East View Housing Management Limited

East View Housing Management Limited - 370 The Ridge

Inspection report

370 The Ridge
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Date of inspection visit:
12 December 2016
13 December 2016

Date of publication:
31 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 December 2016 and the first day was unannounced.

The home provides accommodation for people with a learning disability or mental health needs and offers a communal living area, kitchen and dining area in open plan design. There are four bedrooms on the ground floor, a wet room and shower room. Upstairs there are a further two bedrooms and another shower room. There is a small front garden with a parking area, and a large back garden.

There is 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 were six people living in the home at the time of the inspection. People had been supported to move into the home at very short notice, when the home they had previously been living in suffered storm damage.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs. There were appropriate numbers of staff employed to meet people's needs and provide a flexible service.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home. Staffing levels were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and appropriately.

The staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Systems, processes and standard operating procedures around medicines were reliable and appropriate to keep people safe. Monitoring the safety of these systems were robust.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. The risk assessments we read included information about action to be taken to minimise the chance of harm occurring.

Staff knew the people they supported and provided a personalised service. Care plans were in place detailing how people wished to be supported and families were involved in making decisions about their

care.

People were supported to eat and drink. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required to meet people's needs.

Staff told us the registered manager was accessible and approachable. The manager and provider undertook regular audits to review the quality of the service provided and made the necessary improvements to the service. People were involved in audits of the home's environment.

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 the correct processes to be followed if abuse were suspected.

People had risks to them assessed and plans were in place to manage these risks. There were processes for recording accidents and incidents.

People were supported by enough staff to meet their needs.

People were given their medicines safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the skills and knowledge to meet their needs.

People's rights were respected, and the home was following the best interest's framework of the MCA. People's choices were supported.

People were supported to eat and drink according to their plan of care.

People were supported to attend healthcare appointments and staff liaised with other healthcare professionals as required.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect. People responded well to staff.

People's privacy and dignity were respected and supported.

People were able to access local advocacy services to support them if required.

Is the service responsive?

Good

The service was responsive.

People had plans of care which gave good levels of detail about their care and support needs.

People were supported by staff who were knowledgeable about their support needs, their interests and preferences in order to provide a personalised service.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Good

The service was well-led.

People were involved in some audits.

Staff told us they were supported by their manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their manager.

The registered manager and the provider checked the quality of the service provided and made sure people were happy with the service they received.

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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 12 and 13 December 2016 and the first day was unannounced. It was carried out by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

People had communication difficulties associated with their learning disabilities. We observed staff interacting and supporting people in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During our inspection we spoke with one person who lived in the home, four care staff and the registered manager. After the inspection, we spoke with one healthcare professional. We also phoned four relatives to seek their views; however only one relative was available to speak with us. We looked at the care records for two people. We also looked at records that related to how the home was managed, such as minutes of meetings, training records, four staff files, emergency procedures and a variety of audits.

Good

Is the service safe?

Our findings

The service was safe.

People benefited from a safe service where staff understood their safeguarding responsibilities. The provider had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Whistleblowing is a way in which staff can report concerns within their workplace. Staff were aware of these policies and told us they knew how to recognise and report concerns they might have about people's safety. Staff said that if they had concerns then they would report them to the registered manager. If they were unavailable, they would contact senior managers or external agencies such as the local authority safeguarding teams to ensure that action was taken to safeguard the person from harm. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. One relative said they felt people were safe and told us they knew how to raise any safeguarding concerns they had. The registered manager had notified the local safeguarding authority of safeguarding incidents.

Assessments were undertaken to assess any risks to the people at the home and to the staff supporting them. They provided details of how to reduce risks for people. Care plans and risk assessments had been reviewed regularly. Where someone had been assessed as being at risk, appropriate action had been taken to minimise the risk. Staff knew about the assessments and protocols in place to protect people. For example, Epilepsy guidelines in place and risk assessments which gave clear guidance for staff of the measures in place to reduce risk. Guidelines included descriptions for staff how people's seizures may present and how staff should support the person. Staff said, "We can talk to the manager if things need updating, but generally they're spot on."

