Daimler Green Care Home Limited

Sovereign House

Inspection report

Daimler Drive
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West Midlands
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Tel: 02476596064

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 18 January 2016 and was unannounced.

Sovereign House provides residential and nursing care for up to 60 people, who are living with dementia or have physical disabilities. The bedrooms are located across the ground, first and second floor which are accessible by stairs or elevator. The service is split into three floors; the ground floor offers residential care whilst the first and second floor offer nursing care for people with more complex needs. At the time of our inspection there were 60 people using the service.

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

The service was last inspected on 5 February 2015 when we found the provider was not meeting the required standards. We identified two breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to improve staffing arrangements and record keeping.

The provider sent us an action plan outlining how they would improve. At this inspection we checked improvements had been made. We found improvements had been made and sufficient action had been taken in response to the breaches in regulations .

People told us their care and support needs were met by staff who were knowledgeable and knew them well. Staff had undertaken training relevant to the specific needs of people who lived at the home and staff told us they were supported within their job roles.

Everyone we spoke with said they thought the home was a safe place to live and that they were well cared for. Staff had a good understanding of how to report any safeguarding concerns and how to keep people safe from avoidable harm.

The provider used a dependency tool to assess the number of staff needed and told us that staffing was provided at a level higher than the dependency tool stated. We observed that there were enough staff to meet the personal and health care needs of people and to keep them safe.

People received their medicines as prescribed and checks were undertaken to ensure they received them in a safe way.

The provider followed the principles of the Mental Capacity Act (2005). Mental capacity assessments were completed when needed and specified the nature of the decision the person was being asked to make.

When people had a Deprivation of Liberty Safeguards (DoLS) authorisation in place for continuous monitoring, it was reviewed within the specified time frame to ensure that people were not being deprived of their liberty unlawfully.

Staff ensured they maintained people's privacy and dignity and treated people with compassion and respect.

Health and safety risk assessments had been completed. Specific risk assessments had been completed about the risks associated with people's care and staff had a good understanding of the support to be provided to keep people safe. Any incidents were logged and an analysis of accidents and incidents was completed so the provider and staff could identify any trends and manage them accordingly.

There were robust recruitment procedures in place to reduce the risk of unsuitable staff being employed at the service.

People's nutritional and hydration needs were being met. People had a choice of meals which met their dietary requirements and preferences. People were supported to maintain their health and wellbeing.

People had opportunities to maintain relationships with people important to them. Group activities were provided, however people had limited opportunities to pursue their individual hobbies and interests.

People and their relatives knew how to raise complaints and were confident actions would be taken in response to these. People had opportunities to put forward their suggestions about the service provided.

There were processes to monitor the quality and safety of the service provided and actions were taken to drive improvement in the service.

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

This service was safe.

Staff were aware of how to identify and reduce risks to people. People who lived at the home told us they felt safe and there were enough staff to look after them and keep them safe. People's medicines were stored and administered safely.

Is the service effective?

Good

This service was effective.

Staff received training to ensure they had the relevant skills and knowledge to support people who lived at the home. Staff had a good understanding of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. Consent was always sought from people before providing care. People were supported to eat a nutritional diet based on their needs and preferences and people were supported to maintain their health.

Is the service caring?

Good

The service was caring.

Staff treated people in a caring way and had developed positive relationships with people who lived in the home. People or their representatives were involved in planning their treatment and support. Staff maintained people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and relatives were involved in planning how their care and support was provided. Staff knew people's individual preferences and these were taken account of.
Group activities were offered but individual activities which were tailored to people's interests and abilities were not always available. The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Good

The service was well-led.

People who lived at the home and their relatives were asked to provide feedback of the service and actions were taken in response to their feedback. Staff felt supported by the management team. Quality assurance systems were in place, which had improved aspects of the service through identifying and addressing areas of concern to drive improvement for the benefit of people who lived at the home.

Sovereign 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.

The inspection took place on 18 January 2016 and was unannounced. The inspection was undertaken by two inspectors, a Specialist Advisor and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor was a member of the inspection team who had specialist knowledge about nursing practices.

We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who contract services, and monitor the care and support when services are paid for by the local authority.

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. The information provided by the provider reflected what we found during our inspection.

