the home was well run.

There were systems in place to monitor the quality and safety of the service provided. There was a whistle blowing policy in place and staff knew how to report concerns.

Hampton Lodge (St Basils)

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 23 June 2016 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor in the care of older people living with dementia.

Before this inspection, we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people living at the home and nine family members. We also spoke with the provider's area manager, provider's quality business partner, the deputy manager, a registered nurse, seven nursing or care staff and ancillary staff including the home's administrator, one housekeeper, the chef and maintenance staff. We also spoke to the Chaplin who is employed by the service and a volunteer who assists in the gardens.

We looked at care plans and associated records for eight people, staff duty records, seven recruitment files, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Following the inspection, we spoke with one health care professional who had regular contact with the home, to obtain their views about the care provided.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection of the home which took place in February 2015, we identified there were not enough staff to meet people's needs and infection control guidance was not always followed. We asked the provider to tell us what action they were taking and they sent us an action plan stating they would be meeting the requirements of the regulations by July 2015. At this inspection we found improvements had been made to infection control risks and to meet people's staffing needs.
People were supported to receive their medicines safely. People said they received their medicines regularly and at the correct times. One person told us, "My medicines are given about 8.30 in the morning and midday the staff are very good at that. I find the nurses patient when giving medication." Medication administration records (MARs) confirmed people had received their medicines as prescribed. Training records showed staff were suitably trained and assessed as competent to administer medicines. There were appropriate arrangements in place for obtaining, recording, administering of prescribed medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. Stocks of medicines matched the records which meant all medicines were accounted for. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

Medicines which were to be disposed of were not kept securely according to The National Institute for Health and Care Excellence (NICE) Guidance on the storage of medicines 2014. Two medicine disposal bins were full and had medicines visible at the top of the bin and had not been locked shut. We spoke to the registered nurse who took immediate action to secure the medicines and contacted the provider to organise an early collection.

Topical cream containers were labelled to show the date of opening and the expiry date to ensure creams remained safe to use. However, MAR records for creams did not always state how often the medicine should be applied and records showed creams had been applied between one and three times a day. This meant the decision was left to care staff to make. We spoke to the area manager about our concerns who informed us they would speak to staff, and training was already arranged on record keeping next month.

During our time in the home we saw that the staff provided the care people needed, when they required it. People and visitors felt there were usually enough staff and that staff responded promptly. One person told us, "If I press my call bell in my room staff normally arrive quickly." However some relatives felt they could be short of staff at times, especially if someone needs personal care to change an incontinence pad. But most of the time they were changed regularly and people didn't have to wait. We spoke to staff who felt staffing levels were adequate. One staff member told us, "I feel we have enough staff now, it use to be a struggle and we had to use a lot of agency. But four – five months ago the home had been very active in recruitment, which has now paid off. So now only use agency staff in an emergency basis to cover sickness." Another staff member said, "Staffing is now better, we had so many agency staff before."

Staffing levels took into account the people who were living at the home and the level of support they

needed. The area manager had identified there were certain times of day where people needed more support and had rostered on an additional "twilight" staff member who worked from early evening until midnight. The area manager was clear that when extra staff were needed, the funding was made available and additional staff were on shift. The deputy manager told us how staff had given feedback to the management that a senior carer was required to support people living with dementia overnight and they were in discussions with the area manager about this. Absence and sickness were covered by permanent staff working additional hours or the use of regular agency staff. This meant people were cared for by staff who knew them and understood their needs.

Staff understood individual risks and we saw that people's health and wellbeing risks were assessed, monitored and reviewed. We saw that people were supported in accordance with their risk management plans. For example, people who were at risk of skin damage used special cushions and mattresses to reduce the risk of damage to their skin. We observed equipment, such as hoists and pressure relieving devices, being used safely and in accordance with people's risk assessments. Hoist slings were allocated individually to ensure they were the right size and type to support the person safely.

