Alexander Park Homes Limited

The Bill House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on 25 January 2016 and was unannounced.

The Bill House provides care and accommodation for up to 38 people and there were 36 people living at the home when we inspected. These people were all aged over 75 years and were all living with dementia.

All bedrooms were single and each had an en-suite toilet. There were several communal lounge and dining areas which people were observed using. A passenger lift was provided so people could access the first floor.

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

Staff were trained in moving and handling but we observed one instance where staff failed to follow safe moving and handling procedures.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home. Care records showed any risks to people were assessed and there was guidance on how those risks should be managed to reduce any risk of harm.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

People received their medicines safely.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed and referrals were made to the local authority where people's liberty was restricted for their own safety.

There was a choice of food and people said they liked the food. The provider consulted people about the food and meal choices.

Staff were skilled in working with people who were living with dementia and had access to a range of relevant training courses to enable them to meet people's individual needs.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Staff were observed to treat people with kindness and dignity. People were able to exercise choice in how they spent their time. Staff took time to consult people before supporting them and showed they cared about the people in the home.

Each person's needs were assessed and this included obtaining a background history of people. Care plans showed how people's needs were to be met and how staff should support people. Care was individualised to reflect people's preferences. Relatives and a health care professional said the staff provided a very good standard of care.

Staff supported people with activities and there were two activities coordinators to provide and facilitate a range of activities.

The complaints procedure was provided to people and their relatives. People said they had opportunities to express their views or concerns, which were listened to and acted on. There was a record to show complaints were looked into and any actions taken as a result of the complaint.

There was a culture which reflected an open and caring approach to people and their relatives.
Staff demonstrated values of treating people with dignity, respect and as individuals. Relatives' views were sought as part of the service's quality assurance system. Relatives commented on good communication with the staff and registered manager. Staff views were also sought and staff were able to contribute to decision making in the home.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service which the provider used to make any improvements.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 did not always support people safely when they needed staff assistance to move.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff were trained in a number of relevant areas and had access to nationally recognised qualifications in care. Staff were supported by regular supervision.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards (DoLS).

People were supported to have a balanced and nutritious diet and there was a choice of food.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to people.

People were consulted about their care and their independence and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

There was an activities programme for people.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people and staff to check if improvements needed to be made.

Staff demonstrated a commitment to treating people with dignity and as individuals. There was a culture of openness and strong liaison with relatives of people.

There were a number of systems for checking and auditing the safety and quality of the service.

The Bill House

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 was unannounced and took place on 25 January 2016. It was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with two people who lived at the home and to two relatives. We also spoke with four care staff, the registered manager, the provider of the service, the provider's training office and a quality assurance compliance officer for the provider.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for seven people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for six staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a visiting community nurse who gave their permission for their comments to be included in this report.

The service was last inspected on 2 August 2013 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Staff were trained in moving and handling procedures. The service's moving and handling procedures were assessed in July 2015 by a moving and handing advisor as being satisfactory with the exception that two staff were observed to tip a wheelchair inappropriately. People's moving and handling needs were assessed and a care plan devised of how to safely support each person.

We observed people being supported by staff to move from the lounge to the dining room. We observed five people being assisted by staff to move in a safe way by either encouraging them to stand independently or by the use of hoist. However, we observed one person was helped to get up by two staff by raising the person from a chair by holding onto the person's arm between the elbow and shoulder. This was an unsafe way of assisting the person to stand as it placed strain on people's joints thereby increasing the risk of injury. This was discussed with the registered manager and one of the providers who acknowledged this type of moving and handling was not safe. People's needs in relation to moving and handling were not consistently managed in a safe way. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the registered manager confirmed this had been addressed with the staff concerned, that additional training was to be provided to remind staff of the safe moving and handling of people and that staff would be observed to ensure safe moving of people was carried out.

People and their relatives told us people were safely cared for. When we asked a relative if people were safely cared for the response was, "Yes definitely. I don't go home and worry." A relative described the service as having a safe environment. Relatives said there were enough staff to look after people safely and said staff were skilled in safely supporting those with behaviours that may challenge and this had resulted in an improvement in people's behaviour and mood. A health care professional also said they considered the staff provided safe care to people.

The service had policies and procedures regarding the safeguarding of people so staff had information about how to recognise possible abuse and the action they should take in reporting it. Staff training records showed staff were trained in safeguarding people and this was also included in the induction for newly appointed staff. We spoke to staff about the safeguarding of people and each staff member had a good awareness of the principles of safeguarding procedures and who to report any concerns to. A copy of the service's safeguarding policy was displayed on a notice board in the hallway so people and relatives knew what the procedures were for protecting people from possible abuse.