We spoke with 16 people who lived at the home and spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. 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 also spoke with six relatives to gain their views about the quality of care provided.

We spoke with the deputy manager, the provider, 11 members of care and nursing staff, the cook and the maintenance worker. We reviewed five people's care records to see how their support was planned and delivered. We also spoke with three health professionals who visited the service during our inspection. The registered manager was not present on the day of our inspection however we arranged to speak with her after our visit to gain her views about the service.

We reviewed eight staff files and training records for all staff. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Good

Is the service safe?

Our findings

During our last inspection on 5 February 2015 we identified there was not enough staff available to meet people's needs safely.

This was a breach of regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

Following the inspection the provider sent us an action plan outlining how they would improve.

At this visit we saw that, overall improvements had been made. The provider told us that since our last inspection they had increased staffing levels. They told us this ensured staff greater flexibility whilst supporting people so that staff were available at the times people needed them to undertake their personal care and health care needs. The provider told us that the revised staffing levels had been determined using a dependency tool in order to calculate how many staff were needed to support people who lived at the home. They told us that they provided staffing levels ten percent over the number determined by the dependency tool.

People told us that, overall, staff were available at the times they needed them to meet their care needs. A person told us "I think there are enough [staff] but they are always very busy." Staff told us that they were now satisfied with the number of staff on duty for each shift. They also told us that staff from different floors would support each other if it was required. From our observations during the visit we saw that staff responded promptly to people's requests for assistance and call bells were answered quickly.

The registered manager told us the home did not currently have any staff vacancies and that they did not use agency staff. Staff explained that they had the option of working additional hours to cover shifts when required. This meant people received care from regular staff who knew them and understood their needs.

We asked people whether they felt safe living at the home. A person told us, "Yes I feel safe here, I have an excellent room, a great view and I have settled in very well." Many of the people who lived at the home received their care in bed; they had access to call bells which were used when they needed assistance from staff. During our visit people had no hesitation using call bells to request assistance, which showed they felt comfortable asking staff for help.

All staff we spoke with understood how to recognise the signs of abuse and their responsibilities to report safeguarding concerns. Staff told us they had received safeguarding training and a staff member told us should they suspect abuse, "I would talk to the person to reassure them it is going to be okay, then let the person in charge know ."

We spoke to another member of staff and asked them what they would do if they saw another member of staff using poor practice when moving a person who lived in the home. They told us "I would stop the member of staff straight away and make sure the person was safe. Then I would let management know." These examples showed that staff felt confident in addressing concerns and were aware of their

responsibilities to protect people from harm.

The phone number for the local safeguarding authority was displayed on a notice board in the manager's office. This meant if anyone had any concerns they could raise them with the relevant authorities.

The registered manager understood and followed safeguarding procedures. Through notifications submitted to us we were aware of how the registered manager had raised and responded to safeguarding concerns in the past 12 months. For each of these the registered manager had made referrals to external services to reduce the risk of future occurrences. This included referrals to tissue viability nurses, occupational therapists and district nurses.

Staff told us they were aware of the provider's whistle blowing policy. A staff member told us, "I would speak to my manager but if I couldn't I would phone the whistle blowing number." A whistle blower is a person who discloses any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

Risk assessments were in place for people who lived in the home and were updated monthly to reflect a person's changing needs. A risk assessment is an assessment that identifies any risks to a person's health, safety, wellbeing and ability to manage daily tasks.

Staff were aware of people's individual risks associated with their care and support and were able to describe how these were managed. For example, one person was at a risk of pressure sores due to being cared for in bed. A member of staff told us that when they completed personal care with this person, "I look for any areas of skin that have become red or damaged and I would tell the nurse so that she could make any referrals needed." The member of staff went on to tell us that they also ensured that the person was regularly repositioned in their bed to further reduce the risk of pressure sores. This was in line with instructions in the person's risk assessment which stated the person was to be repositioned every two hours.