Risk assessments had been completed for the environment and safety checks were conducted regularly on electrical equipment. People had individualised evacuation plans in case of an emergency. A fire risk assessment was in place and weekly checks of the fire alarm, fire doors and emergency lighting were carried out. Records showed staff had received fire safety training. Staff were aware of the action to take in the event of a fire and fire safety equipment was maintained appropriately. The home had a business continuity plan in case of emergencies. This covered eventualities in case people had to leave the home for more than twelve hours. However this had recently been reviewed and details were no longer relevant and had not been updated, as a local hotel had been arranged but the hotel was no longer in business. We brought this to the attention of the area manager and another suitable local hotel has since been arranged.

Robust recruitment processes were followed that meant staff were checked for suitability before being employed by the service. Staff records included an application form, two written references and a check with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed this process was followed before they started working at the home.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. One staff member told us, "Safeguarding training, I have completed eLearning on the computer, just waiting for my certificate. If I had any concerns I would report to the senior in charge." Staff were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. The home had suitable policies in place to protect people; they followed local safeguarding processes and responded appropriately to any allegation of abuse.

Arrangements were in place to manage infection control. One person told us the cleaners were "very good." A family member said, "Mum has an ensuite and it is usually kept very clean." Staff demonstrated a good understanding of infection control procedures. All had received training in infection control and had ready access to personal protective equipment (PPE), such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

At our last inspection of the home which took place in February 2015,we identified staff had not received supervision and food and fluids charts were not always completed to enable staff to be confident that people were not at risk of malnutrition. We asked the provider to tell us what action they were taking and they send us an action plan stating they would be meeting the requirements by July 2015. At this inspection we found improvements had been made and staff were receiving regular supervision to support them and the majority of food and fluid charts were up to date.

People who lived in the home spoke positively about the care and support they received. One person told us, "I couldn't be happier really, I'm as happy as can be." Another person said, "I'm happy with the service." A family member told us, "Since my relative has been here she has come out of her shell and been a hell of a lot better." Another family member said, "We had to move from another nursing home as there were big concerns, but we have noticed a huge improvement in their well-being since they have been here, even their speech has improved."

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One staff member told us, "Supervision is my time, and I can talk about the things that are important to me, it is not just a manager's list but genuinely seems to be aimed at helping me. This helps me to reflect on issues at work and in doing so I learn all the time. Things that might be on my mind I can discuss, for example if someone dies, I can talk that through. Supervision really helps us all work together because we can look at different situations in a safe and objective manner."

Staff told us they had the training and skills they needed to meet people's needs. One staff member told us, "I think I have had every training going, but when I have asked for other training, Matron is really keen and encouraging, it's brilliant for training here." Another staff member told us that they had completed some training for dementia awareness and it has helped them "to understand their needs and behaviour, just to remind you, or learn new techniques." They had also enjoyed training around care planning, as it showed staff how "to be more personalised when writing information."

New staff completed a comprehensive induction programme before working on their own. Arrangements were in place for staff who were new to care to complete the Care Certificate. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate support to people.

People were supported to have a meal of their choice. A family member told us, "The food is very good." The chef walked around the home in the morning and spoke to people about what was on the menu that day. If they did not want what was on the menu the chef was happy to make something they would like. The chef was aware that some people could change their mind or forget what they ordered and this was taken into account when preparing the food. During the meal service, staff showed people two different plates of food which meant they could see before they made their choice. Staff asked people if they were still hungry and

would they like some more.

People's dietary needs and preferences were documented and known by the chef and staff. Specialist diets, such as gluten free, or religious dietary needs, such as no beef, were catered for. Where a speech and language therapist had assessed specific needs around swallowing, the chef ensured people had pureed or soft diets. Pureed food was presented individually on the plate so people could taste the different foods. Staff ensured that people were given thickened drinks when they were assessed as needing them. We also looked at records of people's food and fluid charts and the majority had been completed correctly, however a couple of charts had not been totalled up at the end of each day but records showed they had more than their recommended daily fluid each day.

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to 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's care plans showed where necessary, people's capacity to make specific decisions had been assessed and recorded. Staff knew how the principles of the MCA applied in the home and what to do if they were concerned about a person's ability to make decisions.

