The Orders Of St. John Care Trust

Monkscroft Care Centre

Inspection report

Shelley Road
Cheltenham
Gloucestershire
GL51 7DP

Tel: 01242505010
Website: www.osjct.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 22 December 2015 and was unannounced. Monkscroft Care Centre provides accommodation for 80 people who require personal care with nursing.

There were 76 people were living in the home at the time of our inspection. Monkscroft Care Centre is set over two floors and divided into four units known as households in the home. Each household has a small kitchen and adjacent dining room and a variety of lounges and quite areas to sit in. Each household had acess to a secured outdoor space. The home had a shop, cinema and hairdressers. People could also use the hobbies, music and sensory room.

A registered manager was in place as required by their conditions of registration. 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 delivered compassionate care which was focused on people's individual needs. They were knowledgeable about people's wishes and preferred way to be supported. Staff respected people's decisions and provided support when requested. Both people and their relatives complimented the caring nature of staff. We received many positive comments about the home. A wide range of activities were provided for people in and out of the home. People were encouraged to partake in activities. The home explored different opportunities for people to engage in activities to enhance their well-being. People from the local community had been invited into the home. People enjoyed the meals and food provided. Their dietary needs and preferences were catered for.

People's care records reflected their physical and emotional needs. They provided staff with information and guidance about people's support requirements and wishes. People were supported to maintain their health and well-being and access additional care and treatment from other health care services when needed. Their medicines were managed and administered appropriately. However records of when people had received medicinal creams applied to their skin was not always consistently completed.

Staff had been suitably recruited and trained to carry out their role. Their skills and knowledge were checked to ensure they had the skills to carry out their roles. The staff were supported by the teams in their households and senior staff

The home was well-led. The registered manager had a good understanding of their role and how to manage the quality of the care provided to people. Quality monitoring systems were in place to check and address any shortfalls in the service. Where concerns had been raised by people and their relatives these had been addressed immediately. There were sufficient numbers of staff to ensure people's needs were being met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected by safe and appropriate systems in handling and administrating their medicines.

People and their relatives were positive about the care they received and felt safe. Staff understood their responsibilities in reporting any allegations or incidents of abuse.

People's risks and safety were assessed and managed to protect people from harm.

Effective recruitment procedures were in place to ensure people were being supported by suitable staff.

Is the service effective?

Good

The service was effective.

People were involved in making decisions about their care and support.

When people's needs had changed they were referred to the appropriate health and social care professional. People's dietary needs and preferences were met and recorded.

Staff were supported and trained to ensure their skills and knowledge was current and met people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives highly praised the staff. Staff were kind and compassionate to the people they cared for. They treated people individually and with dignity.

People were encouraged to remain independent and express their views.

Is the service responsive?

Good

The service was responsive

People had a purpose to their day. A range of activities provided people with recreational and social stimulation. Where possible, activities were provided to meet people's personal interests. The home had formed good links with the local community.

People received care and support which was focused on their individual needs and wishes. Their care records were detailed which provided staff with guidance on how they preferred to be supported.

Is the service well-led?

Good

The service was well- led.

People and their relatives spoke highly of the staff and the registered manager. Staff felt supported by the provider and registered manager. The culture of the home was fair and open.

The quality of care was being regularly monitored and checked.

Monkscroft Care Centre

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 22 December 2015 and was unannounced. The inspection team consisted of a lead inspector, two other inspectors 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. The expert had experience and knowledge of caring for older people.

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 improvements they plan to make. We also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

We spent time walking around the home and observing how staff interacted with people. 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 with us.

We spoke with six people, three relatives, six members of staff and the registered manager. We looked at the care records of eight people. We looked at two staff files including recruitment procedures, as well as the training and development of all staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Good

Is the service safe?

Our findings

People's medicines were managed safely. Effective systems were in place to ensure people's medicines were ordered, stored, administered and recorded. Medicines were stored securely and storage temperatures were monitored and recorded daily. One care leader who was responsible for managing people's medicines on their household said, "We have a good relationship with the pharmacist. They respond well when the residents are prescribed new medicines and we get them quite quickly". When people had received their medicines, this had been recorded accurately on their medicines records.

The majority of people who required medicines when needed, such as for pain relief, had protocols in place to guide staff. However for some people protocols were not in place. This was raised with the registered manager who immediately requested that the nurses' reviewed everyone's medicines records and completed any missing documents. We also found that records and body maps of where people required medicinal creams for their skin conditions were not always consistently completed.

