

Your Health Limited

Leaholme

Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection took place on 19 September 2016, and the visit was unannounced.

Leaholme provides residential care to older people including people recovering from mental health issues and some who are living with dementia. Leaholme is registered to provide care for up to 17 people. At the time of our inspection there were 15 people living at the home.

A registered manager was not in post. However, the provider has been appointed a manager who is due to commence their post the week following the 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.

At the last inspection of the service in 9 & 10 June 2015 we asked the provider to make improvements in the recording when people's medicines were administered. We received an action plan from the provider which outlined the action they were going to take. This advised us of their plan to be compliant by November 2015. At this inspection we found that improvements had been made and medicine recording was undertaken when they were administered and stored safely. The system in place to monitor care records had also improved.

At the last inspection we also asked the provider to take action to ensure there were always enough staff members around to safely meet people's needs. We found that improvements had been made and found staffing numbers were adjusted in line with people's needs to ensure a safe working environment for people.

At the last inspection we asked the provider to take action to ensure risks to people had not always been assessed, and where risks had been identified and assessed, these had not always been reviewed regularly. We found that improvements had been made and risk assessments were in place and reviewed regularly.

At the last inspection we asked the provider to make improvements to the audits, checks and governance in the home. We found that improvements had been made and a series of checks had been introduced that were overseen by the deputy manager and group quality manager and then referred to the provider.

At the last inspection we asked the provider to make improvements to the efficiency of communication between members of the staff team. We found that improvements had been made and saw that detailed handovers were in place, as well as regular meetings and supervision for staff.

At the last inspection we asked the provider to take action to ensure staff recorded what food and quantity of fluids where people were at risk of dehydration and malnutrition. We found that improvements had been made and found nutrition and hydration were recorded in line with instruction from health professionals, and where staff felt the person's diet required monitoring.

At the last inspection we asked the provider to take action to ensure staff gained people's consent prior to care being offered. We found that improvements had been made and how people were asked for their consent to care prior to their admission to the home. This was in addition to staff agreeing their actions prior to each caring intervention.

Relatives we spoke with were complimentary about the staff and the care offered to their relations. People were involved in the review of their care plan, and when appropriate their relatives were included. We observed staff positively interacted with people at lunch, where people were offered choices and their decisions were respected. Staff had access to people's care plans and received regular updates about people's care needs. Care plans included changes to peoples care and treatment and people were offered and attended routine health checks, with health professionals both in the home and externally.

People were provided with a choice of meals that met their dietary needs. The catering staff were provided with up to date information about people's dietary needs, and sought people's opinions about the menu choices to meet their individual dietary needs and preferences. There was a range of activities tailored to people's interests provided on a regular basis. Staff had a good understanding of people's care needs, and people were able to maintain contact with family and friends. Visitors were welcome without undue restrictions.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.

Staff told us they had access to information about people's care and support needs and what was important to people.

Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. The provider carried out quality monitoring checks in the home supported by the group quality manager and home's staff. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals.

We received positive feedback from the staff from the local authority with regard to the care and services offered to people.

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.

Potential risks to people's needs were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff understood their responsibility to report any observed or suspected abuse. Staff were employed in numbers to protect people. Medicines were ordered administered and stored safely.

Is the service effective?

Good ●

The service was effective.

Staff had completed essential training to meet people's needs safely and to a suitable standard. Staff understood the requirements of the Mental Capacity Act 2005 and sought people's consent to care before it was provided. People received appropriate food choices that provided a well-balanced diet and met their nutritional needs.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Further action was needed to ensure staff consistently maintained people's privacy and dignity. Staff were caring and kind and treated people as individuals. People were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care that met their needs. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People were confident to raise concerns or make a formal complaint when necessary.

Is the service well-led?

Good 

The service was not consistently well led.

There was no registered manager in post, although the provider had appointed a manager.

The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this. People using the service, their relatives and visiting professionals had opportunities to share their views and influence the development of the service.

Leaholme

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 unannounced inspection took place on 19 September 2016 by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience's area of expertise was the care of older people and those living with dementia.

