Richmond Villages Operations Limited

Richmond Village Coventry

Inspection report

Bede Village, Hospital Lane
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Tel: 02476645544

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13 September 2016

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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

The inspection took place on 7 and 13 September 2016 and was unannounced. The service was last inspected on 13 August 2013, when we found they were meeting the Health and Social Care Act 2008 and associated Regulations.

The registered manager had been in post for three years. 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 provides accommodation, nursing and personal care for up to 51 people. They provide respite or longer term care for adults of all ages and specialise in care for people who may have dementia or physical disabilities. Forty four people were living at the home at the time of our inspection. The home was part of the provider's 'village' which included other types of accommodation and services. The home comprised a hairdressing salon, a restaurant for people who lived in the home and their visitors and a small shop in the communal foyer.

People told us they felt safe using the service and staff understood how to protect people from abuse. There were processes to minimise risks associated with people's care to keep them safe. This included the completion of risk assessments to identify and manage risks to people's health and well-being and checks on staff to ensure their suitability to work with people who used the service. People's medicines were managed, stored and administered safely.

There were enough suitably trained staff to deliver care and support to people. Two health professionals we spoke with provided positive feedback about the care provided by staff. Staff received an induction and a programme of training to support them in meeting people's needs effectively. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). For people who were assessed as not having the capacity to make all of their own decisions, records showed that their families, legal

representatives and healthcare professionals were involved in making decisions in their best interests. Staff understood the principles of the MCA, they respected people's decisions and gained people's consent before they provided personal care.

People told us staff were kind and caring and had the right skills and experience to provide the care and support they required. Staff treated people in a way that respected their dignity and promoted their independence.

People were supported to maintain their important relationships and their personal interests. They were encouraged to attend activity sessions and entertainments were provided at the home that people remembered with pleasure.

People were involved in planning how they were cared for and supported. Care was planned to meet people's individual needs and preferences and care plans were reviewed. People knew how to complain and were able to share their views and opinions about the service they received.

Staff felt supported and there was an open culture at the home with good communication between people. People were encouraged to share ideas to make improvements to the service. There were checks in place to ensure good standards of care were maintained, however we found that identified actions had not always been carried out following the checks.

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.

Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff's suitability for their role before they started working at the home and nurses were supported to maintain their professional qualifications. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective.

People were cared for and supported by staff who had the relevant training and skills for their roles. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to other healthcare professionals when their health needs changed.

Is the service caring?

Good

The service was caring.

Staff provided a level of care that ensured people had a good quality of life. People were very positive about how caring the staff were. Staff respected people's privacy and dignity and encouraged people to maintain their independence in accordance with their abilities.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in planning their care and treatment. People's preferences, likes and dislikes were understood by the staff. People were supported to maintain

relationships that were important to them and to engage in activities they were interested in. Relatives and visitors were welcomed and included
in day-to-day activities as well as special events.

Is the service well-led?

Good

The service was well-led.

People were satisfied with the service and felt able to speak with the registered manager if they needed to. Staff told us they felt supported and there was an open culture at the home with good communication between people. Staff were encouraged to share ideas to make improvements to the service. There were checks in place to ensure good standards of care were maintained, however we found that identified actions had not always been carried out following the checks.

Richmond Village Coventry

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 7 and 13 September 2016 and was unannounced. The inspection was conducted by one inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of care service. A specialist advisor is a person who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge of nursing.

We reviewed information received about the service, for example the statutory notifications the provider had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. 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 found the PIR reflected the service. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority. They had no concerns about the service.

During our visit we spoke with six people who lived at the home and eight relatives. We spoke with the registered manager (who was also the clinical lead), the deputy manager, the village manager, the head of hospitality, two nurses and two care staff. Following our inspection visit we spoke with two health professionals. Health care professionals are people who have expertise in particular areas of health, such as nurses or consultant doctors.

Many of the people who lived at the home were happy to talk with us about their daily lives, but they were not able to tell us in detail, about their care plans, because of their complex needs. However, we observed

how care and support were delivered in the communal areas and reviewed four people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Good

Our findings

People we spoke with told us they felt safe at the home. One person who had recently moved to the home told us, "So far I feel quite safe, I really do. I would speak to the nurses if there was a problem, none so far." We saw people were relaxed with staff and approached them with confidence, which showed they trusted them.

