Care Quality Commission

Mr Naushad Heeroo & Mrs Christine Anne Heeroo

Cambridge House

Inspection report

141 Gordon Avenue, Camberley,
Surrey. GU15 2NR.
Tel: 01276 691035
Website:

Date of inspection visit: 02 November 2015
Date of publication: 18/12/2015

Ratings

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

Overall summary

Cambridge House is a privately owned and managed care home registered to provide care and support without nursing for 16 elderly people, some of whom were living with the experience of dementia. At the time of our visit 14 people lived here.

The inspection took place on 02 November 2015 and was unannounced. At our previous inspection in October 2013 we had not identified any concerns.

There was a registered manager 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.

There was positive feedback about the home and caring nature of staff from people and their relatives. A person said, "I am looked after well here." Another said, "It's a good place here." A relative said, "I cannot praise the home enough; they really go that extra mile to support my family member." Health care professionals gave feedback such as, "Friendly and polite staff." "Kind and caring" and "Excellent care."

Summary of findings

People were not always safe at Cambridge House. Not all risks to people had been identified and controls put into place to manage them. For example the risk of entrapment from bed rails had not been assessed, and staff did not always have clear guidelines for supporting people who may have behaviour that challenged themselves or others. The support people needed in the event of an evacuation had also not been recorded, which could slow down the effectiveness of getting people out of the building in an emergency.

The staff were generally kind and caring and treated people with dignity and respect. Staff took time to talk to people and knew them as individuals. One improvement was noted where staff could interact more positively when supporting a person to eat. Some good interactions were seen, such as staff holding people's hands when sitting and talking with them.

Where people did not have the capacity to understand or consent to a decision, the provider had not always followed the requirements of the Mental Capacity Act (2005). Some assessments contained conflicting information, about whether the person had capacity or not. People told us that staff did ask their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected. Staffs understanding of their roles and responsibilities within the DoLS was effective.

People received their medicines when they needed them. Staff managed the medicines in a safe way and were trained in the safe administration of medicines. Some minor areas for improvement were noted, such as ensuring the medicine trolley was locked when left unattended. People were supported to maintain good health as they have access to relevant healthcare professionals when they needed them. Examples were seen where people's health had improved since the came to live at Cambridge House.

The home is light and airy, with good adaptations made for people living with dementia, such as clear signage and colours on doors. The seating in the lounge area did not meet the needs of everyone, as armchairs made it difficult for people to get up without staff support.

People had enough to eat and drink, and received support from staff where a need had been identified. Specialist diets to meet medical or religious or cultural needs were provided. People were happy with the quality of the food, but some felt they wanted more choice to be offered at each meal.

Care plans were based around the individual preferences of people as well as their medical needs. They gave a good level of detail for staff to reference if they needed to know what support was required, although some information was generic. People received the care and support as detailed in their care plans.

People had access to activities that met their needs. Group activities were available to people during the week. Some people told us they felt bored, and there were not many opportunities for people to go out into the community. People who were living with the experience of dementia had one to one activities in their room with staff using memory boxes. These stimulated their memory and helped to prompt conversation. The staff knew the people they cared for as individuals.

The home was well led by the registered manager. People, relatives and staff felt supported, and able to raise any issues or concerns with him. Quality assurance checks were used to improve the home. Results of feedback and audits were made available to people so they could see what had been found, and if any areas needed to improve. Accident and incident records were kept, and were analysed and used to improve the care provided to people. People knew how to make a complaint. Documents recorded that complaints had been responded to in accordance with the provider's policy.

People had the opportunity to be involved in how the home was managed. People told us that residents meetings took place and they also completed surveys about the home. Information from these was used to improve the service that people received.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Personal emergency evacuation plans (PEEPs) needed to be developed for people.

The provider had identified some risks to people's health and safety and put guidelines for staff in place to minimise the risk. Other risks had not been identified or required better guidelines for staff to follow, such as use of bed rails, and supporting people with behaviour that may challenge themselves or others.

People's medicines were managed in a safe way, and they had their medicines when they needed them. Some improvements needed to be made with regards to recording when 'as required' medicines were given, and management of the medicine trolley, so it is not left unattended and unlocked.

People felt safe living at the home. Appropriate checks were completed to ensure staff were safe to work at the home. There were enough staff to meet the needs of the people. Staff understood their responsibilities around protecting people from harm.

Is the service effective?

Requires improvement

The service was not always effective

People's rights under the Mental Capacity Act not always met. Assessments of people's capacity to understand important decisions had been recorded, but contained some conflicting information.

Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

Adaptations had been made around the home to meet people needs; however armchairs in the lounge area made it difficult for some people to mobilise.

Staff said they felt supported by the manager, and had access to training to enable them to support the people that live here.

People had enough to eat and drink and had specialist diets where a need had been identified. They told us they enjoyed the food; however they had little choice at mealtimes.

Summary of findings

People were supported to remain healthy, and examples were seen where people's health had improved due to the effective care and support by staff.

Is the service caring?

Good

The service was caring.

People told us the staff were caring and friendly.

Good interactions were seen, and staff knew people as individuals. Some minor areas for improvement were identified during the lunch.

People were involved in making decisions about their care and support, and were given information in a way they could understand.

Is the service responsive?

Good

The service was responsive to the needs of people.

Care plans were person centred and gave detail about the support needs of people. People had been involved.

People had access to activities; Some people felt they had enough to do, others said they felt bored.

People knew how to make a complaint. There was a clear complaints procedure in place. Complaints had been dealt with in line with the provider's policy.

Is the service well-led?

Good

The service was well- led.

Records were generally well kept, however some had conflicting or missing information.

Quality assurance systems were used to improve the home for the people that lived here.

People and staff were involved in improving the service. Feedback was sought from people, relatives and health care professionals via an annual survey. Results of the surveys were displayed so people could see what had been said about the home.

People were complimentary about the friendliness of the staff. Staff felt supported and able to discuss any issues with the registered manager.

Cambridge House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 02 November 2015 and was unannounced.

The inspection team consisted of three inspectors, who were experienced in caring for elderly people.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete 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.

During our inspection we spoke with six people, one relative, and four staff which included the registered manager. We observed how staff cared for people, and worked together. 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 reviewed care and other records within the home. These included six care plans and associated records, six medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in October 2013 the home had met the requirements of the regulations.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe living at Cambridge House. One person told us, "Yes, I do feel safe." A relative said, "I feel my family member is safe, staff are in and out of her room looking after her."

People's care and support could be compromised in the event of an emergency. Information on what to do in an emergency such as a fire were clearly displayed around the home. These gave clear instructions on what staff were required to do to ensure people were kept safe. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. However it is recommended that the provider review emergency plans to ensure Personal Emergency Evacuation Plans (PEEPs) are in place for each person that would require assistance to evacuate the building.

People's medicines were generally managed and given safely. Improvements could be made with regards to staff awareness of risk when administering medicines. During our inspection a staff member was seen to leave the medicines trolley unlocked and unattended three times. This could leave it accessible to people or unauthorised persons. The providers policy stated that, "the medicine trolley must never be left unlocked when unattended and when open must always be within sight of the person administering at all times" our observations demonstrated staff did not adhere to this policy.

The ordering, storage, recording and disposal of medicines was safe. Some improvements could be made with regards to the recording of when 'As Required' medicines were given. There were some gaps in the recording of these medicines, and staff had not used the correct code (detailed on the MAR) to record on the MAR when they were declined or not required. There were no gaps in the medicine administration records (MARs) for 'routine' medicines, so it was clear when people had been given their medicines.

One person said, "I get my medicines when I need them, and I know what they are for." Staff that administered medicines to people received appropriate training, which was regularly updated. Photographs of people were in place; this ensured the staff administering medicines were able to correctly identify people. Staff ensured they identified the correct person, medication and method of administration. Where homely remedies were used the provider had sought authorisation from the GP to ensure they were safe to use.

Where covert medicine were given the provider had involved the appropriate people to ensure this was in the best interests of the person. Relatives, GP's and pharmacists had been involved in the decision.

People were kept safe from most hazards around the home because an assessment of the risk of harm had been completed. However some improvement was required. Bed rails were in use for some people to reduce the risk of them falling out of bed. When completing the assessment of risk, the provider had not taken into account the gaps and height of the rails to see if there was a risk of entrapment. The provider assured us that these would be done immediately.

Where people may display behaviour that challenged themselves or others an assessment of the risk of harm had been completed. However guidelines for staff on how to manage the risk were not as detailed as they could be. They contained very generic statements and did not give clear instructions to staff on how to safely individuals. When people presented challenging behaviour during the inspection staff were calm and respectful, and supported in a safe manner, so the issue was to do with the recording of information, not the actual care given. Staff understood the behaviours and reasons for the behaviour.