Before the inspection visit we looked at the information we held about Leaholme including any concerns or compliments. We looked at the statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

The provider is required to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This inspection was a follow up visit to check improvements had been made, so the provider did not have an opportunity to complete this.

The group quality manager and deputy manager assisted us on the inspection. We asked them to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our last visit. We received some information following the inspection visit.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. Therefore, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with six people to gain people's experiences of living at Leaholme and a relative. One further relative contacted us following the inspection to share their views about the service. We found communication with the majority of people living in the home was difficult and sometimes limited. The expert by experience used a specialised communication method backed up by 'easy read' prompt cards. This resulted in people answering the expert but some of this communication was one word answers, and some of these relayed as quotes in the report.

A manager had been appointed but had not commenced in post. We spoke with the group quality manager, the deputy manager, three care staff, a maintenance person and the cook. We also spoke with one visiting health professional, and received email information from one further health professional following the inspection.

We looked at three people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily records and risk assessments. We also looked at staff recruitment and training records, quality audits, records of complaints, incidents and accidents and safety records.

Is the service safe?

Our findings

At the last inspection 9 & 10 June 2015 of we found there were not always enough on duty to effectively meet the needs of the people who used the service. At this inspection we found staff were employed in sufficient numbers to protect people from harm. People told us and we saw people's needs and requests were responded to promptly. We spoke with the group quality manager who explained the staffing numbers were adjusted in line with people's dependencies, to ensure a safe living environment for people.

Staff told us that they felt staff were employed in adequate numbers to ensure people were cared for safely. We found staff were employed in numbers sufficient to ensure people's safety. Staff confirmed there was a senior carer and two care staff in a morning, afternoon and evening, and two waking night staff. In addition, there was the deputy manager, domestic, laundry and catering staff. We confirmed these staff numbers were typical with the staff rota.

At the last inspection 9 & 10 June 2015 of the service we found some medicines were not signed for each time they were given. At this inspection we found improvements had been made. We looked at the medication administration records (MARs) for six people which were kept with the MAR's. All the MARs were signed appropriately, and had people's photographs in place to reduce the risks of medicines being given to the wrong person. Information about identified allergies and people's preference on how their medicine was offered was also included. This helped to ensure that people received their medicines safely.

A staff signature sheet was in place which had staff's initials, which helped to ensure that any discrepancies could be followed up. People in receipt of 'as required' or PRN medicines had instructions added to the MARs to detail the circumstances when these should be given and the maximum dose the person should have in any 24 hour period.

We observed how staff administered medicines to people. People were being offered pain relief which was prescribed on an 'as required' basis. We saw staff encouraged people to take their medicine, and provided explanations to what they were. Staff stayed with people to ensure their medicines were taken, which demonstrated that staff understood the safety around administering medicines.

We found that medicines were stored securely. Records showed that the room temperature where the medicines were stored was regularly above the safe limit for storing medicines safely. This was because the room had no means of ventilation. However we also queried the accuracy of the wall thermometer. The group quality manager arranged for a digital thermometer, and we saw the temperatures were within acceptable limits. Staff we spoke with knew the storage temperature limits and what to do if these were exceeded beyond the recommended maximum.

Records showed that the temperature for storing medicines safely in a refrigerator were in place and these were stored within the manufactures recommended guidelines.

Staff who administered medicines told us they had received training to ensure people's medicines were administered appropriately. Staff told us that the group quality manager had observed their practice to

ensure they continued to administer medicines safely. We viewed the training matrix which confirmed staff had undertaken regular medication training.

People told us that they felt safe and staff cared for them safely. When we asked one person they said, "Yes I am safe, I can have my door locked if I want." Another person said, "Yes," when asked if they felt safe.

Care staff told us they were sure that people were safe from harm and said they would follow up any concerns or suspicions of abuse to the group quality manager or deputy manager. They were aware how to contact external agencies such as the local authority safeguarding team or Care Quality Commission (CQC) and said they would do so if they felt their concerns were not dealt with.