People were protected from the risk of abuse because staff knew what to do if concerns were raised. A member of staff told us, "I would make the person safe and then report to my manager. The local authority would investigate if it was serious." Records showed concerns about potential abuse had been appropriately reported and action was taken by staff to keep people safe. However, we found there was no information available to people about who to contact if they had a safeguarding concern. We discussed this with the registered manager who took immediate steps during our inspection visit, to ensure information was made available to people in the communal foyer.

There was a procedure to identify and manage risks associated with people's care. When people started using the service, an initial assessment of their care needs identified any potential risks to them during their care and support. The registered manager and the nurses wrote people's risk assessments and these were reviewed regularly. The registered manager told us staff contributed to the assessments, because they worked closely with people and knew them well. Records confirmed that risk assessments had been completed and care was planned to take risks into account and minimise them.

Staff knew about individual risks to people's health and wellbeing. For example, a member of staff told us about one person whose physical health had deteriorated and they now required increased support to move around safely in the home. They explained how health professionals had reviewed the person's care and specialist equipment had been obtained to support the person and keep them safe. They explained how they took more time to support the person to move about and said, "We reassure [Name]."

The registered manager explained how they encouraged staff to think about positive risk taking. They said, "We constantly say 'why?'." They told us staff came to them regularly with suggestions about how people's care could be improved and made safer. For example, staff had suggested one person be moved to a bigger room, so they could use specialist equipment more easily to support them to move about.

Incidents were recorded and actions taken to protect people and keep them safe. Records made of incidents were detailed and included any actions taken as a result of the incident, for example referral to

another agency such as the local authority. Staff understood the provider's procedure for managing incidents and were able to explain how referrals of serious incidents, were made to the local authority. The registered manager explained how they assessed risks to people by monitoring incidents and reviewing the information to identify any patterns. They described how one person became anxious at night time and had fallen in their bedroom. They explained how they reviewed the incident and took steps to reduce the person's anxiety and protect them in their environment. For example, they provided specialist equipment to alert staff when the person moved about in their bedroom, so staff could provide support quickly if required.

There were sufficient, experienced staff to provide the support and stimulation people required to promote their wellbeing and to keep them safe. People and their relatives told us they were supported by regular staff that they knew well. A member of staff told us, "The busiest time is in the morning. We have more staff on in the morning. This increased when people's dependencies increased." Staffing levels were organised by the registered manager and the deputy manager. The deputy manager told us they took into consideration people's support needs and any additional activities, such as planned health appointments.

The provider checked staff were suitable to support people before they began working in the service, which minimised risks of potential abuse to people. Records showed the provider's recruitment procedures included obtaining references from previous employers and checking staff's identities with the Disclosure and Barring Service (DBS) prior to their employment. The DBS is a national agency that holds information about criminal records.

Records showed risk assessments were completed for the home and the provider had ensured safety checks were completed for gas, electricity, equipment and fire safety. Equipment, such as hoists and profiling beds were serviced by the supplier and staff regularly checked that items such as wheelchairs, slings and walking frames were safe and fit for use. Records showed fire alarm and fire-fighting equipment were regularly serviced and tested and everyone who lived at the home had a personal emergency evacuation plan.

Medicines were managed and administered safely and the risk of errors was minimised by effective procedures. People's medicines were reviewed regularly by their GP, to make sure they continued to be necessary and effective. People told us they had their medicines when they needed them. One person told us, "They can tell when I'm in pain, they sort it straight away." A relative said, "If [Name] rings the bell and needs pain killers they react quickly." Only trained nurses administered medicines, which were kept in locked cabinets. A nurse showed us the individual medicines administration record (MAR) they kept for each person. The MAR listed the name of each medicine and the frequency and time of day it should be taken. Nurses signed to say when people's medicines were administered, or recorded the reason why not, for example, if a person declined their medicines. We saw the nurse wore a red tabard while they administered medicines, to ensure other staff knew they should not be disturbed, to minimise the risk of errors. Medicines administration was focused on the person. We saw the nurse did not rush people and they explained what each medicine was for before giving it.

Good

Our findings

People told us they were happy with the care provided by staff. One person told us, "I would say they know how to look after me, I am quite happy. I think they have the knowledge." Two relatives told us, "I have no doubts that the staff are well trained" and "We are very happy with staff; if they can't help they get someone who can." We saw staff knew people well and provided effective support according to people's needs.