When people had hot deserts, the risk of scalding had not been managed by staff. The temperature of hot deserts was not routinely checked (although the main meal was), which left people at risk. People were served a hot sponge, and could not eat it because it was too hot for them. The chef told us they had expected the staff to stir it to cool it before it was given to people. This had not happened.

Risks that had been identified and well managed included infection control, fire safety and clinical waste disposal. Staff worked within the guidelines set out in these assessments. Equipment used to support people were regularly checked to make sure it was safe to use. Items such as hoists and fire safety equipment were regularly checked. The home's design and maintenance also

Requires improvement

Is the service safe?

reduced the risk of harm to people. Flooring was in good condition to reduce the risk of trips and falls. People lived in a clean home. Bedrooms and communal areas were all clean, tidy and no unpleasant odours were detected.

People were kept safe because the risk of harm from their health and support needs had been assessed. Assessments had been carried out in areas such as mobility, and nutritional risks. Measures had been put in place to reduce these risks, such as monitoring peoples weight were a risk of malnutrition had been identified. Examples seen showed that people's weight had remained constant, so the risk was being managed well. Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs.

There were sufficient staffing levels to keep people safe and support the health and welfare needs of people living at the home. One person said, "I think there are enough staff here." A relative said, "There are always staff around, I feel there are enough staff." Planning to ensure there were enough staff to meet people's needs was safe. Peoples care needs had been assessed and a staffing level to meet those needs had been set by the provider. Levels of staff seen during the day of our inspection matched with the level identified by the provider as being required to meet people's needs. Staffing records also confirmed that the appropriate number of staff had been in the home to support people for the previous month.

People were kept safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the keyworker to look for patterns that may suggest a person's support needs had changed. Support was also put into place for people as a result of these reviews. A relative said, "They have installed an alarm mat which helps my family member and she has a bed rail. I get told straight away about any incidents or accidents."

People were protected from the risk of abuse. Staff understood their responsibilities in relation to safeguarding people. They were able to identify the correct safeguarding procedures should they suspect abuse, and that a referral to an agency, such as the local Adult Services Safeguarding Team, or the police should be made. People were also given information about abuse during house meetings, so they knew what it was and what to do if they felt it had happened.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires improvement

Is the service effective?

Our findings

People told us they thought staff were well trained, knew their needs and were helpful.

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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had not always complied with the requirements of the Mental Capacity Act 2005 (MCA). Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were not always effectively followed. Assessments of people's mental capacity had been completed. However these contained conflicting information, for example blanket statements recording people had no capacity, and then other assessments recorded that they did have capacity. Where people did not have capacity, relatives with a Power of Attorney confirmed they were consulted by staff and involved in making decisions for their family member. It is recommended that the provider reviews the requirements of the MCA and how capacity assessments are recorded.

Staff had an understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They could not describe the purpose of the Act to us and its potential impact on the people they were caring for.

During the inspection staff were heard to ask people for their permission before they carried out tasks, such as supporting them to get out of chairs, or asking people if they wanted to wear protective bibs before eating. Where people said no, staff respected this decision. One staff member said, "I always have to ask people if they want care. If they refuse, I leave it a while and come back later."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

Adaptations had been made around the home, such as clear signs and colours on doors to make it clear to people what the room was; however seating for people in the lounge did not meet everyone's mobility needs. People were seen to struggle to get out of armchairs and on one occasion a person was supported by staff with a support belt around their waist, but ended up using this to almost lift the person. This was bought to the registered manager's attention, as this was not what the belt was designed for. It put the person and staff at risk of injury.

People and relatives told us that care staff had sufficient knowledge and skills to enable them to care for people. A relative said, "The staff are good at moving and handling." Staff had ongoing training to undertake their roles and responsibilities to care and support people. The induction process for new staff was robust to ensure they had the skills to support people effectively. One member of staff said, "I did all the training during my induction, we covered things like moving and handling and dementia care. I also had to shadow experienced staff for about six weeks before my induction was finished."

Staff had been effectively supported. Staff had regular supervisions (individual one to one meetings with their line manager) and appraisals. This gave them the

Requires improvement

Is the service effective?

opportunity to discuss their performance, training needs, and raise any concerns or ideas for improvement. One staff member said, “I have a one to one with my manager every month. It’s about improving my job.”

People had enough to eat and drink to keep them healthy and were happy with the quality and quantity of food and drinks available to them. One person said, “The food is quite excellent.” People told us they wanted more choice, as only one option was generally offered. One person said, “We used to have more of a choice, but not anymore.” Where people required specialist diets these were available and given to people. People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy. People were encouraged to remain independent as equipment such as plate guards and non-tipping bowls enabled them to eat without staff support.