Staff we spoke with had a clear understanding of the different types of potential abuse. One member of staff said, "If anything I raised wasn't dealt with, I would call social services or CQC."

The staff told us they had received training on how to protect people from abuse or harm. Staff were aware of their role and responsibilities in relation to ensuring people were protected and what action they needed to take if they suspected abuse had occurred. All of the staff we spoke with were aware of whistle blowing, and said they had not seen anything that required reporting or gave them cause for concern.

Staff demonstrated their awareness of people's individual needs, and the support they required to stay safe. We saw people were offered the support detailed in their care plan and risk assessments. People's care records included risk assessments, which were reviewed regularly and covered the activities related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided clear guidance for staff in respect of minimising risk. Visiting relatives told us they were involved in discussions and decisions about how risk was managed.

We spoke with the staff about what they would do if they suspected someone was being abused at the service. One member of staff said, "If it wasn't dealt with (by a manager) I would call the local authority or CQC."

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if they suspected abuse. Staff we spoke with had received training in protecting people from harm. Staff had a good understanding of the different types of abuse and were aware of their responsibilities to report on concerns they had about people's safety.

Staff were trained to recognise the different types of abuse and how to identify them. They were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on. They also knew which authorities outside the service to report any concerns to if required, which would support and protect people. The group quality manager was aware of her responsibilities and ensured safeguarding situations were reported through to the Care Quality Commission as required.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff, and found that the relevant background checks had been completed before staff commenced work at the service.

Is the service effective?

Our findings

At the last inspection 9 & 10 June 2015 we found communication between staff was not always effective. At this inspection we found improvements had been made. Staff felt the support and communication between the staff team was good. There were daily handover meetings which provided staff with information about people's health and wellbeing. Staff also told us they were supported through regular staff and supervision meetings with the group quality manager. One staff member confirmed they had arranged extra training through these sessions. Staff supervision is used to support and check staffs' knowledge, training and development by regular meetings between the management and staff group. That benefited the people using the service as it helped to ensure staff were well-informed and able to care and support people effectively.

People told us they were happy with the staff that supported them. They told us they felt staff understood their needs and how they liked to be cared for. We observed people were offered the support detailed in their care plan and risk assessments.

Staff told us that they commenced their training with an induction programme and then had access to courses relating to their role in health and safety, manual handling and food hygiene and infection control. We confirmed the induction programme by speaking with and looking at the records of a recently commenced care staff. The deputy manager confirmed the staff induction training and on-going training were linked to the care certificate, which is a nationally recognised training course.

Staff told us they felt they had enough training and felt they had no gaps in their knowledge. Staff records showed that following their recruitment, staff had commenced induction training. This was followed by training in safeguarding, moving and handling, food and hygiene, fire awareness, health and safety and mental health awareness.

We saw from the training matrix that some staff had not had the updated essential training. The group quality manager said the training dates had been arranged and all staff training would be updated. This information was held at the company head office but was sent to us following the inspection. That showed where updated training had been completed and other courses planned.

The deputy manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

At the last inspection of 9 & 10 June 2015 we found staff had obtained consent before providing people's

care and support though this was not always recorded. At this inspection we found improvements had been made, and people's written consent had been recorded and kept on their personal file.

We looked at how people's consent to care and treatment was sought in line with legislation and guidance. We heard people being asked for consent to care before this was undertaken. We heard one member of staff asking, "Can I help you put your shoe back on?" The person agreed and was assisted on their way out of the lounge. We heard staff asking for similar levels of consent throughout our visit, for example people were asked about the choice of meals and drinks offered or before being assisted with personal care.

Records showed that people using the service had mental capacity assessments in place with regard to making certain choices and decisions. When people lacked the capacity to give their informed consent, the law required registered persons to ensure that important decisions are taken in their best interests. A part of this process involved consulting closely with relatives and with health and social care professionals who know a person and have an interest in their wellbeing.

We found that the deputy manager had ensured that four people were protected by the DoLS. Records showed that they had applied for the necessary authorisation from the relevant local authority. Some of these people have been represented by a family member. They can represent the person's views to those responsible for making decisions about their care and treatment, and check those working with the person adhere to the main principles of the MCA and act as a safeguard for the person's rights.