People were administered their medicines by qualified nurses or staff who had been trained in the management and administration of people's medicines. This system was dependent on people's medical need and the complexity of their medicines. We observed one care leader administering people their medicines competently and appropriately during the lunchtime period. They said, "We are trained to do this. We have to pass a series of competency assessments before we can be signed off as being good enough to give residents their medication. The nurses are always on hand to ask if we have any problems".

Most people and their relatives said they felt there was enough staff to meet people's needs. One relative said "Staffing at lunch time can be a bit rushed and means that some people have to wait for quite a long time to go the loo". People were generally happy about how quickly staff responded to the call bells; however one person told us they sometimes had to wait for staff longer at nights. They said, "I don't have any trouble with the staff. Sometimes at nights they take a while, maybe 10 minutes".

One member of staff had been designated to manage the staffing levels and rotas in the home. They had a good relationship with staff and knew who to contact if short notice cover was required. Gaps on the rota were filled with staff wanting to do some extra work. Staff confirmed that the levels of staff were mostly consistent. One staff member said, "We can be busy if someone is off sick but most of the time it is ok". The registered manager told us the agency cover was minimal. The home was recruiting more staff including a clinical lead. Some staff were acting up in their role and had been given additional hours to address the shortfalls in senior staff. The registered manager said, "We are recruiting and have interviewed several people but I will only accept suitable candidates. They have to be right for the home and the residents here".

People's personal risks had been identified, recorded and were mainly managed well in the home such as if they were at risk of falling, losing weight or allergies. For example, when people had lost weight, there was recorded evidence that staff had responded quickly and put actions into place to support them such as contacting their GP and monitoring the food intake.

People who were known to be at risk of falls were monitored. Their care records described the measures in place to manage and minimise these risks which were reviewed on a regular basis.
For example, the care records of one person who was at risk of falls stated they should be offered a wheelchair if required and to keep the corridors free of clutter to help reduce their risk of falls. However the records of one person did not always reflect the possible cause of their falls. This person was known to experience frequent falls but it was not clear from their records whether they had fallen due to their seizures or their limited mobility. This meant staff were not clear on the cause of the falls and actions to take to help prevent further falls.

Staff understood people's risks and how they should be managed to reduce the risk of harm. We observed staff monitoring people and offering support if required. Staff respected the decision when people refused their support but monitored them from a distance. Some people required additional support with their pressure areas to reduce the risk of pressure sores. Pressure relieving equipment such as air mattresses were being used effectively to protect people's skin and their pressure areas where regularly monitored.

Effective recruitment processes were in place to ensure that people were cared for by suitable staff. Checks on staff's previous employment history, references and criminal records had taken place. One staff file showed there was an inadequate documenting of one required check; however the registered manager took this on board and agreed to make the necessary amendments.

People were protected from abuse and harm. Staff had been provided with training on how to recognise and report allegations and incidents of abuse and had access to the provider's company policy and procedures on safeguarding people. All staff demonstrated a good understanding of the homes' safeguarding policy and processes. They knew who to go to with any concerns both within and outside of the service. One member of staff said "I know where to go if I have any concerns".
Concerns relating to safeguarding people were shared with other agencies that had a responsibility to safeguard people.

Good

Is the service effective?

Our findings

People were supported to maintain a healthy and well balanced diet. People were generally happy with the meals they received. We received comments such as, "It's not too bad"; "It's very good. It's one of my favourites today (curry and rice). We get a choice of cereals for breakfast, or we can have a cooked breakfast" and "I'm pretty awkward to cater for. I'm a very choosy eater. It was chicken curry today, not my cup of tea but there's always an alternative. I had cheese omelette today".

Staff knew people's preferences and choices in their meals. On the day of our inspection, we found people on different households had different dining experiences during the lunchtime period. On two of the households, people were given their meals in a respectful and timely manner. Whilst on another household, the delivery of people's meals was fragmented. Some people waited for nearly 45 minutes before they were served the food they had requested. Some people were not supported adequately during the lunch period. One person supported another person with their meal and then became a little agitated with them. Staff did not appear to be aware of this disagreement between them. Another person sat with their meal in front of them untouched for 15 minutes before staff assisted them. This was raised with the care leader of the household and registered manager who both stated that this unusual and would address this with staff immediately.