People were supported to maintain their health by having access to health care professionals. One person said, “I get to see the GP if I am unwell, they come in regularly.” A relative said, “The home has helped my family member walk again, they really go the extra mile to help her.” Care records demonstrated that where people’s needs had changed appropriate support was sought. People also had access to dieticians, speech and language therapist (SALT), and occupational therapists to aid with their mobility needs. Where a person had broken a bone, their care and support needs had been reviewed to help them to get better. Their staff support ratio had been increased to support with mobility and eating and drinking. Access to a physiotherapist had also been arranged. Care records had been updated to ensure staff provided effective care for the person.

Good

Is the service caring?

Our findings

We had positive feedback from people about the caring nature of the staff. A person said, “I am looked after well here.” A relative said, “Staff are very, very caring here. They put their arms around her and they talk to her with dignity and respect. She is always lovely and clean.” People told us that they had good relationships with staff and that staff were kind and helpful. Feedback the provider had received from a healthcare professional said, “Staff know the residents well and seem genuinely caring and friendly.”

People looked well cared for, with clean clothes, tidy hair and working hearing aids where they were used. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. We did identify some areas for improvement. When supporting people to eat, not all staff interacted well with people. Staff did not ask people if they were ready for the next portion; Staff sat waiting with food on the spoon, looking elsewhere until people finished what they were eating.

Staff were positive about supporting people and knew people as individuals. They were able to describe peoples likes and dislikes, as well as what they had done in life before they came to live here. Examples staff gave us were confirmed with people, and matched with the information in the care records. One staff member said, “I get to know people by sitting and talking with them. I love how every resident is different. I like helping people.” A caring and respectful example was seen where a person needed to take some medicine. The staff member apologised to the person for disturbing them, and then complemented them on the drawing they were working on.

People’s privacy and confidentiality was respected by staff. Care files were kept in an area to be accessible to staff, but not to other people, such as visitors. Care staff did not discuss people in front of others, so people would not overhear confidential information.

Staff were able to communicate effectively with people. They spoke clearly and in a manner that people could understand. Where people were not able to speak, staff were also able to understand hand gestures and facial expressions. One staff member said, “I show how I care by the way I speak to and treat people. I speak in a low voice, use short sentences and always explain what I am doing.” An example was seen where staff went to support someone out of a chair. The person pushed their arm away. Staff asked and tried again, the person pushed their arm away again. Staff then left the person, respecting their decision to stay seated.

People’s dignity and privacy were respected by staff. One person said, “I can lock my bedroom door if I want to. They do respect my privacy” Good examples were seen where staff treated people with respect, such as knocking on peoples doors before entering, identifying where peoples dignity may be compromised due to clothing. Staff explained how they protected people’s privacy and dignity such as ensuring people were covered when they were provided personal care and closing curtains and doors so other people could not look in.

People were given information about their care and support in a manner they could understand. One person said, “Yes, I have a care plan, I don’t worry too much about it, I have a key worker and we talk about it.” Care files recorded were people had been involved in decision making such as advanced decisions they wanted to make if they had a heart attack.

People’s rooms were personalised with family photographs, ornaments and furniture. This made the room individual to the person that lived there. People’s needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to services so they could practice their faith.

Good

Is the service responsive?

Our findings

People were positive about how the service met their needs. People's care and treatment was planned and delivered to reflect their individual care plan. One person said, "I do have a care plan; I don't worry too much about it though." A relative said, "They give her the care she needs."

People had access to activities, however these were not always personalised to people's interests and people had very little access to the local community. People gave a varied response when asked if they had enough to do. People told us they didn't join in with some of the activities because they didn't like them. One person said, "I do get bored sometimes." Another said, "I get to go out once a month with my spending money into town." A relative told us, "My family member can only do a certain amount. They have a priest come in. They do music and they play ball with her. For a small home it's enough for her." One to one activities took place in peoples rooms, by the use of memory boxes. These were used to prompt conversations and memories with people who lived with the experience of dementia.

People's needs had been assessed before they moved into the home to ensure that their needs could be met. They contained detailed information about people's care needs, for example, in the management of the risks associated with people's mobility or dietary needs. The care plans contained detailed information about the delivery of care that the staff would need to provide such as pain management and skin integrity. Care planning and individual risk assessments were reviewed monthly or more frequently if required so they were up to date. For example where a person had experienced an increase in falls, this had been identified by staff, and a referral made to the falls clinic. Risk assessments and support equipment had been updated as a result. People's preferences, such as food likes, and preferred names were clearly recorded. Care was given in accordance with these preferences.