We checked whether people's medicines were managed safely. A person told us, "I always get my tablets when I need them." We saw that medicines were stored safely and procedures were in place to ensure people received medicines as prescribed. There were regular medicine audits to ensure staff administered medicines correctly and at the right time. The provider had protocols for medicines prescribed 'as and when required', for example pain relief or medicines for people who sometimes felt anxious. These protocols gave staff clear guidance on what the medicine was prescribed for and when it should be given. Staff who administered medicines received training and a member of staff told us they had "regular observed practice" with their manager which checked their competencies to ensure they were administering medicines safely.

A member of staff spoke about their recruitment process which included an interview, references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services. This was in line with the provider's recruitment policy.

The premises were clean, tidy and decoration was in good order. We spoke to the maintenance person who told us he completed safety checks including weekly fire drills and monthly maintenance checks of hoists, slings and wheelchairs. He went on to explain that if he identified any problems he would contact the relevant engineers to correct them. These checks meant that the equipment was safe for people and staff to use .

Good

Is the service effective?

Our findings

A person who lived at the home told us, "The staff know how to look after me," and a relative told us, "I am happy, the care is very good. The nurses are good; they go by the care plan."

Staff received relevant training which gave them the skills and knowledge to effectively support people who lived at the home. Staff told us the training was useful and that it helped them deliver better care to the people who lived at the home. Staff told us they received training about dementia awareness and how to support people with dementia. One staff member stated following the training they understood that a person with dementia may develop difficulties with swallowing. They continued by saying that if they were supporting a person to eat and they began to cough a lot whilst eating they would report this to a nurse and would request that the person be referred to speech and language therapists (SALT) for further advice. This showed that the training people received gave them knowledge to identify the changing needs of people they supported and were aware of how to react to these.

When new staff were employed by the service they had an induction period and completed training that was in line with the care certificate. The Care Certificate is the minimum set of standards that should be covered as part of an induction for new care workers. Staff told us that during their induction they would shadow other members of staff in order to understand how to support people in the home.

We observed staff used correct manual handling techniques when assisting people to move from chairs to wheelchairs or in and out of bed. Staff told us that they had completed manual handling training and that they were observed by a senior staff member at regular frequencies to ensure they were competent in this area.

Staff told us that they had regular one to one meetings with their manager. They told us this gave them the opportunity to discuss their training and development needs and we saw that additional training was provided as required.

One member of staff told us that they had completed their NVQ level two for health and social care. This is a nationally recognised qualification that assesses competence and application of knowledge in regards to health and social care.

A person who lived at the home told us, "The food is very good." People told us they had a choice of meals and the cook told us, "We always have options if people want a lighter meal like scrambled eggs or soup." This showed the home took peoples preferences into account when planning menus. Food was provided that met people's dietary needs. We saw information displayed in the kitchen about people's allergies and medical conditions which required special diets and preferences. A visitor told us that their relative had a special diet based on their cultural needs. They told us, "I spoke to the manager and put together a menu, there is one in [person's] bedroom and in the kitchen." At lunchtime we observed this person was given a vegetarian meal as specified on their menu .

Some people had difficulties swallowing or were at high risk of choking. For these reasons, soft and pureed diets were prepared so that food of the right consistency was provided. The cook explained that a list of people's requirements was kept in the kitchen which helped them to prepare meals which met people's needs.

People were offered a choice of meals from a written menu which staff explained to them. People who lived with dementia may not always be able to understand information in this format. We discussed with the provider how they could ensure the information was provided in ways that could be understood. The provider told us that they would suggest to the registered manager using photographs of meals when appropriate.

People were provided with adapted cutlery and crockery to support their individual needs and promote their independence whilst eating. A visitor told us that their relative ate slowly so had bought a special device which kept the plate warm and prevented the food going cold. We saw this in use at lunchtime.

People who were not cared for in bed had the option of eating in the dining rooms of the home. We observed the lunchtime experience for people. The atmosphere during lunch time was relaxed and the seating arrangements encouraged people to interact with each other, this promoted a social event.

At mealtimes, staff understood how to support people in a way that met their needs. For example, staff explained what the food was and offered it to people in manageable portions, and at a pace which suited them.

Each person had a nutritional assessment that was reviewed monthly and was accompanied by a relevant nutritional care plan and weight chart. One person was identified as at risk of being underweight. We saw they were regularly offered milkshakes which contained more calories than other drinks to try to help them gain weight. A member of staff told us that, "Most people get weighed every month but if they are at risk of losing weight they are weighed weekly and are referred to a nutritionist." Staff were aware of how to effectively monitor a person's health and what steps they needed to take if they had any concerns.