The head cook showed us the records about people's dietary needs and preferences that were held in the kitchen. Information included people's food allergies, special diets such as pureed and gluten free diets. They explained how they provided people with extra calories if they had been identified as losing weight. The menu changed four times a year and reflected seasonal foods and people's suggestions. The head cook attended resident's meetings and spoke to people individually about their preferred food. They said, "We try our best to accommodate the resident's meal choices even those who are more fussy with their food likes". Kitchen staff had kept up to date in their training relating to food hygiene and nutrition. They had attended courses about understanding the importance of the presentation of food with people with dementia. They said "It is important that people's senses are stimulated with food which smells good, looks good and with different textures".

People's weights were regularly monitored. Where people had lost weight, their care records provided staff with the possible reasons why they were not eating and also details on how to support them eating or increasing calories in their diet. This information was shared with the kitchen staff so they could produce meals and snacks which had been boosted with additional calories. As a result, records showed people had regained some weight or they had been referred to other health care professionals for additional advice. For example, one person had been reviewed by a speech and language therapist (SALT) to ensure they received a suitable diet to help them maintain an ideal weight.

People were supported to access a variety of health and social care services as required. Their health and well-being were regularly monitored. People had been to the dentist, opticians and chiropodist when required. Staff had maintained contact with specialist health care professionals. Where people's needs had changed the service had made appropriate referrals to other health and social care professionals for advice

and support. Health care professionals spoke highly of the care and support people received in the home. One health care professional said, "The staff are very responsive to my suggestions and will always contact me if they have any concerns".

Staff were proactive in respecting people's human rights and gained their consent before they delivered care to people. People were encouraged and supported to make decisions about their care. Their preferences and wishes were respected. Staff knew how to communicate with people who had limited communication skills to ensure they had gained their consent lawfully before providing personal care.

The mental capacity of people with cognitive impairments or short term memory problems had been assessed as in line with the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Best interest decisions involving significant others and health care professional had been carried out where people lacked the capacity to make specific decisions about their care and support. For example, a best interest decision had been made for staff to control the levels of alcohol consumption for one person, as they would not be aware of the safe levels of alcohol consumption. Where significant others had been given lasting power of attorney of people's health and welfare and finances, this had been documented and known by senior staff. A document which summarised which best interest decisions had been made about people's personal care was being implemented. This gave staff an overview of these decisions such as the agreed best interest decision on how a person's pain relief should be managed.

We checked whether the service was working within the principles of the MCA and whether any condition on authorisations to deprive a person of their liberty were being met. People can only be deprived of their liberty to receive care and treatment when this 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). Documents showed that where people needed to be deprived of their liberty and constantly supervised; the registered manager had applied for authorisation to do this.

The registered manager and staff were knowledgeable about their responsibilities in restricting people in the least possible way. For example, after consideration, it was decided to unlock the main doors of the households which supported people who live with dementia for a few hours per day. This meant people had the freedom to move around the home and not be restricted to their household.

People were cared for by staff who had been trained to carry out their role. Two members of staff had been given the additional responsibility to overview and monitor the training of staff to ensure their knowledge and skills were kept up to date. An induction programme was in place for new staff to be introduced in to their role and understand their responsibilities within the home. This consisted of shadowing an experienced colleague, initial training and reading people's care plans and the home's policies and protocols.

New staff were also expected to complete and read a 'Care Induction passport' which gave them information about their role, their training requirements and further information. This ensured all new staff delivered the standard care as required by the provider. New staff or staff who were required to refresh their knowledge were also required to complete additional workbooks which assessed their knowledge and

competency to carry out their role. The provider also had training assessors who visited the company's homes to provide additional training support and observe staff carrying out their role.

Staff felt they had received adequate training to equip them to do their job well. They had received training as deemed as mandatory by the provider such as manual handling and fire safety. Staff had also received additional courses such as dementia awareness. One health care professional told us they had delivered specialist training to staff as requested by the registered manager. The provider supported the qualified nurses to keep up to date with their skills and practices. A nurse told us the provider had been supportive of their need to revalidate their qualifications and was confident that the study days and training they had attended would be sufficient for revalidation.

Staff told us they felt supported and could seek advice and support from any senior member of staff. Most staff had received regular individual support meetings in line with the provider's requirements however this had not always been recorded. The registered manager was aware of the staff who hadn't received regular formal support meetings and had delegated some of this responsibility to senior member of staff. We were told that meetings were being arranged for those staff who worked at night or infrequently within their shift times.