There were arrangements in place to keep people safe in an emergency. Information was available for staff which included contact numbers for relatives and staff, and important utility locations such as the water stopcock, various fuses and gas supply. A first aid kit was also available and was regularly checked. Personal emergency evacuation plans contained information about the assistance people needed, including any equipment they might use. Some of these needed to be updated; however the registered manager had this in hand. Staff and people took part in regular fire drills when the alarm was sounded and people were supported to leave the building.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. For example, one person had been involved in several incidents in September 2016 and October 2016. As a result, the registered manager had arranged for the person to have appropriate professional support. The layout of the communal area had also been changed around to reduce the likelihood of the incidents recurring. Staff had been reminded about the requirements to supervise people and risk assessments had been updated. One relative told us, "I'm kept informed if anything happens, I really appreciate that."

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. One healthcare professional told us, "This is my second visit, there seem to be enough staff when I visit." Where people required two to one or one to one support; there were sufficient staff available to provide this level of support. Staff rotas showed there were always a minimum of three staff on duty during the day; one waking and one sleeping staff at night. Where agency staff were used, the registered manager had identified when additional staff would be needed and booked early enough to secure staff who had worked in the home previously and knew people. Agency staff were provided with an induction which included fire and other emergencies, and reading people's care plans.

The service followed safe recruitment practices. Appropriate checks had been completed to ensure staff were suitable to work with vulnerable people. Staff personnel files contained copies of their application form, documents proving their identity and eligibility to work in the UK, their terms and conditions of their employment, two satisfactory references and confirmation that a satisfactory criminal records check had been obtained. A health questionnaire and declaration were also obtained.

Peoples' medicines were managed and administered safely. Where people took medicines which could interact with certain foods, this was clearly described in people's care plans. For example, one person took medicines for calcium deficiency; their care plan specified the foods they must not eat such as spinach and rhubarb.

People's medicines were administered by registered staff who received annual training and had their competency assessed on an annual basis to make sure their practice was safe. We noted that all the Medicine Administration Records (MAR) had photographs of the person on them; these photographs had been dated which showed the photographs had been taken recently and were a true likeness of the person.

No one was receiving covertly administered medicines and no one was self-medicating, though the providers medicines policy contained information about self-administration of medicines for staff to follow should this be necessary. One person's care plan gave guidance for staff about the times the person could have their breakfast, as they took a medicine which meant they needed to wait half an hour before eating. Staff we spoke with were all aware of this, and we saw it had been appropriately recorded on their MAR chart.

Secure cupboards which provided suitable storage facilities for medicines were used. Secure storage for medicines which required refrigeration was also available if needed. The home used a blister pack system with printed medication administration records for some medicines, and boxes for other medicines. We saw medicine administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. There were no medicines that required additional security and recording on the premises, but there were appropriate storage facilities and processes in place should these be necessary. We checked records against stocks held and found them to be correct. One person's creams had not been dated with the date of opening, but all other topical medicines had this information on the container. Some people were prescribed medicines on an 'as required' basis. A GP had agreed the use of these medicines.

A master signature list was available; this ensured that in the event of an error the dispensing practitioner could be quickly identified from the MAR chart initials.

Fridge and room temperatures had been recorded daily to ensure the optimal storage of medicines, such as those used for diabetes. This meant there were safe medication administration systems in place and people

received their medicines when required.

All visitors had to ring a doorbell and be invited in by a member of staff. Every visitor was asked to sign the visitor's book when they arrived. This meant people were able to have visitors but were kept safe by staff.

Good

Is the service effective?

Our findings

The service was effective.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us and records confirmed they completed a range of training courses such as first aid, moving and handling, infection control and food hygiene. Staff were able to access training courses provided by East Sussex County Council which meant they benefitted from face to face training provided by trainers who had been recognised by the council as being of a good standard. Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training. Staff had been supported to complete specialist training for topics such as epilepsy; staff told us they felt the training gave them the skills they needed. Staff said, "Some of the training is very good" and "If you want to do extra training the manager will put you forward."

