

# Dolphin Property Company Limited

# Cherry Tree Care Centre

## Inspection report

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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 4 February 2016 and 8 February 2016. The first day of the inspection was unannounced which meant that the staff and registered provider did not know that we would be visiting. We informed the registered provider of our visit on 8 February 2016.

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Cherry Tree Care Centre is a purpose built care home providing accommodation over two floors. There is a garden area to the exterior of the property and onsite parking facilities. The service is located close to local amenities including shops and cafes.

The service is registered to provide residential care and support for up to 42 people. At the time of our visit there were 38 people using the service. The Jasmine Suite provides residential care on the ground floor and the Sunflower Suite on the first floor provides care for people living with dementia. The two floors are accessed by both stairs and a passenger lift.

The home had a registered manager in place. 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.

When we last inspected the service we found that the provider was failing to comply with Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010), consent to care and treatment. Decisions were being made that limited people's rights without the appropriate assessment of capacity and no DoLS applications had been made in respect of those individuals who were at risk of being deprived of their liberty.

At this inspection we found that improvements had been made in this area. Care records contained appropriate assessments and staff understood the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards which meant they were working within the law to support people who may lack capacity to make their own decisions.

From our observations it was clear that staff knew the people who lived at the service well and we saw that they responded to their care needs accordingly.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about different types of abuse and were aware of the action they should take if they suspected abuse was taking place. Staff were aware of whistle blowing procedures and all said they felt confident to report any concerns without fear of recrimination.

We looked at care plans and found that they were written in a person centred way but were sometimes lacking detail. The care records we viewed showed us that people had appropriate access to health care professionals such as dentists and opticians. We saw that individual risk assessments were not in place in place to cover all of the key risks specific to the person however we saw evidence that this was being addressed during our visit.

We observed that people were encouraged to be independent and to participate in activities that were meaningful to them. We saw people enjoying a film on television in the afternoon and a singer also visited to entertain people during our visit. We were also told that in good weather people enjoyed spending time in the garden. Some people had expressed the desire for a pet during a residents' meeting and there was now a fish tank and a pet rabbit in the home.

There were sufficient numbers of staff on duty to meet the needs of people who used the service. Safe recruitment and selection procedures were in place and appropriate checks had been undertaken prior to staff starting work. The checks included obtaining references from previous employers to ensure that staff were safe to work with vulnerable people.

Staff received appropriate training and demonstrated that they had the skills and knowledge to provide support to the people they cared for. Staff also received regular supervisions and annual appraisals.

Appropriate systems were in place for the management of medicines so that people received their medicines safely.

We saw that people were provided with a choice of healthy food and drinks to help ensure their nutritional needs were met. Staff demonstrated knowledge of people's likes, dislikes and special dietary requirements. Food was fortified with butter and cream for those people who needed extra sustenance and alternative dishes prepared for those people who needed to monitor their intake of sugar or gluten.

The service had a complaints procedure in place and this was clearly displayed within the home.

There were systems in place for monitoring and assessing the service. Action plans were produced to address any issues identified during the quality assurance process and any necessary changes were implemented.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and electrical safety.

We spoke with staff who told us they felt supported and that the registered manager was always available and approachable. Throughout our visit we saw that people who used the service and staff were comfortable and relaxed with the registered manager and each other. Staff were observed to be caring and respected people's privacy and dignity. There was a relaxed atmosphere and we saw staff interacted with each other and people who used the service in a very friendly and respectful manner.

## 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 we spoke with knew the different types of abuse and what action to take if they wanted to report anything they were concerned about.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. There were sufficient skilled and experienced staff on duty to meet people's needs.

Appropriate arrangements were in place for the safe storage, management and administration of medicines.

### Is the service effective?

Good ●

The service was effective.

People were cared for by staff who had the right skills and knowledge to care for them. Staff had received the appropriate training.

Staff had received training on the Mental Capacity Act (2005) and demonstrated some understanding of how to apply this in practice.

People were supported to access healthcare and their nutritional and hydration needs were met

### Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect.

Care and support were delivered with kindness and staff knew people well.

People had access to advocacy services.