People's care records included risk assessments regarding possible falls, mobility, activities, nutrition and the risk of skin damage. There were also risk assessments related to people's mental health. There were corresponding care plans of the action staff needed to take to minimise these risks to keep people safe. Specialist equipment was used to reduce the risk of pressure areas developing on people's skin, such as pressure relieving mattresses and cushions. Risk assessments were reviewed and updated on a regular basis and following an incident or accident such as a fall or injury. A pro forma was used to review people's risk of falling and to re-evaluate this if someone experienced a fall. We saw copies of these reviews following an

incident or fall. Staff were supported in their knowledge by the provision of a training course regarding the management of risks to people.

The service provided sufficient staffing levels to meet people's needs. We based this judgement on observations of staff with people, what people, relatives and staff told us as well as the views of a health care professional we spoke to. The health care professional, however, said one additional staff member would be desirable but stated there were enough to staff to meet people's needs. One staff member also said they felt an additional staff member in the morning would be helpful as this was one of the busiest times of the day but also said staffing levels were sufficient to meet people's needs.

At least six care staff were on duty from 7am to 8pm each day plus the hours worked by the registered manager and deputy manager. The service also had two activities coordinators, a cook, a kitchen assistant, staff to prepare and serve the early evening meal, and between three and four cleaning staff each day. Night time staffing consisted of three staff on a 'waking' duty. The registered manager and provider said a dependency tool was not used to assess the level of staffing required to meet people's needs, but this was something they were looking into using in the near future. The registered manager said the provider was always receptive to providing additional staff if people's needs increased. Staffing arrangements were organised on the staff rota and these reflected the provision of six staff from 7am to 8pm each day. The rota also included details about how staff were deployed to different areas of the home and to individual people.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting. These checks ensured staff were safe to work with people.

There were policies and procedures for the safe handling of medicines. Only those staff who were trained, assessed and observed as competent to handle and administer medicines did so. Medicines were supplied to the service in a monitored dosage system which meant they were organised in a pack for each time the person needed the medicine. Staff completed a record each time they administered medicines to people and we observed this practice taking place. Stocks of medicines showed people received their medicines as prescribed. One person had medicines administered covertly meaning it was disguised in food as this was the only way the person would take it. There were records to show this was discussed and agreed with the person's community psychiatric nurse and GP who had confirmed written agreement for this to take place. Where people had variable doses of medicines, records showed this followed the correct guidance. For example, records showed warfarin medicine was administered according to the blood tests carried out by the local health services.

Where people had medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms of when the person needed this medicine. There was some lack of clarity about this as one of these medicines was administered on a daily basis and the registered manager explained this was an error on the medication administration records (MAR) which should have said it was to be taken on daily basis. We noted one protocol for one person's medicine to be taken on an 'as required' basis did not have sufficient detail so staff would know when it should be administered. Following the inspection the registered manager confirmed in writing to us that the pharmacist had been contacted to correct the error on the MAR regarding the 'as required' medicine and that the protocol guidance for the use of 'as required' medicines was being reviewed.

Checks were made by suitably qualified persons of equipment such as the passenger lift, gas heating, electrical wiring, hoists, wheelchairs, the call points, fire safety equipment and alarms and electrical

appliances as well as checks regarding the prevention of Legionella. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. First floor windows had restrictors on them to prevent people from falling out. Temperature controls were in place to prevent any possible scalding from hot water, and the temperature of water was checked each month. Radiators had covers on them to prevent any possible burns to people. Call points were installed in each person's room so they could summon help from staff. People said staff responded quickly when they used this facility. We noted the call point lead was removed in one person's room so the person would have to activate by getting up from their chair and walking to the call point. This was raised with the registered manager and following the inspection the registered manager confirmed the lead was put back in place so it could be accessed by the person when they were sat in their chair.

The service employed cleaning staff who we observed vacuuming floors throughout the visit. A relative said the service was generally clean and that bedrooms were cleaned frequently and staff were always vacuuming, but also commented that the floors were not always clean and there were occasional odours caused by urinary incontinence. One relative also said they considered some areas of carpet needed to be replaced. The service was found to be generally clean, which included people's rooms and the communal areas. However, we observed food on the floor in several communal areas such as a dining room and in the lounge, but we also observed staff continually cleaning. There were slight odours caused by urinary incontinence in hallways. These shortcomings in keeping the environment clean and odour free were discussed with the registered manager and provider who stated they were aware of the need to continually check the environment regarding this. This was an area for further improvement.

Good

Is the service effective?