When we spoke with care staff they recalled their training on MCA and DoLS and who was subject to DoLS. Care staff told us that they felt they would be able to recognise if a person liberty was potentially deprived and required a DoLS application to be completed. Records we viewed confirmed that care staff had been trained in both the MCA and DoLS.

At the last inspection of the service we found a balanced and varied diet was provided but records relating to nutrition and hydration were not always consistently completed. At this inspection we found improvements had been made. We viewed records that were regularly completed by staff which detailed people's dietary and fluid intake. We saw where people had been referred on to medical professionals where people were at risk from malnutrition or dehydration.

People were supported with a nutritious and healthy diet that helped maintain their weight. People told us they felt the meals provided were good. One person said, "Love the food, and its perfect when (named) is here. It's lovely."

We observed staff offer morning drinks to people and their visitors. However people were not offered a choice, and everyone was offered tea. We raised this with the group quality manager, and deputy manager, who said they would follow this up with the staff concerned, as they offered a range of drinks. The staff also offered snacks such as a biscuit or an apple.

Menu preferences were discussed at regular 'resident and relative' meetings between people using the service, their relatives and staff. Information about people's likes and dislikes of food and drink were recorded in their care plans, which were available to staff. This information included any known food allergies was made available for catering staff. The staff were able to explain what this meant for people, and how the information was used. That helped to ensure meals prepared were suitable for everyone.

People had the choice to eat in the dining room, lounge or their bedroom. People were assisted to choose meals by using the picture prompts that were kept in the dining room. Staff explained how these were used to promote choice, and said these were widely used for many of the main meal choices. This demonstrated

staff were able to communicate with people and promote choices.

We observed people at lunchtime. People looked relaxed throughout the meal. We saw some people had been provided with adapted cutlery and crockery to enable them to eat their meals independently. Others required prompting and some required one-to-one assistance to eat their meal. This was done at a pace to suit the person, and staff were positioned to enable good eye contact.

The atmosphere at lunchtime was relaxed and staff supported people to eat without rushing them. Staff served the ready plated meals from the kitchen, which included gravy or cheese sauce as per the meal chosen. This meant people had no choice on the amount of gravy or sauce on their plate. We spoke with staff about this and they told us they knew the people and their individual likes, dislikes and allergies.

Staff were attentive and responded to requests when people wanted second helpings or assistance with cutting their food into smaller pieces. We saw all staff maintained relaxed conversations with people throughout the meal. Fluids such as water and cordial were freely available in the dining area. Staff were observed to give choices to people throughout the meal.

We saw people's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) and the dietician. This ensured any changes to people's dietary needs were managed in line with professional guidelines. One person was recorded as having a poor appetite. Records showed how much the person should eat and drink as a minimum and staff monitored their food and fluid intake to ensure they had sufficient to maintain their health. The group quality manager said if they had concerns about the health of anyone monitored this way, they would seek further medical advice. This approach helped to ensure that people received effective support with their nutrition and hydration.

People's care records showed that they received health care support from a range of health care professionals and were accompanied by staff to routine medical appointments. Records we viewed confirmed people were subject to regular health checks by the GP, specialist nursing staff and hospital consultants.

Is the service caring?

Our findings

People told us the staff were caring and approachable. One person said, "My staff are good." Another person said, "Yes the staff are quite good," and another, "Yes the staff are quite good."

We spoke with a visiting relative and asked if care staff knew how to support people well. They replied, "Yes, first class. I don't think they would be in the job if they didn't want to do it."

We observed people were mostly treated with kindness and compassion by a caring staff group. We observed staff interactions with people throughout the inspection which showed that staff were caring, helpful and people were treated respectfully most of the time. However we overheard another member of staff who raised their voice, and called instructions and advice to another member of staff about the support a person required for their meal. This did not demonstrate that they respected the person's dignity.

We also observed two members of staff walking into a person's bedroom without knocking. This again did not respect the person's right to privacy and dignity. We spoke with the group quality manager, who said they would speak to the staff group, about respectful communication and said further training and support would be offered to staff.