Good

Is the service caring?

Our findings

People received care and support from staff who knew and understood their history, likes, preferences, needs, hopes and goals. The relationships between staff and people receiving support consistently demonstrated dignity and respect at all times. Staff knew, understood and responded to each person's diverse needs in a caring and compassionate way. We observed staff interacting with people in a warm and friendly manner. They chatted to people about their day or discussed their personal interest with them. We saw a staff member pushing a person in their wheelchair down the corridor; they were both singing Christmas carols and talking about the Christmas decorations in the home. Staff were responsive and attentive to people's wishes. One staff member asked a person if they would like a drink; they declined and the staff member replied "Just ask when you do and I'll get you one".

People were supported by carers who were kind and passionate about supporting people to have a good quality of life. We received positive comments from people about the care they received. Comments such as; "I'm very pleased with it (the home). The place is nice and the staff are very helpful" and "Here they help me in every way possible. Everything's sorted out for me".

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. Relatives were welcomed in the home. They told us they were pleased with the care their loved ones received and always invited to be involved in any of the events in the home. One relative said, "I'm absolutely happy with the care. It's very, very good. They bend over backwards to resolve any issues and make my relative as comfortable as possible. I've no qualms at all".

Health care professionals spoke highly about the manner of staff. One health care professional told us "The staff are definitely caring. They are focused on people's needs. They treat people individually. They are very good". Another said "I have found the staff to be very caring towards people in their care, specifically the people I have been involved with".

People's bedrooms had been personalised to their taste, although one person thought theirs was a bit plain. The home had décor and facilities which indicated that the staff had a good understanding of providing an environment which supported and orientated people. Items and pictures of interest were displayed on the walls. People had been involved in the making and putting up of some of the Christmas decorations.

Staff respected people's privacy and dignity. They knocked on people's bedrooms doors and waited for a response before entering people's bedrooms. People were dressed to their liking; they told us they were always asked what they would like to wear. Their preferred personal hygiene and grooming standards were documented and adhered to. We saw that one person had painted and groomed finger nails which was stated in their care plan.

People could choose where they spent their day. One person said, "I've got freedom. If I want to go out, I can go out. If I want the TV on, I can have it on. I spend a lot of time in my room. I've got my TV and radio. Sometimes I go down to the lounge. I know the people there". We saw strong friendship bonds between

people. Staff knew who people like to sit with or avoid. People were informed if other people in their household had passed away. One staff member explained that "It's not hidden from them". They told us that people were supported to 'pay their respects' if they wished.

People's care records guided staff on how they should communicate and approach people. For example, one person's records stated 'speak clearly and don't mumble'. This person's care records also reminded staff to help them to clean their glasses and have the light on so they could read their newspaper. This showed that the detail of people's care and wishes were valued. Whilst we didn't observe this person during our inspection, we saw that staff were knowledgeable about the specific needs of others.

Good

Is the service responsive?

Our findings

People had a sense of belonging and meaningful purpose to their day. Their care records reflected their interests and recreational preferences. The ethos of the home was to focus on people's well-being and happiness. One staff member said, "We are always trying to find ways on how we can improve and to make sure the residents have a good day". One person's care records stated that they liked to feel helpful. We observed this person enjoying dusting and chatting to staff and showing visitors around the household. The notice boards at the entrance of each household provided people and their relatives with information about advocacy support and dementia as well as photographs of people enjoying a variety of activities such as visiting a garden centre. People's sensory and recreational needs where being met in the households which supported people who live with dementia. There were items of interest for people to pick up and investigate or use. Secured tactile items were fixed to the walls for people to touch and explore.

The home had two designated activity coordinators. A weekly activities programme gave people the opportunity to engage in meaningful activities. They benefited from a range of activities which they could be involved in, such as the film, gardening or knitting club. They were able to choose what activities they took part in and suggest others they would like to complete. People and their relatives were very positive about the recreational activities in the home. Photographs on the walls showed their involvement and achievements. In addition to group activities people were able to maintain their own hobbies and interests. The activities coordinator and staff had thought of innovative ideas on how to fulfil people's personal interests and aspirations. For example, the activities coordinator had applied for funding so one person who had an interest in cars could experience a 'Supercar Day'.