### Is the service responsive?

Good ●

The service was responsive.

Care plans were written in a person centred way but did not always contain enough detail.

People had access to a wide range of activities.

The service had a complaints policy in place and complaints were correctly investigated and documented.

### **Is the service well-led?**

**Good** ●

The service was well led.

Staff and people we spoke with told us the management team were approachable.

Staff said they felt supported in their role and regular staff meetings were held which helped to promote staff engagement.

There were effective systems in place to monitor and improve the quality of the service provided. These looked at things such as medication, finances and care records as well as accidents and incidents.

# Cherry Tree Care Centre

## **Detailed findings**

### Background to this inspection

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

The inspection took place on 4 February 2016 and 8 February 2016. The first day of the inspection was unannounced, which meant that the staff and registered provider did not know that we would be visiting. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed all the information we held about the service including statutory notifications we had received. Notifications are changes, events or incidents that the provider is legally obliged to send us. We also spoke to commissioners of the service who raised no concerns about Cherry Tree Care Centre.

The registered provider completed a provider information return (PIR) which we received prior to the inspection. 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 the inspection we spoke with five people who used the service and one relative. We also spoke with the registered manager, operations manager, second chef, activities co-ordinator, administrator, two senior support workers and three support workers.

We spent time in communal areas and observed how staff interacted with people. We also observed the meal time experience.

We reviewed a range of records. These included staff files, training records, medicine records and records relating to the management of the service such as audits, surveys and policies. We reviewed the care plans of six people to check that the records matched with the support we observed and the information provided by staff.

# Is the service safe?

## Our findings

The people we spoke with said they felt safe. One person said, "oh yes there are plenty of staff about and they all take good care of me."

Staff had all received up to date safeguarding training and demonstrated a good knowledge of the issues involved. They knew the various types of abuse, and the signs to look for to indicate someone may be a victim of such abuse. One member of staff told us, "I would report anything I had concerns about." The service had an up to date safeguarding policy in place that had been reviewed in November 2015. All incidents of safeguarding had been appropriately reported to both the CQC and the local authority.

We saw a poster in the service that gave contact details for reporting safeguarding concerns or whistleblowing. Whistleblowing is when a person tells someone they have concerns about the service they work for. All of the staff members we spoke with said they would report any concerns they had without fear of recrimination. They told us that they knew how to escalate any concerns if they felt it necessary and who they could report these concerns to. One member of staff told us, "I would whistle blow if I had to. I know what to do but I haven't ever felt the need here."

We saw that people had individual risk assessments within their care files. These included areas such as falls, moving and handling and nutrition. Each care plan included the question "Is a risk assessment needed?" In the majority of cases this question had not been answered. Despite this we saw that risk assessments had been drafted appropriately in most instances. We saw that on one file some risk assessments were not in place, for example diabetes and hearing loss. This meant that there was no evidence to say if or how these risks were being mitigated. When we discussed this with the registered manager we were told that the way care plans and risk assessments were produced was due to change in line with new documentation being introduced by the provider. They told us that in future this type of omission would be less likely to occur as risks would be looked as a priority and care plans produced based on these identified risks. The registered manager said that missing risk assessments would be put in place until the new documentation had been completed and during our visit we saw that the deputy manager was tasked with overseeing this.

We saw that appropriate arrangements were in place for the safe management, storage, recording and administration of medicines. The service was responsible for ordering people's medicines. Each person's medicines were kept securely in their room. Adequate stocks of medicines were securely maintained to allow continuity of treatment. We checked the medicine administration records (MAR) together with receipt records and these showed us that people received their medicines correctly. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

All staff who were responsible for medicines management received training in it. We spoke with people about their medicines and they said that they got their medicines when they needed them.

We saw that there was a system of regular audit checks of medication administration records and regular checks of stock. This meant that there was a system in place to promptly identify medication errors and ensure that people received their medicines as prescribed.