Our findings

People and their relatives described the staff as skilled in working with people. For example, one relative said, "All the staff never cease to amaze me with their skills." A comment was also made by a relative that staff had skills in supporting people with behaviours which may challenge had resulted in people experiencing less distress. Another relative described the registered manager and staff as dedicated in their work. Relatives and people described the food as "very good" and one person said how much they liked the cakes and desserts. Relatives described how people were supported with their health care needs and that staff were vigilant in contacting them if there were any concerns or changes to people's health or care needs. One relative added that staff had a thorough knowledge of people's changing needs and were always able to update them with full details of any developments.

Staff received training, supervision and appraisal of their work in order that they had the skills and knowledge to look after people well. Newly appointed staff received an induction training programme to prepare for work at the service. A member of staff who recently started work at the service described how their induction consisted of working with more experienced staff in a 'shadowing' role to observe how to look after people. There was an induction procedure and staff were supplied with a Staff Handbook which included key information about the service's policies and procedures.

The provider had its own training officer to organise and provide training for staff. We spoke to this staff member who was motivated to ensure staff had the knowledge and skills to be effective in their work. The registered manager maintained a spreadsheet record of staff training in courses considered mandatory to provide effective care and when staff had completed these. This allowed the registered manager to monitor this training and to check when it needed to be updated. These courses included managing conflict, infection control, moving and handling, fire safety, first aid and equality and diversity. Training consisted of distance learning courses via a local college, on line training and face to face courses or instruction. Moving and handling training was carried out by the registered manager who confirmed she was trained to provide this training. Records showed this training consisted of a theory part and a practical assessment. Each staff member had a folder with details of their training and supervision which showed staff had completed additional training to that on the spreadsheet such dementia care, dignity and respect, and communication.

The registered manager confirmed staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. The provider confirmed 14 of the 21 staff were trained to NVQ level 2, 3 or 4. The manager was trained to NVQ level 5. Three kitchen staff were trained to NVQ level 2 and one of the housekeepers also to level 2. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Therefore staff were supported to achieve further qualifications to enhance their skills and knowledge.

Staff told us they received regular supervision and appraisal of their work. We saw records of staff supervision sessions as well as appraisals which showed staff performance was monitored and

arrangements put in place to support staff to improve in certain areas if this was needed. For example, one staff member had a 'facilitation skills development plan' to address areas of performance identified as needing to be improved. Staff said they were able to suggest relevant training courses which would enhance their skills. Staff said the standard of training was good and it helped them to develop their skills. Staff were motivated to improve their skill level by completing training. A health care professional considered the staff as competent and skilled in care work but added there was the occasional communication issue between some staff and people due to language differences as English was not the first language for some staff.

The service had a menu plan which showed varied, nutritious and balanced meals. People were offered a choice of food and were asked in advance what they wanted to eat which was recorded for the kitchen staff to follow. We observed the lunch when it was noted people had different meals according to their choice. Staff gave people assistance to eat by either encouragement or by assisting them to eat. Some people ate independently and this was respected by staff.

People's nutritional needs were assessed using a malnutrition universal screening tool (MUST). This is an assessment tool which identifies if people are at risk of malnutrition and if a referral is needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). A relative said how the registered manager had made appropriate referrals regarding any dietary needs. A health care professional said the staff were skilled in ensuring people were well hydrated by checking people had enough to drink and providing foods with high water content such as jelly. We saw people had access to drinks including in their rooms. One person said how they always had drink in their room and we observed staff encouraging people to drink. The registered manager confirmed none of the people at the service had any special dietary needs such as pureed food.

Care records showed people's health care needs were monitored by staff and arrangements made for health care checks and treatment. These included eye sight checks, dental treatment and health checks with a GP. Records also showed medical attention and advice was sought from GPs and health care professionals. For example, a record showed staff were aware of one person experiencing pain which was referred to the GP and resulted in additional treatment for the person. A relative described the staff as "very proactive" in seeking appropriate health care and another relative said how the staff worked well with the local mental health team regarding care needs for those living with dementia. Each person had a document called a 'Care Passport,' which included a medical history of the person to accompany the person to hospital so hospital staff and paramedics had relevant information. Care records included guidance about the management of people's diabetes and what were the safe ranges of blood sugar levels; this did not, however, include action staff should take if the blood sugar readings were outside of the safe range, such as when to contact medical services. The registered manager said she and staff would know to contact the GP and agreed this should be recorded.