Staff were clear about the need to seek verbal consent before providing care or support and we heard them doing this throughout our inspection. People's consent to care and treatment was sought in line with legislation. One staff member told us, "I ask people for consent and maintain eye contact and explain what I am going to do. If they refused I would inform a senior and try again later." The home had a large notice board downstairs with a 'topic of the month' and the current topic was the MCA and advocacy. Staff told us they found this very helpful and the information displayed was very clear and eye catching for staff, visitors and people living at the home.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met. DoLS had been authorised for seven people and applications had been made for a further fifteen people who were being processed by the local authority. Staff were aware of the support required by people who were subject to DoLS to keep them safe and protect their rights.

People had access to health and social care professionals. We spoke to a health professional who regularly visits the home who told us, "We have a good working relationship and I have lots of trust with the staff." They also told us, "The home is on the ball with making appointments with health professionals. Staff know the residents well, and they know when they are unwell and can provide history to their concerns so people can be treated appropriately." Records showed people were seen regularly by GPs, social workers, opticians and district nurses. People's general health was monitored and they were referred to doctors and other healthcare professionals when required.

The environment was appropriate for the care of people living there. The upstairs residential area of the home had been decorated and accessorised to provide a positive and suitable environment for people living with dementia. This followed the best practice guidance on providing environments which were both safe but also provided opportunities for people to explore and encouraged memories. The home was also suitable to meet the physical care needs of people with corridors, doorways and bedrooms large enough for

the use of any specialist equipment required. All bedrooms were for single occupancy and had ensuite facilities of at least a toilet and wash hand basin. Individual bedrooms had been personalised to meet the preferences of the person living there. People were able to bring in items of their own including furniture to make their rooms feel homely and familiar.

The building was easy to navigate and good signage was used around the home. The home had four lounges which provided sufficient areas for people to relax, with a choice of seating in quiet or busy areas, depending on their preferences. Good lighting levels, bright colour schemes and pictures placed at appropriate heights were used to create an environment suitable for people living with dementia. Clocks and calendars were generally showing the correct time, although one in the residential unit was showing the wrong day. Clocks and calendars are a good aid to orientation for people living with dementia, but can confuse people if they are not accurate.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person told us: "I think the home and staff are brilliant I'm really happy with the home." Another person said of a staff member, "He's really good he is, really funny guy and he gets my jokes!" A family member told us, "All the staff are worth their weight in gold, all the staff are nice and we can have a laugh with them, you can't fault them." Another family member said, "I find it so great here if anything happened to me this is where I would want to come." Other comments included, "I enjoy all the staff, and we have a laugh with the chef." As well as, "The nurse is really good and I get on with all the staff."

We observed care and support being delivered in the communal areas of the home and saw good interactions with people. Staff were kind and compassionate; for example, we observed staff make sure people had a drink with them most of the day, and when their drinks needed refreshing or topped up, staff offered an alternative. Staff seemed to know what the person would prefer such as 'tea' or 'milk'. Staff interacted in a friendly way and there were many moments when people seemed happy and were laughing with staff. People were supported in an unhurried way and staff kept them informed of what they were doing.

Staff told us that privacy and dignity was adhered to and we observed care was offered discretely in order to maintain personal dignity. One staff member told us, "When I am providing personal care, I shut the door and close the curtains. If I am transferring ladies I put a blanket over their legs and always talk to them and explain what is happening." People's privacy was protected by ensuring all aspects of personal care was provided in their own rooms. Staff knocked on doors and waited for a response before entering people's rooms.

People's care records included information about their personal circumstances and how they wished to be supported. When people moved into the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. There were no restrictions on visiting and visitors and relatives were made welcome.

Hampton Lodge employed a chaplain who provided a church service once a week, as well as supporting people with their spiritual needs. They told us, "I am also here to provide a link to the local church." People also benefited from staff having received end of life training, which was enhanced by the Chaplain who worked with staff by talking about any worries they may have. We observed the Chaplin sitting with people at lunch time in the dining room, who appeared familiar, engaged, friendly and caring towards people living at the home.

We observed caring behaviour in staff interactions with people, which demonstrated person-centred care in their familiarity with each person, and the ease of communication. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it. When staff discussed people's care and treatment they were discreet and ensured conversations could not be overheard.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of the home which took place in February 2015, we identified that care plans had not been updated and reviewed as required. We asked the provider to tell us what action they were taking and they send us an action plan stating they would be meeting the requirements by July 2015. At this inspection we found people's care plans were reviewed regularly; however we had concerns with some people's records and how they were recorded.