People were very positive about the activities provided in the home. One person said, "There is lots to do, we are kept very busy". Another person who was listening to classical music on the radio said, "I feel safe and sound in here. I have a lovely view from my window and I listen to my music, I like classical music". A relative also said "They put on a lot of things on for the residents and they join in. If there's any expression or suggestion of what could be done to stimulate them, they put it on".

People had easy access to a secured outside area either in the garden or on a large balcony. They were encouraged to visit and be involved in the garden which had raised beds, rabbits and chickens. The home had a shop which people could purchase small items such as toiletries. Produce from the garden was sold in the shop. People could use the home's hairdresser/barber or alternatively use their own. The cinema room allowed people the opportunity to watch films of their choice. A music room and sensory room were available for people and their relatives to use at any time. We were told that these rooms had huge benefits to people and were often used an alternative for of stimulation or relaxation for people.

The home and staff had formed links with local people who lived in the community. People told us they enjoyed having visitors in the home. One person said, "I love to see the children. It makes me happy inside". People and staff told us about their trips in the community, such as visits to the local library, church and also trips to the local rugby ground, villages and garden centres. People from the local community were regularly invited into the home. For example, members from a mother and toddler group and local school children

had visited the home to spend time with people who lived in the home. People who live nearby were invited to the home for weekly coffee mornings.

The home had recently engaged in a six week projected called 'Move it or lose it' with an occupational therapy and physiotherapy student from Worcester University. The students had devised and implemented an exercise programme designed to improve people's mobility, stability and mood. The students were monitoring people's progress and the impact on their well-being. They had also worked with people who were nursed in their bed. A staff member said "There was little they could do with them, but they did and this attention made the people feel more valued".
People and staff were positive about the programme. Staff had been trained to continue to deliver the exercise programme. One person said, "We do quite a lot of exercises. We've had physiotherapy students for 6 weeks. They've gone now but this morning the carers got us together and said let's have an exercise session, which we did". One staff member told us about the improvement of one person's range of movement in their arms.

Each household was provided with an activities folder for the staff. This gave staff suggestions of quick activities which they could provide throughout the day such as a walk in the garden or hand massage.

People and their families had been involved in their assessment of needs to ensure the home was suitable for them. They told us they had received personalised care which was responsive to their needs. People's care records reflected how they would like to receive their care, treatment and support. Their care records were very detailed and provided staff with lots of guidance on their preferred routine and wishes such as having their slippers by their bed or a light on at night. Details about their family and personal histories were also recorded. Most people had a 'cloud picture' which gave staff a quick reference to people's likes, dislikes and preferences; for example, 'I like roast dinners'. People's choices were valued, for example one person preferred not to wear their hearing aids which was respected. Their care records reflected this and how this person preferred to communicate.

People's needs were reviewed regularly, or as required when staff had recognised when people's needs had changed. Their well-being and health was regularly being monitored and where necessary, health and social care professionals were involved. One visiting health care professional was positive about the care being provided. They said "We have a good relationship with the home. They always contact us in time and are very responsive to our recommendations".
Handover information between staff at the start of each shift ensured that important information about people was known, acted upon where necessary and recorded to ensure people's progress was monitored.

People received care from staff who were committed and passionate about the care they delivered. One staff member said, "Staff here show such care and attention, people's needs are always met". The registered manager ensured that people were supported by a dedicated core of staff which enabled good continuity of care. The service had a dementia lead with an obvious passion and commitment to their role. They had recently completed a dementia lead award and said "I really like to make a difference even though it is sometimes difficult with people living with dementia. But if you see a person arriving at the home who is anxious and then you help to reduce that anxiety so that they are happy that makes me happy". The home also had access to an admiral nurse who could be called on to provide more specialist advice about supporting people with dementia. We observed Staff responding well to people who had different communication abilities. They adapted their approach to ensure that people could understand and converse with them. People's communication and sensory impairments such as hearing and visual impairments were recorded to provide staff with guidance on people's ability to communicate.