Each person had a personal emergency evacuation plan (PEEP) on their file. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEPs had also been placed together in an emergency file which meant they were easily available to the emergency services if necessary. These documents stated that they were to be reviewed every six months however they had last been updated in March 2015. The registered manager acknowledged this and explained previous templates had stated reviews were to take place annually. The registered manager began working on this immediately and we saw that PEEPs had all been reviewed and updated by the end of our inspection.

The service had a disaster plan in place that covered all essential business continuity in case of an emergency, for example fire evacuation, power failure or the building not being habitable. The disaster plan also contained copies of people's hospital passports and PEEPs along with basic care information for emergency situations and an essential telephone contact list.

We saw that accidents and incidents involving the people who used the service or staff members were recorded appropriately. Falls were monitored daily and audited every week. The registered manager told us that this analysis of falls data had identified a higher number of accidents occurring during the evening and as a result an extra member of staff had put on the rota to cover a twilight shift, between 4pm and 10pm.

We saw maintenance records which confirmed that the necessary checks of the building and equipment were regularly carried out. Equipment such as hoists had been regularly serviced. The home had an up to date gas safety certificate and comprehensive COSHH (control of substances hazardous to health) assessments were carried out six monthly. Portable appliances testing (PAT) had also been completed on all relevant electrical items. These checks helped to protect the health and safety of the people using the service.

The fire alarm was tested weekly and the fire equipment monthly. Records showed that the last fire drill took place in August 2015. These had been carried out twice yearly for day staff and three times a year for night staff. We were told that new protocols being introduced by the registered provider meant that fire drills will be conducted every month.

We looked at six staff files and saw that safe recruitment processes and pre-employment checks were in place. We saw application forms and interview records along with evidence that identification had been checked and references had been received. Disclosure and Barring Service (DBS) checks had also been undertaken for all staff. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. At the time of our visit it was noted that whilst checks had been undertaken there was no record to say whether or not any offences had been recorded on the disclosure. The registered manager showed us new paperwork that is being introduced by the provider which includes an area specifically for the recording of this information.

We were told that staffing levels were calculated using a dependency tool. We looked at the records from the previous six months and saw that staffing levels were consistently above the 'upper average' for the level of dependency identified. People's dependency needs were calculated by considering areas such as eating, dressing, mobility and continence. The registered manager told us that dependency was reviewed on a



monthly basis but that staff need was looked at on a daily basis to ensure a safe level of cover is being provided.

During our inspection we observed there to be sufficient staff to meet the needs of people using the service. We saw staff rotas that were prepared well in advance to ensure adequate cover. The service did not use agency staff. We were told that if cover was needed for holiday or sickness then either bank staff or staff from the registered provider's neighbouring service would step in.

We saw that the service was clean and tidy and there was plenty of personal protection equipment [PPE] available to staff.

# Is the service effective?

## Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection we found that the provider failed to meet the requirements of the then regulations relating to consent and the appropriate application of the Mental Capacity Act 2005. We had found that the care records we looked at contained three generic care plans relating to people's ability to make decisions. These plans stated the reason people required support / people to make decisions on their behalf was because the individuals lived with a dementia. We found that each of the plans referred to the Mental Capacity Act 2005 but did not incorporate the two stage assessment of capacity as required by the Act. For example, we saw that in each set of records it was identified that the individuals could not leave the premises unsupervised because of their dementia. This was a decision made that limited people's rights without the appropriate assessment of capacity.

During this inspection we found that the staff had developed their understanding of the Mental Capacity Act 2005 (MCA) and what actions they would need to take to ensure the home adhered to the code of practice. The care records we reviewed contained appropriate assessments of the person's capacity to make decisions. Assessments were only completed when evidence suggested a person might lack capacity, which is in line with the MCA code of practice. Care records also described the efforts that had been made to establish the least restrictive option for people was followed and the ways in which the staff sought to communicate choices to people, for instance via people going with the staff or pointing to what they wanted. We discussed with the registered manager how these could be further enhanced but overall we found that the service followed the principles of the MCA when delivering care.

When people had been assessed as being unable to make complex decisions there were records to confirm that discussions had taken place with the person's family, external health and social work professionals and senior members of staff. This showed any decisions made on the person's behalf were done after consideration of what would be in their best interests. Best interest decisions were clearly recorded in relation to care and support, finance, administering medicines and going out amongst others.