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 be 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person at the home was subject a 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 were being met. There was some inconsistency and

lack of clarity regarding whether those without capacity to consent to care and treatment had this assessed in line with MCA and the Code of Practice. The registered manager told us people's capacity to consent to care and treatment was assessed using a 'toolkit' devised by a local authority. However, assessments of capacity were not available for two people whom the registered manager had applied for a DoLS for. Copies of these were forwarded to us after the inspection but were dated 26/01/16after the inspection. We discussed the importance of ensuring an assessment of capacity being carried out in order to determine if a DoLS application was needed. The registered manager maintained a list of those people who had a DoLS application to restrict their liberty; this had been done for all of the people accommodated at the service with the exception one person whose application had been authorised.

Relatives informed us they attended best interests meetings regarding decisions which needed to be made on behalf of those who lacked capacity to make decisions themselves. A relative told us how the meetings involved a range of professionals as well as themselves.

Records showed staff were trained in the MCA and DoLS. Staff were aware of the principles of the MCA and DoLS and were able to tell us what the legislation was used for. Staff were observed to follow the principles of the MCA by offering choices to people and consulting people before they provided care to them.

Good

Is the service caring?

Our findings

People and their relatives described the staff as kind, approachable and supportive. One relative, for example said, "The staff are very natural and very caring." Another relative said of the staff, "They have blown me away. They are mindful of family members and skilled in supporting families. The staff are kind, treat people with dignity, are open to discussion in a family atmosphere." People were also very positive about the approach of staff. For example, one person said of the staff. "They are all darlings. They are excellent." Another person said, "Anything you want they get for you. I'm looked after well."

Staff were observed to treat people with kindness and compassion as well as being patient with people. We spent time observing staff with people in the lounge and a dining room. The staff made eye contact with people and crouched down so people could see them rather than standing over them. Staff were aware of people's needs and preferences and spoke to them calmly. People were asked by staff how they wanted to be supported. We observed the registered manager and a staff member assisting a person with dementia; this was done with patience and skill which took time after which the person became alert and engaged with the staff by laughing and smiling.

Care plans included details about people's mental health needs so staff had information on how to support people appropriately. A relative said how the staff engaged with people in a skilled way which had resulted in a marked reduction in disturbed behaviour due to dementia, adding, "The staff are good at dealing with behaviour. They understand mental health needs very very well and are understanding. My (relative) is now content and settled." Staff were observed paying attention to people who were either unsettled or agitated to reassure them.

Care plans were personalised to reflect people's preferred routines and choices, such as activities people could do themselves to maintain their independence. We saw how guidance was recorded in care plans about the actions people could themselves regarding personal care and the exact support staff needed to give. People also confirmed they were able to choose how they spent their time and a relative said how staff took account of people's wishes.

Staff demonstrated values of compassion and said they provided care based on people's needs, and treated people in the same way they would treat a member of their own family. For example, one staff member said they made sure they promoted people's dignity and privacy and paid attention to people's emotional needs. Another staff member said, "It's their home. We are working in their home. We try to fulfil their lives as much as possible to meet their needs." Staff were trained in equality and diversity as well as communication and the Provider Information Return stated staff performance was monitored to ensure people were treated with dignity and respect. We could see this was done through the supervision and appraisal process and by new staff shadowing experienced staff.

People's privacy was promoted by the staff. We observed staff knocking and waiting before entering people's bedrooms. We noted there was no privacy lock on a bathroom door which the registered manager said would be attended to. The registered manager said most people would be unable to use a key to their

bedroom door due to their dementia. However, there was no system to check if people wished to have this facility such as at the time they moved in. Likewise, whilst the registered manger said one person had made a wish regarding a preference to receive care from either a male or female care staff member, but this was not checked as a routine when people moved in. Whilst there were no issues raised by people or relatives about possible locks on bedroom doors or the gender of the staff who provided care, this was raised with the registered manager and provider as important considerations to ensure people's privacy and choice were always promoted.

Relatives said they were always made to feel welcome by staff when they visited people. There was an information notice board specifically for relatives, which included the service's confidentiality policy, people's rights, local advocacy services and the safeguarding policy. Relatives said they felt supported by the staff which they said helped them deal with the emotional impact of having their relative in care.

Good

Is the service responsive?

Our findings

People said they were satisfied with the standard of care they received and that care reflected their preferences. For example, one person said, "I'm looked after well," and another person said how they were able to get up and go to bed at times of their choosing. Relatives said people were looked after well and that the staff and the registered manager kept them updated of any changes in care or health needs. Relatives also said they attended care reviews and were able to contribute to these. Relatives said staff listened and acted on what they said and took account of people's wishes. People and relatives confirmed there were organised activities. For example, one person said how they enjoyed board games and another person said, "I like the outings in the summer."