Training was planned to support staff development and to meet people's care and support needs. This included training such as moving and handling, safeguarding adults, dementia, nutrition and hydration and medicine administration for all care staff. A member of staff told us they were given medicine training even though they did not administer, so they had the knowledge to support nursing staff better. Different methods of training were provided which suited different ways of learning, for example online or paper based training courses and practical training. Staff were positive about training, they told us it was readily available and they felt supported by their manager to access it. The registered manager told us, "If we see local training sessions, we put them out to staff." They gave an example where some staff had attended external training facilitated by the local NHS tissue viability team, about wound care. Training was also provided to support staff in meeting people's specific needs. For example, the registered manager had arranged training for care staff in percutaneous endoscopic gastrostomy (PEG) feeding. PEG feeding is where a tube goes into the stomach and allows nutrition, fluids and medicines to be fed directly through, bypassing the mouth. Nurses had lead roles in certain areas of practice, such as continence and tissue viability. They supported staff in these areas and ensured best practice was shared by attending link nurse meetings with other nurses in the community.

Staff told us they had supervision meetings. Supervision is a meeting between the manager and member of staff to discuss the individual's work performance and areas for development. The registered manager told us they assessed staff's effectiveness through supervision and observation. They told us they used supervision to focus on certain areas, for example on how to complete people's daily notes accurately. A member of staff told us, "Supervision is very useful. I can talk about new documentation and any changes." Nursing staff also used supervision for reflective practice. Reflective practice is the analysis of actions in a process of continuous learning. A member of staff told us, "We look to see how we can improve things."

Staff were encouraged to develop within their roles. Staff told us they felt well supported by the provider to study for care qualifications. The registered manager told us how they encouraged staff to obtain care qualifications, even if they were above the level of their role, in order to develop their skills. The registered

manager explained how nursing students from the local hospital regularly came on placement to the home and had a nurse mentor to guide them. They told us they had first come to the home on such a placement whilst they trained to become a nurse. The registered manager told us staff were supported to widen their skills and try other roles within the service, such as training and nursing support roles. Some care staff had gone onto train as nurses following this experience.

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 provider was working within the principles of the MCA.

The registered manager demonstrated they understood their responsibility to comply with the requirements of the Act. They had made DoLS applications for 20 people because they had identified a potential restriction on those people's liberty. They told us, "We look at who need DoLS at the pre-admission assessment of people's needs." At the time of our visit 12 of the DoLS applications had been authorised and eight applications were still being assessed by the local authority. Staff we spoke with understood the requirements of the MCA, they told us how decisions were made in people's best interests where required. A member of staff told us MCA was about, "Whether someone has the capacity to think about their own safety in their actions."

The registered manager told us most people living at the home had capacity to make decisions about how they lived their daily lives. They told us some people lacked the capacity to make certain complex decisions, for example how they managed their finances, but they all had an appropriate person, either a relative or independent advocate, who could support them to make these decisions in their best interest. An advocate acts on behalf of a person to obtain their views and support them to make a decision in their best interest. Records showed decisions were made in people's best interests, where they did not have capacity to make them. People such as family and health professionals were involved in supporting people to make decisions.

People were supported to make their own choices where possible. Two people told us, "I can choose what to do; I go out with my walker to look at the activities in reception" and "If you want to get up earlier you can, or if you stay in bed it is fine."

People and their relatives told us staff gained their consent before supporting them. One person told us, "They knock on my door and say 'Can I come in?' I give them permission." Staff told us they knew they could only provide care and support to people who had given their consent. During our inspection visit, we observed staff asked for people's permission before supporting them.

People told us the food was very good and they always had a choice. Two people told us, "They give you a sheet at supper time to choose for the following day, they come and collect it" and "The food always looks good." We saw people chose where they ate their meals, either in the communal lounge, dining room or in their bedroom. Staff supported people to receive their food and drink in a way that met their needs. A relative told us, "There's always plenty of staff at lunch. We've never found food sitting in [Name]'s room, there's always a carer sitting with [Name]." We saw one member of staff supported someone in their room. The person changed their mind about the meal they had ordered. The staff member said to the person, "Don't worry if you don't like it we'll get you something else."