At the last inspection we found that a number of doorways were secured with a numeric key pad lock. However no DoLS applications had been made in respect of those individuals who were at risk of being

deprived of their liberty.

At this inspection we found that the registered manager had ensured that where appropriate DoLS authorisations had been obtained. The registered manager had also set up a system to ensure that the application to renew any authorisations was completed in a timely way. None of the DoLS authorisations that we reviewed had additional conditions imposed but in discussion with the registered manager we found that the processing for monitoring these authorisations would be enhanced by the addition of checks that conditions were being met. The registered manager was very responsive to this feedback and added this to the existing checks.

The registered manager was aware of the person's right to contest the DoLS and apply to the Court of Protection for a review of this order.

Staff we spoke with had an understanding of DoLS and why they needed to seek these authorisations. However staff were not able to tell us with confidence who exactly was subject to a DoLS authorisation and what these authorisations allowed them to do when working with people. We found that staff had completed basic MCA and DoLS awareness but this needed to be supported with additional more in-depth training in order to ensure they had gained a full insight into the legislation and legal requirements of the Act. The registered manager had identified this as a gap in the training and was actively taking steps to ensure staff received additional training and support. Overall we found that the service followed the principles of the MCA when delivering care.

We saw that people's rooms were nicely decorated and included personal items that added a homely feel. We saw a collage of photographs in one person's bedroom that had been put together by a member of staff. The lounge areas and dining room were comfortable and welcoming but it was noted that the corridors and doors to people's rooms were very bare. There was no dementia friendly decoration or signage on the Sunflower suite and there was nothing identifiable on people's bedroom door to make orientation easier. A number of rooms did not even have people's names on the door. We discussed this with the registered manager who told us they had recognised this to be an issue and there was a programme of improvement already scheduled to take place. The provider had consulted with the Alzheimer's association and Stirling University to decide on the best way to tackle the refurbishment and work was scheduled to begin in April 2016.

We looked at the training matrix for the service which detailed all of the training staff had received and when this was due for renewal. There was a red, amber and green coding used which highlighted at a glance those staff who had not completed certain courses or were overdue refresher training as well as those staff whose refresher training was almost due. Staff received mandatory training in health and safety, infection control, first aid and food hygiene, and the majority of this was up-to-date. Mandatory training is training that the provider thinks is necessary to support people safely. New online courses had recently been introduced to further enhance staff knowledge and there were still a number of these courses outstanding. The registered manager told us that reminders had been sent out to all staff and a deadline had now been set for completion by the end of February 2016.

Staff we spoke with felt that they had received a good standard of training. One staff member said, "We're told when we need our training updated. I've had all of my face to face training now I just have some online training to do." Another told us "The online training is good, if anyone is struggling with it they can come in to the office and someone will help them with the technical side."

New staff underwent a comprehensive 12 week induction programme and did three days of work shadowing

before they were included in the rota.

All staff received annual appraisals and we saw evidence that regular staff supervision was taking place. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

We spoke with one of the chefs who demonstrated a good knowledge of people's dietary requirements. Special meals were prepared for people who had diabetes and coeliac disease. We saw that the kitchen also prepared special cakes and biscuits for those people on restricted diets so that they were not left out when other people had the option of this type of snack throughout the day. Special milk shakes were provided for people in need of extra calories to help maintain a healthy weight. These were made using ingredients such as full fat milk and bananas. Food was also fortified with butter and cream as necessary.

The chef said that the kitchen was supplied with everything needed to cater for the people using the service. We were told that moulds had recently been ordered to make food look more appetising to those people who needed a pureed diet.

We observed lunch time in the Sunflower suite dining room. There was a relaxed atmosphere and those people who needed support with eating and drinking received it in a calm and caring way. Tables were attractively set and condiments were available on each table for those who required them. The overall dining experience was seen to be a positive one.

People spoke positively about the food provided by the service, one person told us, "Lunch was fine thank you, the meals here always are." Another person told us, "The food is very good actually, very good." One relative told us, "[person's name] can be a fussy eater but they seem to be able to cope with that."