Staff asked people for permission before undertaking a task, for example we saw they would ask, "Can I assist you?" They told us what they would do if a person refused. A staff member said, "You can't do it but it is sometimes worth going back after a short while to check to see if they have changed their minds." This showed that staff understood the importance of gaining people's consent and were aware that their decision could change.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.
When we asked staff about their understanding of the MCA they demonstrated a good knowledge of the principles of the Act.

The registered manager told us that some of the people who lived at the home did not have capacity to make their own decisions. This meant they needed support to make decisions. Within people's care files we saw their mental capacity had been assessed as required by the Mental Capacity Act 2005. There were also individual care plans detailing the day to day decisions that the person could make and the support they needed. One care plan stated "[Name] will often refuse a bath or shower but [Name] does not have capacity to understand how regularly not bathing can impact on their health." The care plan continued to give staff instructions on how to support the person. We asked a staff member how they would support this person; they told us "If they refuse [a bath] I will remind them that they need a wash to get clean. If they continue to refuse I will ask the staff on the next shift to encourage [Name] to have a bath or shower." The member of staff showed a good knowledge of the Mental Capacity Act by explaining that they would never force the person to do something against their will but would encourage them to do something that was in their best interest. They explained that if they had further concerns they would speak to their manager to allow further assessments to be made .

Where a person lacked capacity, best interest decisions were recorded which included discussions with family members and professionals who knew the person. This ensured that any decisions made would reflect the wishes of the individual if they had capacity to make the decision.

Where DoLs authorisations were in place, these included best interest decisions. We saw input in one DoLS authorisation from an Independent Mental Capacity Advocate (IMCA). An IMCA is a legal representative for a person who lacks the capacity to make specific important decisions mainly where there is no one independent of services who is able to represent the person, such as a family member or friend,. In other DoLs authorisations, family members and health professionals were involved in making the best interest decisions. The DoLS authorisations were reviewed regularly and this ensured that people's freedom was not being deprived unnecessarily. The provider was following the correct procedures if a person's liberty was restricted.

Health records showed that people had access to health professionals as appropriate to their needs. A practice nurse, a Parkinson's nurse and a palliative care nurse visited the home during our inspection. These visits were routine visits to monitor the health of people who lived at the home and to provide routine nursing care. This showed people's health needs were regularly reviewed and guidance was sought from health professionals when required.

Staff told us that they were able to request visits from health professionals if there was a change in a person's health. Records showed that staff had requested visit's from GP's, tissue viability nurses, district nurses and SALT if they had concerns, this meant people received appropriate and timely care.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were kind and caring. A relative told us, "The staff are very friendly, professional and helpful." We observed staff treated people respectfully and acted on their requests.

All visitors we spoke with agreed the culture at the home was welcoming and positive. One visiting healthcare professional said, "It is lovely here, the staff really care about the people who live here."

We saw staff approached people appropriately, for example, we observed one member of staff greeting a person by their preferred name whilst another person preferred a more formal title and staff respected this when they spoke with them.

Staff were in the process of creating "Life History Books" for every person who lived there. The aim of these was to provide staff with more understanding of each person's life before they moved to the home so they could reflect on people's past events of personal importance. This information would assist staff to hold more meaningful conversations with people

A person who lived at the home told us, "Staff protect my privacy and dignity, if I had any problems I would tell them." Staff told us that it was important to them to maintain people's privacy and dignity when they were supporting them. One member of staff said, "You should always put yourself in the position of the other person and see how you would feel." We observed staff knocked on people's doors before entering their rooms. This showed that staff worked in a way that respected people's dignity.

Staff told us they respected people's confidentiality by not discussing people's care in front of other people and keeping their records secure. We saw that care records were kept in lockable cupboards which were not accessible to members of the public or other people who lived at the home. We observed that visiting health professionals would record their notes and have discussions with staff at nursing stations in the corridors. We fed back to the provider that this could lead to confidentiality not being maintained and actions were put in place to ensure that all future discussions or note writing would take place in a private room. This would ensure that all information related to a person's care remained confidential.