We observed the lunch time meal in the dining room and saw it was relaxed and people chatted between themselves and with staff. We spoke with the head of hospitality who was eating with people in the dining room. They told us the menu for the main lunch time meal was suggested by the provider and changed seasonally. They told us they were able to adapt the menu according to people's preferences. People's care plans included a list of their food preferences, needs and allergies, to ensure people were supported to maintain a diet that met their needs. Staff knew people's dietary needs and for example, could tell us who required encouragement to eat. Staff were able to tell us how they supported people to maintain their diets and wellbeing. One member of staff said, "A lot of people are supported and we document what they're eating and drinking…We report any concerns we have to the nurse, then the nurse may contact the dietician." People were offered drinks and snacks throughout the day, in accordance with their needs. Drinks were available in people's bedrooms and were in easy reach.

People's healthcare was monitored and where a need was identified, they were referred to the relevant healthcare professional. A GP visited the home each week and saw people who had any changes to their health. One person we spoke with told us, "The doctor comes here on Tuesday….I received a letter about my eye test the other day, the chiropodist also comes. I went to the dentist recently". We spoke with a health care professional following our inspection visit. They told us, "Staff really communicate well and ring me if there is a change in someone's needs." Records showed that people were supported to attend routine health appointments to maintain their wellbeing such as with the dentist, chiropodist and optician. A member of staff told us one person was recently referred to a speech and language therapist to review their diet following recent health issues. They told us the therapist recommended their diet was changed in order to encourage them to eat more easily. Records showed the person's support was changed to reflect this advice.

Good

Our findings

People told us they liked living at the home. One person told us, "They [staff] have a polite and friendly attitude, they are very respectful." Relatives told us, "They are very patient and friendly" and "This must be the best home in Coventry." A member of staff told us, "I feel we're helping people here. I feel like we're making a difference to people and their families." A health professional we spoke with following our inspection visit told us, "They definitely want to do their best for people. I would choose this service if I went into a care home. They listen." We saw good communication between people and staff and the interaction created a friendly atmosphere. Staff knew people well and we saw them sharing jokes with people and enjoying each other's company. People did not hesitate to ask for support when they wanted it, which showed they were confident staff would respond in a positive way.

Staff told us they liked working at the service and they enjoyed helping people to be independent and supporting people according to their individual needs. One member of staff described how they supported people to be independent. They said, "We give people encouragement to do things and don't take over. For example, doing a button up, they do it and that's what matters." Another member of staff told us, "Carers get to know residents very well. For example, we had a tea party for one person who is very poorly and they really enjoyed it. Most people in the home joined in."

We observed care and support offered to people in the communal lounge before lunchtime. We found staff's interactions created a warm, caring environment, for example, sometimes staff touched people's arms when they spoke with them. Staff included people in conversations and activities and supported people to join in so they felt empowered. We saw people enjoyed the interaction because they smiled or made positive comments. We saw people had been asked what activities they were interested in and had agreed a plan to do some Halloween and Christmas crafts. The activities coordinator supported some people in these projects and they painted Christmas decorations together. We found staff took time to interact with people on a one to one basis about things they were interested in, such as newspaper articles they were looking at.

A member of staff told us how they took time to get to know people and what they liked. They told us, "I ask my colleagues about people's backgrounds…We get a lot of information from people's families." They described how they had, "Made good friends", with one person they supported, because they had discovered a mutual interest in a hobby.

People and their representatives were involved in decisions about their care and support needs. A member of staff explained how they reviewed people's care needs with them. They told us, "We go somewhere

private and we go through it with them. We get to know them and their ways of communicating, so we know if they agree or not."

We observed staff were kind and treated people with dignity and respect. For example we heard staff speak with people quietly and discreetly when they discussed personal issues. A member of staff explained how they maintained people's dignity whilst supporting them. They said, "We close doors and curtains if we are supporting people with personal care…We don't discuss people in corridors and any private phone calls are made in the nurse office with the door shut."

Good

Our findings

People told us they were happy with the care and support staff provided. One person told us, "I am happy about the care being provided, it instils confidence. They are professional people working here." Two health professionals we spoke with following our inspection visit told us, "They have complex patients and are very proactive at coming up with solutions to help support people" and "The nurses are very experienced and proactive. They will tell us people's story and will have done all the observations they can do."

People's views about their care had been taken into consideration and included in care plans. Relatives told us they were invited to meetings to review their family member's care where appropriate. A relative told us, "[Name] can make decisions about their own care. The staff encourage [Name]." Care plans were personalised and included details of how staff could encourage people to maintain their independence and where possible, make their own choices. One person told us, "I can choose what to do; I go out with my walker to look at the activities in reception."