People were supported to access the services of health and social care professionals to maintain and promote their health and wellbeing. Care plans contained evidence of involvement with GPs and district nurses as well as services such as opticians and chiropodists. One person's care file described how impressions had been taken for them to have new hearing aids made. The registered manager described a very positive relationship with a local GP practice who sent a GP to visit the service and check on people's wellbeing every week. People were also referred to services such as the falls prevention team, speech and language therapy and the dietician when a need was identified.

## Is the service caring?

### Our findings

People we spoke with were happy with the care they received. One person told us, "I can't complain, I like it here." Another person said, "the staff are all good, crazy but good, we have a good laugh."

We spoke with a relative who told us, "[person's name] is much improved since they moved here. They care for [person's name] really well."

There was a calm and relaxed atmosphere within the service. We spent time in communal areas observing staff interaction with people and care practices and throughout the inspection we observed staff interacting with people in a positive, caring way. There was a lot of light hearted conversation and we saw staff delivering care and support with kindness. One person was transferred from a wheelchair to a lounge chair and we saw that staff were patient and reassuring during this process.

Staff were observed treating people with dignity and respect. One person told us, "they're polite and they always treat you right."

We were told that people were involved in decisions about their care and in the writing and review of their care plans. We saw that people had signed their care plans to agree the content, however the reviews were not signed and there was therefore no record to show that people had been involved. We discussed this with the registered manager who was going to look at better ways of recording care plan reviews to reflect people's involvement.

A minister came in to provide regular church services in one of the lounge areas. People were also given the option of a private service in their room. This showed that people's religious needs were being considered and catered for appropriately.

We saw evidence on care files of contact with relatives. These records showed that family members were informed of things such as any changes in their relative's health. A family member we spoke with was happy with the level of contact from the service and felt able to speak to staff or management if they had any concerns.

The registered manager produced a monthly newsletter that included a diary of upcoming events, a review of the month and general news and updates from the service. These were distributed to every person in the home and copies were also left in the entrance for visitors to take if they wished.

One person was using an advocate at the time of our inspection. Advocates help to ensure that people's views and preferences are heard. This arrangement had already been in place when they came to the home but we did see that there was information available regarding access to advocacy and we were told that a representative from a local advocacy service was booked to come in to give a talk to people.

Although end of life care is not a mandatory element of the training the registered manager had arranged for an external trainer to deliver level 3 palliative care training to a number of staff. We saw that some people had DNAR (do not attempt resuscitation) forms on their care plans and that these were regularly reviewed by people's GP. At the time of our visit no one was receiving end of life care.

## Is the service responsive?

### Our findings

We looked at the care plans of six people using the service. Care plans were reviewed on a monthly basis. The documents contained up to date and accurate information regarding people's care needs. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. The care plans we saw were written in a person centred way but they did not always contain sufficient detail. For example, the food and drink care plan of a person with diabetes listed their likes and dislikes but made no reference to their diabetes and the associated dietary requirements.

We saw that care files contained 'My Life Story' documents and some of these were seen to contain a detailed life history however on one of the files we looked at this document was completely blank and another had lots of information in some sections but not others. We also saw that a form entitled 'All About Me' had been left blank on one file. We discussed this with the registered manager who pointed out that there was now a one page profile on each person's daily notes file which contained this information. We saw that these documents were in place and up to date but also noted they did not contain the same level of detail as the other forms. If some documents were no longer in use this was not made clear within the files and could lead to confusion when accessing information.

We saw an activities timetable in the reception area giving details of daily activities. These included quizzes, singing, pampering and bingo. There were also posters displayed around the home advertising events such as an Easter raffle and a pantomime being performed in April. The home also had an onsite hairdressing salon and a hairdresser visited every Friday. One person we spoke with told us they enjoyed having their hair done, saying, "I've just had a colour put on, it makes you feel a bit better."

The service employed two activities co-ordinators who provided support seven days a week. We spoke with one of them who told us that they are regularly trying new ideas. They said that they spoke with a number of other activity co-ordinators from services across the region to discuss and share ideas. They told us, "I try lots of things to see what people like and what works. Some things I think will be really popular, like baking, but only one person joined in so I had to think of something different."