Each person's needs were assessed at the time they moved into the home. These included assessments of personal care, mobility, continence, sleep patterns, mental state, skin care, health care needs and an assessment of activities the person would be interested in. Relatives confirmed they were involved and consulted in this assessment process which took account of people's wishes. Care plans were based on the results of the assessments of need. Information from agencies such as social services and health care services such as specialist care assessments and care plans were included with care records so staff knew about people's needs. Care records showed care needs were regularly reviewed and updated which relatives said they were also involved in. The provider confirmed in the PIR that staff worked with other agencies such as the dementia crisis team and the community nurses to help ensure people were appropriately supported.

A health care professional stated that people were, "Looked after extremely well," and that people were always well groomed such as having regular hairdressing and that people had access to activities such as music sessions.

The service employed two activities coordinators who arranged activities for people such as board games, music sessions, dancing and day trips. The registered manager described how activities were provided based on what people wished to do. There was a notice board of the activities programme for the week ahead. A separate notice board was used to help people living with dementia orientate themselves by including information such as the day and date. People were observed sitting together and chatting. In one of the lounges people chatted, joked, laughed and had fun playing a soft ball game. This helped ensure people's social and recreational needs were met and that people were not isolated.

The service had a complaints procedure which was displayed in the hall so people and relatives knew what to do if they had any concerns. Relatives said the staff and registered manager were receptive to any suggestions or issues they raised. There was a record of any complaints made and the service had received one complaint in the last 12 months. This had been investigated and there was a record of this along with an action plan of how the outcomes of this were being addressed. There was also a record of feedback to the complainant of the outcome of the investigation to keep them informed.

A record of compliments made to the service was also maintained and these included positive remarks

about the standard of care and the way people were treated with respect.

Good

Is the service well-led?

Our findings

People and their relatives were complimentary about the attitude and commitment of the registered manager. For example, one relative described the registered manager as approachable and that they felt able to raise any issues or concerns with her, which were acted on. Relatives commented that the registered manager's commitment to the running of the service was reflected in her availability in the home at weekends as well as the week.

People and relatives told us their views were sought about the standard of care either by being asked at care reviews or via satisfaction survey questionnaires. Survey questionnaires had been completed by relatives and staff which were part of the provider's quality assurance process to plan for any improvements. Copies of the quality assurance questionnaires showed relatives were satisfied with the standard of care and considered people were always treated with dignity and respect.

Relatives and people were encouraged to get involved in the way the service ran, such as people being consulted about meals, activities and any redecoration. There was a notice board for relatives, which included details about the service's improvement plan as well as people's rights. Relatives' meetings took place and were recorded; these showed relatives were consulted and their views sought regarding activities for people and any other subjects they wished to raise.

the registered manager and staff had values which promoted the safety and rights of people and demonstrated they were committed to promoting people's welfare.

The staff and registered manager were supported by the provider's training officer and a 'quality assurance compliance officer' who were both present during the inspection and explained their role in terms ensuring staff were suitably trained and the service delivery was monitored.
Regulation 20, Duty of Candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 specifies providers must act in an open and transparent way and must notify relevant people about any incident which must be looked into, investigated and responded to with an apology if applicable. The provider stated in their PIR, 'We are confident that we already exercise a duty of candour.'

There was a registered manger and the staff team had a line management system of a deputy manager and senior care staff to help ensure there was a structure of leadership and decision making. Staff told us they felt supported in their work and they felt able to raise any issues they had with the registered manager. Regular staff meetings were held, which staff said allowed them to discuss people's care needs and any other issues they had. For example, one staff member said, "Staff can contribute to what is happening. The manager really helps us." Another staff member said how they were able to make suggestions at team meetings which were "taken up." Other staff also said they were able to contribute to decision making in the service. Staff and management staff had access to relevant training courses. This demonstrated there was support for staff and a culture which was open to learning and improvement.

The provider and registered manager checked the quality and safety of the service in a number of ways.

These included a monthly audit visit by the provider which was recorded as a report. Copies of these were available and showed checks were made regarding staff levels, staff supervision, staff records and staff competencies. There was also a monthly management checklist regarding safety of equipment and the building. Where any defects were identified there was an action plan to show how they were addressed. Annual audits were carried out and covered safety in the home, medicines management, how complaints were handled and risk assessments. Records showed incidents were looked into and changes made so lessons were learned.

The provider confirmed there had links with organisations both locally and nationally regarding updates to policies and procedures for their care of people with dementia, such as the social care for excellence, 'Culture for care: your toolkit.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. Regulation 12 (1)