We observed one member of staff who assisted a person to eat their lunch. The member of staff ensured the people's clothes were protected from food spillages, which assured their dignity. That demonstrated staff took steps to promote people's dignity.

We overheard a member of staff explaining they needed to assist a person in a wheelchair. This was done in a caring and unhurried way giving the person time to follow the instructions given by the staff. We observed staff greeted people in a friendly way when entering communal areas and people were given the choice of where to sit. We observed care staff had a good rapport with people and engaged them in meaningful conversation.

Some people were unable to express their views and opinions. Records showed that family members had been involved in care plan reviews and there was information in care plans to ensure people were referred to by their preferred name. Staff knew people and the name they preferred to be called.

The group quality manager confirmed some people's family relatives were involved in care planning and reviews. Some care records were not signed by the individuals or a family member, but staff told us care plans were read to people and their comments recorded. The group quality manager told us care plans reflected people's needs and were reviewed every month. Staff said people were asked to take part in care plan reviews but only a few of them chose to take part in this process. The deputy manager added relatives and close family members were informed when people's health or wellbeing changed.

We observed that staff checked on people's well-being throughout the day. Individual choices, preferences and decisions made about people's care and support needs were recorded. These daily records included the

care and support people received, and demonstrated that staff supported people's decisions about how they wanted to be cared for.

Staff said there was a good staff team who knew people's needs and they all helped each other. They all said they enjoyed working at the home and got on well with the people they supported. One member of staff said, "I am happy here, happy in my job. " Another said, "The deputy manager fits in with the team, and helps on the floor."

We received information from a health professional who thought the home had a relaxed and caring environment. They also said staff were very friendly and welcoming and supplied them promptly with the information they required. They added, when they updated information to staff over the telephone they found this had been dealt with efficiently.

Is the service responsive?

Our findings

At the last inspection of the service we found people's needs had not always been assessed before they moved into the service. We found improvements had been made, and that people received personalised care that was responsive to their needs.

One person told us they felt the staff knew them well in the time since they had moved in. They said, "I think they are very clever that way." Another person explained, "My daughter sorts out the finances and the care plan." We asked if they thought staff knew how to support people. They replied, "Yes I do, people who are the real Leaholme staff (named) is awfully good."

We looked at people's care plans and found they all included pre-admission assessments, which identified each person's individual needs. The group quality manager said these were carried out before people moved into the home, which ensured that staff could meet the person's identified care needs.

Care planning was linked to people's needs which ensured care plans were individualised. We saw evidence of information on allergies, likes, dislikes, wishes and aspirations, and detailed life histories completed by people's families. One person had regressed through their dementia and had times where they reverted to their first language which was not English. Some of the staff could speak the person's first language and other staff communicated by asking questions in English which the person recognised and responded in English. Staff also used picture prompt cards if communication was difficult.

Staff had access to people's care plans and received updates about their care needs through daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, some of which resulted in changes to the care plans. We saw where a reduction to a person's mobility resulted in a changed care plan. That suggested the care process responded to people's changing needs.

One person told us they, "Enjoyed watching TV, reading the newspaper and thinking about the past." Another person was colouring in a picture and said they did not think they had made a good job of it. When prompted they started a conversation about the picture which was of the sea. We asked if they were interested in the sea, and they proceeded to tell us about their former life which involved boats and the sea. The person indicated they would like a trip to the seaside. We spoke with the group quality manager about this who said they would follow this up and prompt the new manager to look at more individualised trips out.

We spoke with the group quality manager about how activities were decided in the home. They said people were asked through the regular meetings for those in the home. People were also asked to comment through the quality questionnaires that were sent to people's relatives.

We looked at the copies of the 'residents and relatives meetings' which included discussions around activities, the menu, staffing changes and changes to the home environment. Suggestions from these included more art and craft activities and the water fountain in the garden to be repaired. We saw the arts and crafts sessions had increased and staff had created an 'art wall' where people's art was displayed.