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. New staff were supported to complete an induction programme before working on their own. They told us, "I've done loads of training this year and I'm doing the Care Certificate." The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Handover forms recorded whether people had been given their medicines, if they had eaten their breakfast and staff were also expected to count the cash to ensure this was correct. If people had any appointments such as a GP appointment, this information was also recorded.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us and records confirmed supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "I think they're very useful, it's good to sit down with the manager. We talk about how we think we're doing and how she thinks we're doing". Annual appraisals give both managers and staff the opportunity to reflect on what had gone well during the year and areas for improvement or further training required. Staff were given time to prepare for their appraisals and were encouraged to celebrate successes.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Mental capacity assessments in people's care plans clearly guided staff to assess people's capacity on a day to day basis, and reminded staff that any decisions were specific to one activity. Capacity

assessments were completed for everyday situations and explained what people could do for themselves, such as when or what they wanted to eat, when they chose to go to bed or get up and washing and dressing.

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).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

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 registered manager had applied for DoLS for three people and was awaiting the outcome for these. Staff said, "If [name] wanted to walk out she would be very vulnerable in the community, so it's in her best interest to stay here and go out accompanied."

Families where possible, were involved in person centred planning and "best interest" meetings. A "best interest" meeting is a multidisciplinary meeting where a decision about care and treatment is taken for an individual, who has been assessed as lacking capacity to make the decision for themselves. The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. Where people had capacity to make some decisions, their decisions were respected, even when they made decisions others may consider unwise. For example, one person needed a surgical operation and had declined to have the operation. After some changes had been made, the person changed their mind.

Although people's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes staff were not fully aware of everyone's dietary needs. People's needs and preferences were clearly recorded in their care plans. Staff told us they had all the information they needed and were aware of people's individual needs; however they were not aware of certain foods one person should avoid. The person's care plan said they should not eat certain foods because it would react with medicines the person was taking. As this person required mashed foods there was little risk to the person, as the foods they could not eat were unlikely to be offered to them. Staff told us about the person's need for soft foods and drinks that had been thickened so they could swallow them without choking. Staff said, "They have a fork-mashable diet and it has to be soft" and "We have to tell her to slow down." We discussed this with the registered manager, who assured us they would remind staff of people's dietary needs.

We observed lunch in the main dining room and saw that people received the support they required in a dignified manner. We also noted that people were provided with appropriate equipment such as small sized cutlery, to enable them to eat independently. One person told us they liked the food and were able to make choices about what they had to eat.

Food charts which showed people's intake of nutrients was being recorded where required. People's weights were recorded on a monthly basis unless otherwise stipulated. The manager explained that should anyone be observed losing weight, they would be referred to a GP who in turn would refer to a dietician. Other reasons for weight loss would also be investigated if necessary. Some people who used the service required soft foods; we saw that these were provided as required. We saw two people's care plans; one of

which stated fluid charts must be maintained. We saw these were being done. For another person, the care plan stated the person must drink between 1500 and 2000 ml per day; however there were gaps in this person's records in November, which meant it was not possible to be certain the person had had enough to drink. However, we saw staff gave the person drinks regularly during the inspection. Staff told us the person was able to ask for drinks if they were thirsty.

Some people living in the home had complex needs and required support from specialist health services. One relative told us, "They'll take [name] to the doctor if there's anything wrong." People's care records showed relevant health and social care professionals were involved with people's care, such as Speech and Language Therapists and dentists. Care plans were in place to meet people's needs in these areas and were regularly reviewed. People had a health action plan which described the support they needed to stay healthy.

Good

Is the service caring?

Our findings

The service was caring.

Most people using the service were not able to give us feedback directly about the care they received, however we made observations and were able to speak with one person during our inspection. From our observations, we could see that people were relaxed in the presence of staff and appeared to be happy. We observed staff were attentive and had a kind and caring approach towards people. We observed staff were very polite and addressed people by their preferred names, and collectively addressed people as "the ladies". One relative said, "Staff are kind and considerate." Staff said, "I really enjoy caring for them." One healthcare professional told us, "People always seem happy."

Staff were offering people choice, encouraging them to undertake tasks independently and supporting them where needed. People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. Staff said, "If people don't want to do anything we don't force them, and if they do want to do something we encourage them."