People were involved in their care and support planning. People confirmed that they had been always been involved in completing the care plans. Where people could not be involved themselves relatives were involved. A relative said, "I am involved in decisions about her care, they always ask for my opinion, and consult me."

People were involved in their care reviews. Care plans and risk assessments were regularly updated in line with people's changing needs, and the records were legible and up to date. There was sufficient information in care plans about people's health needs for staff to understand the support required; however some parts of the care plan were generic, rather than individual to the person. Daily care records recorded the care given, but were quite generic and did not give too much detail. Comments such as 'care given as per plan' were commonly seen. This would make it hard for the registered manager, or senior staff member to see exactly what care had been provided, nor the experience people had.

People's choices and preferences were documented and those needs were seen to be met. There was detailed information concerning people's likes and dislikes and their preferences around the delivery of care. This covered areas such as specific dietary needs, or medical support needs. Care plans were comprehensive and were person-centred in varying degrees. However repetitive information was found which was at times contradictory, which could cause confusion to staff, and make it hard to know what the most up to date information was.

People were supported by staff that listened to and responded to complaints. People and relatives knew how to raise a concern or make a complaint. One person said, "I haven't felt the need to complain about anything." A relative said, "If I wasn't happy about something I would tell the manager." People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. One person said, "Oh yes, I'm sure they would listen to me." People and relatives had signed to say the complaints process had been explained to them.

Good

Is the service responsive?

There was a complaints policy in place. This was prominently displayed in the home. People were positive about the home and staff. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission. People and a relative confirmed they knew how to make a complaint, but have never felt the need to. Complaints had been dealt with in line with the provider's policy.

Good

Is the service well-led?

Our findings

There was a positive culture within the home between the people that lived here, the staff and the registered manager. A person said, “It’s calm and quiet here, just the way I like it.” A relative said, “The registered manager is 100% there for my family member.” “I think it’s well led. I came here and found the registered manager was supportive.” Staff told us they felt valued by the registered manager and provider.

Record keeping was generally good within the home, but over the course of the inspection we had identified some areas that the registered manager should focus on. These included inconsistent/conflicting or generic information in some care records; inconsistent recording of ‘as required’ medicines; and some missing information on certain risk assessments to make it clear to staff exactly what support is required.

Regular checks on the quality of service provision took place there results were actioned. The registered manager and other senior staff told us they regularly checked to ensure a good quality of care was being provided to people. Regular audits were completed on all aspects of the home for areas such infection control, health and safety, and medicines. Results of audits and other feedback were used to improve the service. A staff member said, “These tell us how good we are doing and the results are fed back to us. Where amendments are found we find a solution to put them right.”

People and relatives were included in how the service was managed. One person said, “We have house meetings, and the staff have meetings as well.” Relatives confirmed they were asked for their feedback and that the manager was available and listened to what they said. The registered manager ensured that various groups of people were consulted for feedback to see if the service was met people’s needs. This was done annually by the use of a questionnaire and included, people, relatives and health care professionals. The feedback was analysed by the registered manager to see if there were any areas that required action.

The survey results for 2015 were all very positive about the care people received. Areas covered by the survey included asking if staff were caring; sought appropriate advice when people were ill; the skill of staff; and did staff know the people they care for. Results of the feedback received was displayed on noticeboards, so people and visitors could see what had been said about the home, and what action the registered manager had taken as a result.

Staff felt supported and able to raise any concerns with the management. One staff member said, “I feel supported, I can trust the registered manager and the provider. They thank me, and I feel part of the family.” Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

Staff were also involved in how the service was run. They were invited to staff meetings held by the manager. These discussed any issues or updates that might have been received to improve care practice.

The registered manager provided good leadership for the home and supported the staff team in providing care and support when needed. The manager was visible around the home on the day of our inspection. They were available to people and relatives if they wished to speak to them. It also gave the opportunity to observe the care and support that staff gave to people, to ensure it was of a good standard. The manager knew the people that lived here as individuals.

The manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home. Staff understood what whistle blowing was and that this needed to be reported.

There was a clear values statement in the home. This was recorded and displayed in a ‘resident’s charter’ sign in the reception area. It recorded that people should be treated as an individual, have

Good

Is the service well-led?

choice and their independence promoted. It also covered being treated with dignity and respect. During our observations over the course of the day, staff were seen to understand and work in accordance with this charter.