Most care plans reflected people's current needs and were reviewed regularly. They included detailed information and guidance to staff about how people's care and support needs should be met. They also contained information about people's medical and physical needs. There was also an outline of care needs covering activities of daily living, as a quick reference for staff to use. However, some care plans did not provide up to date information about how people's needs should be met and current information was not always easy for staff to find. For example, on one person's care plan it stated they were to have thickened fluids at stage two. However when we spoke to a staff member they informed us it they thought it was meant to be stage one, and we also spoke to the registered nurse who also thought it should be stage one for thickened fluids. Care plans we looked at were also not easy to follow and it was not always easy to find the most updated guidance and it is not clear whether old guidance was still relevant or not. We spoke to management about our concerns who informed us that they would make sure fluids were being thickened to stage two for that person as stated in the care plan and inform all staff and will contact the GP and speech and language therapist to arrange another assessment straight away. Whilst improvements had been made to people's care plans there was still work to do to ensure care plans were clear for staff to follow and contained up to date guidance.

Information about how staff should support people with their skin integrity was not always adequate to allow staff to support people appropriately. For one person, a skin integrity plan was reviewed and was in place because a risk was identified. Information about it was also in the person's continence plan. However, information about the frequency of checks of the skin integrity, and the areas to check was not documented to ensure they took place. The person was at risk of developing pressure injuries and they had experienced this before they came into the home yet their records did not show their needs in this area had been monitored.
We spoke to the area manager and the quality business manager who informed us they were aware that records are not always updated or recorded accurately and have arranged some training next month for all staff on effective recording and reporting of records. A health professional told us, "There has been a big improvement on people's pressure areas and the staff monitor people's weight and pressure areas very well." They also said, "When I first came into the home it was hard to find people's care files. Now they are easy to find as they are kept in people's rooms, and we have own section in the care plan which is easy to find and record in."

Care plans provided information about how people wished to receive care and support. They gave detailed instructions about how people liked to receive personal care, how they liked to dress and how they liked to spend their day. Initial assessments had been completed using information from a range of sources,

including the person, their family and other health or care professionals. For example for one person their support plan for living and recreation was really individual and person centred. Their plan informed staff that music therapy will help the person rediscover their time as a musician as they were in a band in their earlier life. We observed them taking part in a one to one music session and they seemed to really enjoy taking part in this activity.

People had a range of activities they could be involved in. people were able to choose what activities they took part in and suggest other activities they would like to undertake. One person told us, "Activities are good; I like to do knitting and baking on a Friday." Another person said, "I play the piano for the hymns." A family member told us, "People seem to enjoy singing and someone comes twice a week. They can also do exercises, painting and cooking."

We observed a group music therapy session during the inspection. One person told us, "I help usually with the music therapy by playing the keyboard." People were singing and using percussion instruments and clapping along, while the music therapist went around the group. People were clearly enjoying the session and the music therapist worked hard to engage each person and make the session interactive and inclusive. People told us afterwards how they had really enjoyed the session. Comments included, "We've had some real laughs here, and its lovely" and "They play cracking tunes, it makes my day".

Hampton Lodge was well resourced to meet and respond to the needs of people living with dementia. A health professional told us, "They know the people living with dementia very well and staff are very good with people." There were various memory areas that were specific to the ages of the people living at the home. There were, for example, tactile and visual experiences in most corridors where people could experience the products evident in their youth and adulthood. We saw photos of activities that people had taken part in, such as 'Zoo Lab', as well as framed photos placed on tables and other furniture, of people who lived there. We also saw a 'Where were you?' board which had newspaper pictures about Victory day, Elvis dying and Kennedy assassination. This supported people with dementia to explore and reminisce.

People told us residents meetings were held every three months. One person told us that even though they didn't attend the meetings, they would get sent a copy of the minutes afterwards. The minutes showed people were kept informed about any changes and asked their views about aspects of the service such as meals and activities. The area manager told us, "We are planning to hold resident's meetings monthly going forward." We saw a quality survey had been carried out for people living at the home. People's views were prominently displayed; however, there was not an action plan to monitor if improvements had been made and if people's view were listened to.