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. People's privacy was respected and all personal care was provided in private. Throughout the inspection we observed staff knocked on people's doors before entering their rooms. However, one relative said they recently observed a member of staff walking into someone's room without knocking. Staff said that their understanding of showing respect for people's privacy and dignity included making sure people were covered when receiving personal care and they ensured the door was shut. Staff said, "It also means discreetly taking someone to the bathroom if they're wet and not making a song and dance about it."

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. For example, when one person required assistance from other professionals' staff made the person as comfortable as possible while they waited, and talked to the person throughout to reassure them.

People's bedrooms were personalised and decorated to their taste. One person told us, "I've got a big bed, a wardrobe and a table." They were happy for us to see their room; we saw the room contained items that were important to the person. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private.

Staff knew people's individual communication skills, abilities and preferences. We viewed two care plans and saw that they gave a comprehensive picture of people's needs and the way in which the person should be supported. Plans showed that people's level of need varied but it was clear where people were able to be independent. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. People and their relatives were given support when making decisions about their preferences for end of life care. One person's care plan recorded the person didn't like talking about their end of life because this made them "very sad", but they wished to stay

at home.

The home had links to local advocacy services to support people if they required support. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. Staff said, "People can have an advocate if they're not good at communicating important decisions, and we use picture cards or show them for other choices."

People had access to easy read guidance about treating everyone fairly. The guidance explained that people should not be treated differently.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. People's documents were stored in the office or in a locked cupboard. The office was always occupied by members of staff, but if required could be locked. By doing this people's private information was protected from being seen by unauthorised parties.

The provider has signed up to the department of health's initiative 'The Social Care Commitment.' This is the adult social care sectors' promise to provide people who need care and support with high quality services. The PIR stated, "The senior management team attend or subscribe to forums, events or professional body updates to keep up to date with good practice and legislation. These include: Attendance at provider forums held by commissioners of funding authorities." The provider also received notifications and alerts from CQC and had membership of two nationally recognised bodies, the British Institute of Learning Disabilities (BILD) and membership of Social Care Institute for Excellence (SCIE).

Good

Is the service responsive?

Our findings

The service was responsive.

People received care that was responsive to their needs and personalised to their wishes and preferences. People were supported to make choices about all aspects of their day to day lives.

People's needs were assessed before they began to use the service and reviewed regularly thereafter. One relative told us they were invited to attend annual reviews. People's assessments considered all aspects of their individual circumstances, for example their dietary, social, personal care and health needs and also considered their life histories, personal interests and preferences.

Care plans were person centred and clearly identified the particular ways of providing support that were unique to that person. People or their relatives were involved in developing their care, support and treatment plans. Care records were comprehensive and provided clear and detailed information about the person's care and support needs. Plans had been completed for dietary needs, communication needs, lifestyle and socialising. Information was also included about who the important people in their life were, how they communicated, what medicines they took and what daily routines they had. Monthly summaries were written for each person by their key worker. These were used to review how effective each person's plan of care had been and to note any significant events.

Staff knew how people wanted their care to be provided, what was important to them and how to meet people's individual needs. For example, one person's care plan described the parts of their life they liked talking about, and parts of their life they preferred not discussing. One healthcare professional told us, "I've no concerns about this home. The care plans are good and staff follow the guidance."

The staff responded to changes in people's needs. As a result of storm damage to their previous home, people had to be moved at very short notice to a new home. Staff told us they would have liked to have taken time introducing people to their new home, for example by visiting to have tea before moving in. The registered manager told us they would normally have spent three weeks preparing people, and moving at short notice had been very traumatic for them. People were therefore somewhat unsettled when they first moved in, and staff had provided reassurances and support to make the experience of suddenly moving a positive one. One relative told us, "It was a good move. I'm pleased they thought ahead about how people were going to cope getting older because some residents couldn't manage the stairs in their old home."

There were some gaps in records in November 2016 and early December 2016. One person's daily exercise chart had not been completed on 15 days prior to the inspection; their food diary and sleep chart also had gaps. We noted these gaps started around the time people had moved into their new home. The registered manager assured us staff would be reminded of the importance of keeping these records up to date.