Pictures were included on a photo board which demonstrated the range of activities on offer. We also saw where the fountain had been repaired, and was in working order.

We spoke with a visiting relative about what activities their relative enjoyed. They told us, "Staff provide activities; mum isn't always able to take part in." We saw there was a range of planned activities on offer. However staff told us if people wanted to do different activities they would do their best to provide alternatives.

The provider had systems in place to record complaints. One person said, "I would discuss it with my family and those involved." Another said, "Absolutely no faults at the moment." A visiting relative said, "I have no complaints, if I had, I would speak with (named)."

None of the people we spoke with said they knew how to make a complaint, although were aware to speak with a member of staff. The relatives we spoke were aware how to make a complaint, and were aware who to approach in the staff group to have these followed up. Records showed the service had received three written complaints in the last 12 months. An outcome had been provided for each, and changes were made to the service, as a result of this. The outcome of one complaint had been to distribute written instructions on how to launder clothing, which had resulted in a reduction in damaged clothing.

Analysis by the group quality manager did not reveal any patterns or themes with previous complaints. The information was fed back to staff through staff meetings or individual supervision sessions, so that staff were aware of the issue and any change required.

Is the service well-led?

Our findings

There was no registered manager in post, as the previous registered manager had left one year prior to this inspection. The provider had appointed a manager who was due to commence employment after this inspection.

At the last inspection of the service we found auditing systems did not always pick up shortfalls within people's records or other areas of the service. We found improvements had been made at this visit. We discussed the checks and audits the provider and the group quality manager conducted in order to ensure people received the appropriate support and care.

The group quality manager told us there were regular audits undertaken by the deputy manager and staff in order to ensure health and safety in the home was maintained. We saw records of these checks that had been completed to ensure the building was safe for people. These also included regular checks on the medicines system, care plans, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements. These had resulted in follow up appointments being arranged for people at risk of malnutrition or dehydration.

An additional audit was completed by the group quality manager on the records and checks made by the staff. They examined the findings to ensure that people who lived in the home were safe and well cared for. Staff confirmed the provider regularly spent time in the home.

We saw a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. There was an in house maintenance person who undertook repairs on a regular basis. That meant the improved checks and audits had led to an increase in safer environment for those in the home.

Staff were aware of the process for reporting faults and repairs, and had access to a list of contact telephone numbers if there was an interruption in the provision of service. Other information included instructions where gas and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

The deputy manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. The deputy manager promoted an inclusive and transparent management style in the absence of the registered manager. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required.

We saw evidence that people who used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process. They were sent questionnaires, so they could comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary staff assisted them in completing questionnaires. We saw some of the feedback had been

adopted by the provider, and changes had been made to the care, food and nutrition, activities and laundering of clothes. This was a collated response that was circulated to people in the home and their representatives. The outcomes were also added to the agenda of the residents and relatives meetings so people were aware of the outcome and could comment on this.

People who lived at the home and their relatives were also invited to meetings with the home's management team. We looked at the minutes of these meetings. We saw that people requested to be able to have more activities such as arts and crafts, and to then display what people had made. We saw evidence of this on the day with the photo board and activities on the day. That meant the provider embraced the quality assurance process and also provided evidence of a culture which was person centred and empowering.

The provider understood their responsibilities and ensured that we were notified of events that affected the people, staff and building. The provider had a clear understanding of what they wanted to achieve for the people at the home and they were supported by the group quality manager, deputy manager and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

Staff had detailed job descriptions and had regular staff and supervision meetings. These were used to support staff to maintain and improve their performance. Staff confirmed they had access to copies of the provider's policies and procedures. They understood their roles and this information ensured that staff were provided with the same information. This was used to provide a consistent level of safe care throughout the home.

A visiting relative told us they could make comments or raise concerns with the management team about the way the service was run. They had noted that staff had not adhered to the laundering instructions for their relatives clothes. That had resulted in them being un-wearable and had to be replaced. The staff were spoken with and re-trained, which had resulted in fewer mistakes taking place.

A copy of the last inspection report was displayed in the foyer of the home, which displayed the rating from the last inspection.