Further guidance was in place to support people who had additional emotional needs. For example, the care records of one person recognised that they were younger than the majority of the other people in the household and the support they may require. Staff described people positively and the support they required. They showed a good understanding of the triggers which may cause some people's anxiety and how they should be supported. For example, staff told us how they supported people if they became agitated such as distracting them with items of personal interest. We were told people responded well to the home's cat when they became anxious. The care records of another person who had no cognitive impairments highlighted that they lived with people who lived with dementia and how they should be supported to communicate and interact with those people around them.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People and their relatives told us they could talk to staff and the registered manager if they had any concerns about their care. A relative said, "If the care leader was here I would talk to her, she is the most responsive". Another relative said, "Very, very good. They bend over backwards to resolve any issues and make them as comfortable as possible". They could also feedback their concerns at resident and relatives meetings which were held every three months. Cards of appreciation and thanks were displayed in the households from people and their relatives.

Good

Is the service well-led?

Our findings

The home had a registered manager who had been in post since the opening of the home in 2012. They had overseen the merger of staff and people from two former homes into Monkscroft Care Centre. They told us, "Bringing the two homes together into Monkscroft has had it challenges, but we are getting there now. The residents and the staff seem happy and we are all working together as a new team". The registered manager went on to tell us they felt that the home's core value was that 'people come first'. They said that their aim was to have a happy staff group that put the residents at the heart of everything they do. Staff we spoke with also commented that people were the most important part of the home. A member of staff said "It's the residents that matter".

The registered manager was supported by the provider through regular contact with the operations manager, feedback from quality assurance audits and attendance at manager's meetings and conferences. The registered manager said that she felt well supported in her role and senior management were always available to be contacted if she had a concern or query. She continued to develop her own skills and knowledge through attendance at relevant conferences and keeping up to date with best practice through reading articles in on line sites such as the National Institute for Health and Care Excellence (NICE) and journals.

Staff told us the registered manager was approachable and always ready to listen to and discuss ideas about how to improve the service. A member of staff said "I know I can speak to her at any time. If I have a problem I just speak to her". Another member of staff complimented the registered manager's leadership skills and how they develop the staff. They said "It's unusual to get people in key roles who work so well together. People here work together in a very professional constructive way. If there's a good person at the top, then it filters down". They went on to say "The Manager is very good at getting the best out of people, just because someone's a carer, they may have a different skill set at home but the Manager brings that into the home." Minutes of staff meetings demonstrated that staff were kept informed of developments and were able to provide their own feedback. For example, staff had the idea of developing a 'walking pathway' in one of the households for people living with dementia. This would be a series of pictures and objects through the corridor designed to emulate specific landscapes. This had been agreed and staff were beginning the process of developing this idea.

Communication was also supported by a daily meeting held between all heads of department. The head of departments shared any issues that needed to be resolved such as faulty equipment or changes to the home that may have an impact for example new people coming to live at the home. There was also a communication book where staff shared further relevant information for the smooth running of the home.

Minutes from residents and relatives meetings showed that they were also involved in the development of the service. For example the home's sensory room was a result of feedback from staff and residents. People's views about the service were also sought through comments cards available in the foyer. People and those important to them could give feedback on-line or by posing comments to carehome.co.uk. A sample of reviews looked at from this online site evidenced that all respondents thought the home was

excellent.

The home had only one complaint for 2015 which had been investigated and managed appropriately. People, relatives and staff all knew how to make a complaint and information about this was on notice boards and in people's rooms in their handbook. All of the feedback from relatives and people living at the home was very positive with a significant number of compliment and thank you cards seen.

Staff demonstrated a clear awareness and understanding of whistleblowing procedures within the provider's organisation and where outside agencies should be contacted with concerns. Information about whistleblowing was available in the staff handbook and discussed at their induction. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

The quality of care in the home was checked regularly through a variety of quality assurance audits. For example the provider, via their quality team, undertook an annual audit to ensure the service was compliant with CQC regulatory requirements. Regular audits were also undertaken for areas such as infection control, pharmacy and medicine management. Accident and incident data was also provided to the registered manager on a monthly basis. The registered manager said that she used this data to identify any areas or patterns of concerns. For example a person living in the home who had a sudden spate of falls was identified and an action plan put in place to keep the person as safe as possible. The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been notified of these events when they occurred.

There was some evidence that any shortfalls identified in the audits were actioned. For example an issue was raised in an audit around the lack of décor in the bathrooms and it could be seen from viewing the bathroom that some action had been taken to remedy this. However actions taken were not always documented. The registered manager understood that any identified areas from audit that required action should have, as a minimum, recorded evidence of whether action was taken, when and by whom. The registered manager agreed to make the necessary additions that would close the audit loop.