People had been assisted to complete key information documents about "this is me"; "this is important to me"; "this is important for me"; and "mind my business". Where necessary health and social care

professionals were involved. Health Action Plans were in place describing the support the person needed to maintain their health. People also had a 'Care Passport' which described things other healthcare professionals would need to know in order to support the person effectively. These were sent with an individual when they attended hospital.

Staff showed an understanding of how to respond to behaviours which may cause harm to the individual or others. There were behaviour plans in place for some people. These identified how staff could and should respond to any behaviour which they found challenging. This included aggression to staff or others, distress and agitation. We asked staff about this and they were able to demonstrate an understanding of how they supported people. For example, we saw staff followed the guidelines in one person's care plan when they shouted.

People were able to take part in a range of activities according to their interests. People's care plans described the activities they enjoyed. For example, one person enjoyed going shopping, to parks, to the theatre and a local attraction. Their hobbies were also identified, such as knitting, puzzles, listening to music and watching films. We saw they were supported to do all of these.

People who used the service and their families had been made aware of the complaints procedures. Complaints were analysed to identify patterns and trends. There had been no formal complaints recorded for over a year. One informal complaint had been raised which had been thoroughly investigated. Once the context of the complaint had been established the person's care plan had been updated. One relative said, "I don't have any complaints."

There were monthly meetings for people who lived at the home. Agendas were prepared in an easy read format. People were asked how they felt about the home, menus and planning future activities. Staff told us four people were able to give their views verbally, and one person was supported to give their views using picture cards. This showed the registered manager sought people's feedback and took action to address issues raised.

Good

Is the service well-led?

Our findings

The service was well-led.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Annual surveys had been sent to people using the service, relatives, staff and healthcare professionals. The latest surveys had been due back on the day of our inspection, so these had not been analysed. However, we saw the results of the 2015 survey. When the surveys had been analysed, a letter was sent to each respondent giving the overall findings and information about how any points they made would be addressed. Some very positive comments had been received, including "Carers are excellent" and "I can think of nothing I would change."

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were a variety of monthly audits and checks in place to monitor safety and quality of care, such as emergency plans, care plans, medicines and safeguarding. People had been involved in environmental audits such as whether lights and taps were able to be turned on and off and checking bedrooms had everything needed. Where shortfalls in the service had been identified action had been taken to improve practice. For example, one audit of a care plan identified that a page needed to be re-printed; this had been completed. The PIR stated, "…. a further measure of self-assessment will be introduced by way of 'peer to peer' audits. Instead of carrying out a 'self-audit', twice a year managers will undertake an audit at another East View Housing service and vice versa." The registered manager confirmed this would be carried out and felt this would be a valuable exercise.

There were also a number of maintenance checks being carried out weekly and monthly. These include the water temperature and safety checks on the fire alarm system and emergency lighting. There were up to date certificates covering the gas and electrical installations and portable electrical appliances.

Staff were aware of the values of the organisation and said, "The values are to spend time with people making sure they're happy" and "To ensure we meet people's needs, given them a homely, clean environment." Staff told us, "I treat people like family" and "It's a lovely place to work." Staff told us the registered manager was approachable and they would be able to raise any concerns with her. One relative also told us the nominated individual was very good; they said, "He's very straightforward and honest." The nominated individual is an important role for providers, with a key relationship and responsibility to the Care Quality Commission (CQC).

Staff meetings had been held regularly. We saw minutes from January, April, May and August and if staff had not attended the meeting, they were required to read the minutes and sign to show they understood what had been discussed. A variety of topics had been discussed during staff meetings, such as discussing people's needs to ensure staff were reminded how to meet people's needs. For example, staff were reminded that one person was a sun-worshipper and to ensure they had sun cream applied. Another team meeting had been used as a medicines refresher training session. Staff said they found the meetings useful and they were able to raise topics for discussion if they wished.

All accidents and incidents which occurred in the home were recorded and analysed. Changes had been made to reduce the likelihood of accidents and incidents occurring. Incidents had been followed up and care plans had been reviewed and updated as a result.

The PIR said, "An out of hour's system is in operation allowing staff to have direct contact with a manager at any time day or night. The Senior Management offer 24hr support to all on call managers." Staff we spoke with confirmed they were able to access support at any time.