People's care plans reflected their care and support needs, however we found some plans had not been recently evaluated by senior staff and were not up to date. For example, some people's monthly weights had not been recorded in their care plans and regular evaluations of people's care had not been recorded. This made it difficult to see if the service was meeting people's needs. We discussed this with the registered manager who was already aware of the issue and had a plan in place to ensure people's care plans were up to date within the month of our visit.

Care plans contained information about people's personal history and preferences. One person told us, "They know more about me than I do." Staff told us they read people's care plans so they knew what people's preferences were and to ensure they supported people in the way they preferred. The registered manager told us, "Care plans are all about people's preferences as well as their needs. For example, just because someone is diabetic doesn't mean we shouldn't take into account their food choices, as long as we can manage it together safely."

Staff supported people to express themselves according to their abilities to communicate. Staff told us they used different communication methods to meet people's needs, such as using objects of reference, for example clothing, to help people make choices. A member of staff explained how they communicated with one person who had no verbal communication. They explained the person used different ways of communicating, for example they blinked to reflect different responses. The person also used an electronic

system called a 'possum', which allowed them to use a laptop to communicate. The member of staff explained how they supported the person and this reflected the preferences the person had agreed in their care plan. They told us this method of support had a positive effect on the person's well-being and had improved their quality of life.

People lived fulfilling lives because they were engaged in activities that were meaningful to them. For example, people told us how staff arranged parties when people who were important to them were invited and which they really enjoyed. A relative told us, "They have lots of events, they come and tell [Name] and encourage them to join in." On the day of our visit, we saw people took part in a variety of activities such as, painting, playing dominoes, reading the paper, singing and listening to music of their choice. Staff described other activities people were interested in, such as trips to the local garden centre and weekly shopping trips.

People were involved in building links with the local community in individual ways that suited their needs. For example, local school children involved in a World War 11 project, were invited to the home to speak with those people who wished to take part. The children shared memorabilia for people to look at. Staff told us how they encouraged people to maintain their religious beliefs. A relative told us, "Someone from [Name]'s local Catholic church came this morning and gave communion". Other local churches were invited to hold services for people at the home.

People were supported to develop and maintain relationships with people who were important to them. People told us their relatives visited them regularly and staff told us they encouraged as much contact with people's families and friends as possible. Two relatives told us, "There are no restrictions at all on visits. They have called us out at night when [Name] has had a turn" and "They involve us and regularly keep us up to date."

Communication between staff allowed them to share information and ensured people received care which met their needs. A member of staff told us, "Information is shared well within the service about people's needs. Handover is good and we can always ask another member of staff." Relatives told us staff shared information with them where appropriate. One relative said, "They always keep us informed of doctor visits etc."

People and their relatives said they would raise any concerns with staff. One person told us, "If I had a problem I would see the manager, I have never had a problem." One relative told us they had raised a complaint in the past and were satisfied with how the issue had been dealt with. There was information about how to make a complaint and provide feedback on the quality of the service in people's welcome packs in their rooms and in the communal foyer. The policy informed people how to make a complaint and the timescale for investigating a complaint once it had been received. The registered manager confirmed there had been two formal complaints within the last 12 months. Records showed these had been dealt with in accordance with the provider's policy. The registered manager explained how they had recently started to record any comments made by people, to help them identify where improvements could be made to the service. There was evidence of compliments from relatives about the standard of care provided by the service.

People told us meetings which were held for people at the home to attend every three months. Records showed that people's views were recorded and suggestions were acted on by staff. For example people had made suggestions for improvements to meals and these had been made by the head of hospitality. There was a comments and suggestions box in the communal foyer. The village manager told us they shared comments at senior staff meetings, in order to ensure improvements were made to the service wherever possible. A regular newsletter was produced for people who lived at the home and who used the provider's

other service, it included information about scheduled activities, such as fitness classes and mobile library visiting times.

Good

Our findings

Everyone we spoke with told us they were satisfied with the quality of the service. One person who lived at the home told us, "I can't think of anything to improve. I would say 10/10." A relative told us, "This is the best home in the world, they're [staff] all top here." A member of staff said, "I really like it here, I like the atmosphere, I feel like we're helping people." A health professional we spoke with following our inspection visit told us, "We have a very positive working relationship with the service." We saw the registered manager was visible and accessible to people in the home. Staff told us the registered manager was approachable, they told us they could make suggestions and these were acted on. The deputy manager told us, "The door is always open for staff. I've every confidence that staff would come to us with any queries. We are open and transparent." People told us they felt able to raise issues with senior staff and they were asked for their opinion about the service.