Staff supported people to be as independent as they wanted to be. Staff told us that some people who lived at the home maintained a lot of independence whilst others needed more assistance. One member of staff told us, "I always encourage a person to do something for themselves rather than just doing it for them. I'll offer them a flannel to wash their face or give them their fork rather than assuming they can't do it." They went on to explain they would support the person if they were unable or did not want to do the activity themselves.

People and relatives told us they had been involved in decisions about people's care and were invited to annual meetings to review their care plans. Not all people living at the home had capacity to be involved in reviewing their care plans, and when this was the case we saw details of best interest decisions and capacity assessments. People who had capacity had been asked about their preferences and what support they

would like to receive. The care plans included details about what level of support people needed to maintain their independence. One care plan said, "I can choose my own clothes if you show them to me but I need help with doing up buttons." This showed people were involved in deciding the level of care and support they needed.

Relatives told us, "I come and visit whenever I want," and "I come and visit any time of the day, I'm made to feel welcome." This helped people to maintain relationships that were important to them.

Staff told us that when a person was at the end of their life they would receive support from palliative care nurses and other health professionals. End of life plans were recorded in individual care plans which included any religious or cultural rituals that they wanted adhered to. The member of staff also told us that family were involved in planning this and would often stay with the person overnight. The registered manager told us that at the end of a person's life a member of staff would sit with them to provide comfort and familiarity. This helped a person to receive a comfortable and dignified death.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on 5 February 2015 we identified people who lived at the home were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. This was because an accurate and complete record in respect of each person was not available.

This was a breach of regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

Following the inspection the provider sent us an action plan outlining how they would improve .

At this visit we saw that, overall, improvements had been made. Care plans had been reviewed and each person who lived at the home now had an individual care plan which detailed their health needs, likes and dislikes, personal histories, and included people that were important to them. However, some staff told us that they did not always have time to read care plans but would find out people's needs by talking to the nurse on duty. One member of staff told us, "I used to read the care plans a lot but now people's needs have changed I don't have the time."

Handover meetings were completed between each shift. These provided updates for staff about the changing needs of people who lived at the home as well as identifying any actions that needed to be completed during the coming shift. For example, we saw that during the handover meeting a member of staff informed the incoming shift team that a person's wound dressing had not been changed that morning and asked the afternoon staff to complete this. We saw that this had been completed during the afternoon. This showed that staff had the information required to respond to people's changing needs .

We asked people who lived at the home if they received care and support that reflected their preferences and needs. One person told us "I get up when I want, I go to bed when I want and I can do what I want, the staff know what I like."

Most relatives told us they were happy with how people's care needs were being met, including those people who were cared for in bed. We asked a person if they were offered choice about what they wanted to do during the day and how they spent their time. They responded, "Yes, if I wanted to stay in bed all day I could!" Information in care plans documented people's preferred daily routines for example "I like to listen to the radio in my room" This showed that people were offered choice in how they spent their time.

People were supported to follow their chosen faith. For example, one relative told us they visited their mother every Friday to pray, they said "The staff always make sure that [Person] has had a shower before I arrive because it is important that we are clean before we offer prayers." This demonstrated staff understood the importance of and how to support people to pursue what was important to them.

However, people gave us mixed feedback about whether they had opportunities to take part in hobbies and interests of their choice. This was, in particular for people who were not able or who chose not to join in with

group activities. A person who was cared for in bed told us, "I get fed up in bed, there isn't anything to do." On the day of our inspection we did not see individual activities taking place. We discussed this with the provider who told us they were recruiting additional activity workers.

There were some activities provided tailored to meet the needs of people who lived with dementia. For example, in one of the lounges we observed a group reminiscence activity led by the activity co-ordinator. We saw that this staff member knew people and greeted them by their names. A story was read about how certain activities were carried out in the past to encourage memory recall. The story focused on cleaning, and photographs which accompanied the story were passed to people. The activity co-ordinator encouraged participation and at an early stage of the activity each person was participating and discussing cleaning products they had used in the past..