During our inspection we observed the activity co-ordinator regularly engaging with people, chatting and joking. A singer came to give a performance during the afternoon and people we spoke with told us that there were similar events held regularly. One person said, "Last time we had a singer and a man playing the guitar, they were very good."

At one of the residents meetings people had requested that the home get a pet. Initially a fish tank was purchased but the registered manager told us people felt they would like a pet they could interact more with and so the service obtained a pet rabbit. This was regularly taken around to visit people in all areas of the building.

We observed people being given choice throughout the day regarding what food and drink they would like

and whether or not they wished to participate in certain activities. One member of staff told us, "We ask them on a morning what they would like for lunch but they sometimes change their minds and there is always an alternative. It's really up to them."

The home had an up to date complaints procedure in place and this was also clearly displayed at the service. People told us that they knew how to make a complaint but none of those people we spoke with had felt the need to do so. One person told us, "I would certainly tell the manager if I wasn't happy with anything, I'm quite happy with everything at the moment." Another person said, "I can't complain, I like it here."

We saw that complaints were correctly handled and recorded. A summary sheet gave a brief outline of the complaint and who had dealt with it along with whether or not it was substantiated and the date it was resolved. The individual complaints forms contained a detailed description, actions and outcomes were recorded and complainant's satisfaction was also noted. This demonstrated that there were effective procedures in place to investigate complaints.



## Is the service well-led?

### Our findings

The home had a registered manager in place who had been registered with the Care Quality Commission since 21 November 2014.

Staff told us that they were happy working in the home. They said they felt the culture was open and honest and during our visit we saw good rapport between staff, people using the service and management. One person we spoke with said, "The manager's door is always open." A member of staff told us, "I like it here. I feel supported and if they support us we can do a better job supporting the people who live here." Another staff member said, "I really enjoy working here, it's like a proper home, like a big family."

Staff surveys had recently been introduced by the registered provider and the first one was sent out in December 2015. We were shown a copy of the questionnaire staff had been asked to complete and saw that it covered areas such as management support, training and the environment within the home. At the time of our inspection the results from the survey were not yet available.

Staff meetings were held regularly and the minutes identified that issues such as staffing and the day to day running of the home were covered. Staff told us they found these meetings useful but that they also felt able to go to the registered manager to discuss things at any time outside of these forums. One member of staff said, "I can go in and talk to [registered manager] and [deputy manager] any time. I feel confident I can talk to them about anything."

Meetings were held approximately every two months for people who used the service. We saw minutes from these meetings and they covered a range of topics including food, laundry and the plans for future outings. The next meeting was scheduled to take place on 25 February 2016 and we saw posters around the home promoting this.

The registered manager told us they felt well supported by the registered provider. They told us, "I have a really good operations manager and a really good team supporting me. I know I can call them about anything. The support I receive is fabulous, absolutely fabulous."

The registered manager carried out a number of checks and audits. These included monthly audits of medicines, health and safety and accidents. An infection control check was done every month by the manager and once a year an infection control nurse visited to undertake a full audit of the premises. Malnutrition Universal Screening Tool (MUST) audit was also done weekly as there were a number of people whose weight was being monitored every week. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. We saw records that confirmed these checks were being conducted regularly.

Care plans were also regularly audited. The registered manager informed us that 25% of current occupancy were checked every month meaning that every person's care plan was subject to two full audits every year. Action plans were produced to address any issues identified during the quality assurance process and any

necessary changes were implemented. This meant that effective checks were in place to monitor, maintain and improve the quality of the service.

The law requires registered providers to send notifications of changes, events or incidents at the home to the Care Quality Commission and they had complied with this regulation.

The registered manager demonstrated a good knowledge of the people using the service and their care needs. They told us that their vision for the future was to continue to improve the service by maintaining high standards of care through encouraging best practice and developing the staff team with an improved programme of training. They also described the plan to make the surroundings more homely and create a more dementia friendly environment during the planned refurbishment.