People knew how to make comments about the service and the complaints procedure was prominently displayed. Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy. The area manager described the process they would follow as detailed in their procedure. The area manager told us, "I will follow up complaints and see if improvements have been made."

Good

Is the service well-led?

Our findings

At the last inspection of the home which took place in February 2015, we identified that the home did not have an effective audit system in place to continually assess and monitor the service provision. We asked the provider to tell us what action they were taking and they sent us an action plan stating they would be meeting the requirements by July 2015. At this inspection we found the provider had introduced a series of audits around the home.

At the time of our inspection the registered manager had left the service and a new manager had been in post a few weeks and had applied to be registered with CQC and their application was being processed. Staff spoke highly of the new manager and felt they were supportive. One staff member told us, "I feel really supported we have a great team on housekeeping and the care staff and the new manager seems really good."

People and their families felt the home was well run. One person told us, "The new manager seemed nice and held an open evening." They also said, "I can see some small changes since they have joined, but I think they have the right idea." A family member told us, "New manager seems good, feels she will do a good job. Lovely person who will turn this place around." Another family member said, "Can't fault this place, I can't praise it enough and the manager is great."

The provider had introduced a series of audits and improved the way they monitored the quality of the safety of the service. These included medicines, care and support plans, bedrails, hoist and slings, mattresses and call bell response times. Safeguarding, complaints and compliments, supervisions, training, health and safety audits were also sent to the area manager as part of a monthly report. This meant that lessons could be learnt to reduce the risk of reoccurrence. The deputy manager told us, "As well as the audits the manager and I will carry out daily checks of the home which addressed issues such as are people dressed appropriately. Are people being addressed correctly and treated with respect and dignity."

In addition to the audits, the area manager visited Hampton Lodge twice a month to support staff and speak to residents. The area manager told us, "We have just recently changed our roles and structure in the company so I can now offer more support in the home and work more with the manager. Before the quality assessments were being completed annually, but I am now looking at support on a monthly basis." They also said, "I will pick up a couple of charts and plans on each visit and check and explore that if people are losing weight, I will check records to see if the GP has been called for example. I tend to work with staff on the floor to see if there are any problem's and if so, how can we put it right?" We also spoke to the quality business partner who also was visiting the home on a more regular basis who told us, "I have been looking at some new training, person centred care planning, reporting and recording. This is planned for all staff next month, and then once staff are aware of the correct recording process then we can work with staff afterwards about any recording issues on records. We want to work with staff in a supportive role and looking hard to change the culture and grow in quality."

There was an open and transparent culture in the home. The previous inspection report and rating was

displayed prominently in the reception area. Staff felt they could raise concerns, make suggestions or improvements and would be listened to. Staff spoke highly of the home and were pleased to work there and felt supported by management. One staff member told us, "I really enjoy working here a lot, good place to work. I feel I am being supported as I expressed to management that I wanted to go into management. So have now started developments goals and training, so if a role becomes available I will be ready to apply." Another staff member said, "I feel supported I was able to complete NVQ 2,3 and 4 and the company have good packages for management as they know I want to go further and I was offered a deputy role but it was too far away."

Staff meetings were held every six to eight weeks. Staff meetings were used to discuss concerns about people who used the service and to share best practice. Minutes from a meeting in June 2016 showed food and fluid charts had been mentioned and suggestions that if targets were not being met to offer people alternatives such as ice cream, ice lollies and jellies. Also a new policy on tissue viability would be discussed in group sessions explaining the policy update and procedure.

Staff also completed feedback surveys, which allowed the provider and manager to identify areas of concern or specific training needs. The last one was sent in March 2016. However, an action plan had not been produced and it was unclear if concerns staff had raised had been listened to. We spoke to the area manager who agreed to put an action plan in place and work with the new manager on improvements to the survey straight away.

Staff understood the values and vision of the service; the aims of the service were, 'to improve the quality of life for older people, inspired by Christian concern.' While putting their values into practice 'we are open to all older people in need, irrespective of their beliefs.' The values of the home were clearly displayed around the home.

The provider and manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. There was a whistleblowing policy in place and staff were aware of it. People benefited from staff who understood and were confident about using the whistleblowing procedure. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The provider had appropriate polices in place which were updated regularly.