We observed that, overall staff responded to people's care and support needs. However, we observed one occasion during the lunch time period where a person who had chosen to stay in the lounge became tearful and was complaining of being in pain. Staff were not present in the lounge during this time so we went to get assistance for this person. After notifying staff of this, appropriate actions were taken to ensure the person was made comfortable. We discussed this with the registered manager who assured us action would be taken to ensure closer monitoring of the lounge area during meal times.

A person who lived at the home told us, "If I had any complaints I would speak to the staff or I could go to the manager." Relatives told us they knew how to raise concerns and complaints.

Information was provided to people when they first came to live at the home about the provider's complaints procedure and complaints information was available for each person in their room. We reviewed the record of complaints held at the home and found they had been responded to in a timely way in line with the provider's complaints policy. Meetings with the registered manager were offered for people to discuss their complaint and response letters confirming actions taken following a complaint were sent to the person who had complained.

Four complaints had been made to the service in the 12 months prior to inspection. These included people's belongings being moved to a different bedroom, concerns about moving and handling procedures and confidential information being discussed in a corridor. The registered manager analysed complaints received and information in the written response included what steps would be taken to improve standards in the home. These steps included disciplinary action, training with staff and information to be given to all staff at team meetings as well as a formal apology to the person and their family.

Good

Is the service well-led?

Our findings

People we spoke with told us they knew who the registered manager was that they thought the home was well run. Staff told us that management team were caring and that they were comfortable in raising concerns with them.

A visitor told us they had spoken to the registered manager because they had concerns about the suitability of their relative living in one area of the home. They went on to explain that the registered manager listened to their concerns and their relative was moved to a different area, where they would receive additional support. This showed the registered manager listened and acted on information provided by relatives, for the benefit of people who lived at the home.

The registered manager had an extensive knowledge of people who lived at the home and was actively involved in the day-to-day running of the service. They acknowledged that having oversight of all aspects of the service presented challenges and that they delegated aspects of their role, such as responsibilities for completing staff supervisions and completion of audits to other senior members of staff. Staff we spoke with had a good understanding of their roles and responsibilities in relation to this.

The provider's policies and procedures were clear and comprehensive. The policies were reviewed and updated regularly by the registered manager which ensured that current best practice was followed in the home.

A range of audits and checks took place to assess the quality and safety of service provided. This included checks on the premises to ensure it was safe. Checks on the quality of care people received also took place and we saw that actions were taken to address any shortfalls. For example, it had been identified that a care plan needed to be rewritten because there were too many alterations which could lead to confusion about how to provide care. A deadline had been set for the care record to be updated and we saw that it had been rewritten before this deadline.

The home had received a visit in December 2015 by the Local Commissioners who identified three action points for the home to address. This was in comparison to 40 action points the year before which showed that the provider and registered manager had worked to improve the service provided.

The registered manager told us that it was her aim for the home to be awarded an 'outstanding' CQC rating in the future. In order to help to achieve this she told us that the provider visited the home every week and completed 'spot checks' at random times. She also told us that the provider undertook unannounced quality visits to the home every three months and the format of these were similar to a CQC inspection.

Following each visit an action plan was updated to drive continuous improvement. One action identified in October 2015 was that "cleaning of personal equipment including chairs and wheelchairs needs to be added to the cleaning schedule." This was added to the night staff's duties and commenced within ten days of the issue being identified.

Monthly staff meetings took place. Staff told us these helped to ensure that they were aware of any changes in the support needs of people at the home. Staff also stated that this helped the team work in a consistent manner.

People and their relatives told us they had opportunities to put forward their suggestions about the running of the home at weekly meetings. At one meeting it had been asked that a Diwali party was held and another suggestion was that a person had asked to make decorations. We saw in minutes of other meetings that both these requests had been done. This showed that the home actively sought feedback and suggestions from people who lived there and their families and acted on suggestions made.

Service satisfaction surveys were sent to people and their relatives. We reviewed the results of the most recent surveys and found they indicated high levels of satisfaction with the service. There was one area of improvement being suggested, namely activities. The manager had responded to this by arranging for the home to employ two activity co-ordinators who worked over the seven day week.

The results of the surveys had been analysed and were displayed in a communal area of the home. In the entrance area comments from relatives and thank you cards were displayed. This meant the registered manager involved staff and people who lived at the home in considering how the service could continue to improve.