Staff throughout the service, told us they felt supported by their line manager. A member of staff told us, "If I've got any troubles I feel I can speak to my manager, they make me feel at ease." The registered manager told us they had access to services offered by the provider to support them in their role, such as 'manager's advisory services', which offered guidance for example, in staffing matters.

The registered manager told us they made sure staff understood their roles through the use of supervisions meetings and staff meetings. Some staff had worked at the service for several years and all the staff told us they enjoyed working there. The registered manager echoed these statements, telling us they had worked at the home for nine years in various roles. They said, "I came originally as a student nurse on placement, I qualified as a nurse and then returned to work at the home." They told us they were, "Proud of our external reputation. We develop staff and in the last 18 months we have stopped using agency staff and have over recruited and now have bank staff, which builds consistency in our care."

There were regular staff meetings held for different staff groups within the home, for example, head of departments met three times a week. Staff told us meetings were useful and they were encouraged to be involved in making improvements to the service. For example one member of staff explained how the provider had changed some information recording processes and staff found the changes difficult to manage. The member of staff told us they suggested a change to improve the provider's new process. The changes were accepted and improvements were made in how staff recorded information. Staff were asked for their feedback by an evaluation survey. The registered manager told us regular meetings were held with staff to discuss the results of the surveys and inform staff where changes had been made. For example, some staff had requested specific training on epilepsy awareness, which had been provided. This showed the

registered manager encouraged staff to develop and make improvements to the service, which helped them to deliver high quality care to people.

People could provide feedback about how the service was run and their comments were acted on by the provider. People who lived at the home were encouraged to share their experiences of the service by completing surveys. The registered manager told us the provider analysed the responses and fedback any issues to them. We looked at the responses received in 2015 and saw that feedback about the quality of the service was 85% positive. We saw the survey results were accessible in a communal area of the home, along with a plan of improvements the provider had made as a result of the feedback.

People told us about 'residents meetings', which were held regularly for people at the home to attend. The registered manager told us if people raised a comment in a meeting, they would speak with them on a one to one basis to try and resolve any issue. For example, we saw in the meeting minutes that one person made a comment about the quality of the food. The registered manager explained how this had been raised with the head of hospitality and the chef, who had made improvements. They had then met with the person to ensure they were satisfied with the changes.

The manager was aware of their responsibilities as a registered manager and had provided us with notifications about important events and incidents that occurred at the home. They notified other relevant professionals about issues where appropriate, such as the local authority. They had completed the provider information return (PIR) which is required by law. We found the information reflected the service well. The registered manager understood their responsibilities and was aware of the achievements and the challenges which faced the service. The registered manager kept up to date with best practice by receiving updates on legislation from the provider, attending external events such as the 'providers forum' and regularly sharing information with the provider's other services. A provider's forum is an external event hosted by the local authority and enables service providers to get together to share their knowledge and new initiatives. The registered manager explained how they shared best practice with staff at meetings and through supervision. A health professional we spoke with following our inspection visit told us, "Staff are happy to move forward and use best practice."

The provider held internal awards for staff to recognise their contribution to their services. For example, an activities coordinator from the home had won an award in 2015 for their work with people in the home. Staff at the service had been nominated for external national awards, such as the 'care home awards'. The registered manager explained she was very proud of the services high rating on an external website, which recommended care homes by people who used them.

There were systems in place to monitor the quality of service. This included unannounced checks made by the provider's quality assurance manager. We looked at a check of people's care plans, made in April 2016 which had identified some plans were not up to date. Following the audit by the provider, the registered manager had evaluated all the care plans during May and June. We found some action points raised by the audits had not been carried out and actions had not been checked for completion. For example, one person's care plans had not been brought up to date. This meant both the provider's audit and the registered manager's audit had not been effective because not all the care plans were up to date. We discussed this with the registered manager who gave us their assurances people's care plans would be updated within the month of our visit.

We saw other audits carried out by the provider and the registered manager, where actions were required, action plans were followed and improvements had been made. The registered manager forwarded a monthly report to the provider, including information about accidents, medication, infections and other

events which may call into question people's safety. They told us they received comments back from the provider and were supported to address issues at regular meetings with the provider's quality assurance manager.