Downlands Care Limited

Mountside Residential Care Home

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?	Requires Improvement

Summary of findings

Overall summary

About the service:
Mountside Residential Care Home is registered to provide support to a maximum of 52 people and 47 people were living at the service at the time of our inspection. The service is intended for older people, who may be living with a physical disability, sensory impairment or a dementia type illness.

People's experience of using this service:
People told us and we observed that they were safe and well cared for and their independence was encouraged and maintained. Comments included, "I feel safe, don't think there is anywhere better," and, "A nice clean and comfortable place to be."

• The service had made improvements since our last inspection. However, whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. This included ensuring that medicine errors and discrepancies were acted on and appropriate action taken. There were policies and procedures in place but these had not always been followed by staff. Care plan audits had not identified that one person did not have a care plan for the management of their diabetes despite the GP identifying their blood sugars were high.
• People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was safe.
• People's risks were assessed and strategies put in place to mitigate the risks.
• Environmental risks were satisfactorily assessed and managed.
• Staff received improved supervision and training since our last inspection, which provided them with the knowledge and skills to perform the roles they were employed to do.
• People received their care and support from a staff team, that had a full understanding of people's care needs and the skills and knowledge to meet them.
• Staff were given an induction when they started and had access to a range of training to provide them with the level of skills and knowledge to deliver care efficiently.
• People and relatives provided consistently positive feedback about the care, staff and management. They said the service was safe, caring and well-led.
•Staff treated people with respect and kindness at all times and were passionate about providing a quality service that was person centred.
•People were encouraged to live a fulfilled life with activities of their
choosing and were supported to keep in contact with their families.
• People's care was now more person-centred. The care was designed to ensure people's independence was encouraged and maintained.
• People were involved in their care planning. End of life care planning and documentation required further development but this had been identified and work was on-going.
• There were positive changes to the management team. Improved audits and checks were put in place to ensure the service was well-governed.

• There was a happy workplace culture and staff we spoke with provided positive feedback.

The service met the characteristics for a rating of 'Good' in four key questions we inspected with the well-led question remaining 'Requires Improvement.' Therefore, our overall rating for the service after this inspection has improved to "Good".

More information is in our full report.
Rating at last inspection:
• The service was rated "requires improvement".
• Our previous inspection report was published on 14 August 2018.

Why we inspected:
• All services rated as 'Requires improvement' are re-inspected within one year of our prior inspection. This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received and the improvements made.

Follow up:
• We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Mountside Residential Care Home

Detailed findings

Background to this inspection

The 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 checked 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.'

Inspection team:
•Two inspectors and an expert by experience conducted the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
• Mountside Residential Care home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

• The service is required to have a registered manager. 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. At the time of our inspection, there was a registered manager in post.

Notice of inspection:
• Our inspection was unannounced.
• We visited the service on the 4 and 7 February 2019.

What we did:

• Before our inspection we reviewed the information we held about the service including previous inspection reports. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

• We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

• We used a range of different methods to help us understand people's experiences. Some people who lived at the home had limited verbal communication. Therefore, as well as speaking with 24 people, 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 used the SOFI in communal areas throughout the inspection visit.

• We spoke with the manager, provider, deputy manager, six members of staff, the activity coordinator, the maintenance person and the agency cook.

• During our inspection process we spoke to two visiting professionals who provided specialist support to people who lived in the home.

• To help us assess how people's care needs were being met, we reviewed eight people's care plans and associated records. We also case tracked a further three people who received specialist diets and with other more complex needs, such as diabetes. Case tracking involves talking to the person (if they are able), observation of their care, talking to staff directly supporting the person and examination of care records. We looked at other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

At our last inspection in July 2018 improvements were needed to ensure risks to people's health and safety was monitored and updated to provide consistent safe care.

At this inspection, we found the service had taken the necessary steps to improve people's safety. Therefore, the rating for this key question has improved to Good.

People told us they felt safe living at Mountside Residential Care Home. One person said, "I feel very safe living here and I have enjoyed it, I moved in because I wasn't safe at home and this is a good place." Another person said, "It's a very safe home and I am happy to be here. Staff are very helpful. Staff check that I am ok each day and talk to me. I'm not worried and I'm very happy. I have nothing to worry about."

Assessing risk, safety monitoring and management:
• This inspection found that improvements to risk management had been made and sustained.
• Risks within the service were managed safely and consistently. The provider carried out comprehensive individual risk assessments to ensure people were supported safely. These were person centred, consistent and written in a respectful way. We saw a range of information to confirm this, for example, risk assessments for pressure care, moving and handling, choking and nutrition and falls were clear and detailed.
• Where people needed constant monitoring due to health risks, we saw that staff were aware and appropriate checks were in place to manage the risks. For example, food, fluid and repositioning charts were used where appropriate. These were monitored and action taken as required, such as encouraging more fluids and offering fortified snacks.
• Staff could tell us about risks to people's health and wellbeing and how they managed to keep them safe and maintain their independence.
• Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).
• Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.
• People had personal emergency evacuation plans which showed how they would need to be supported in an emergency.

Systems and processes to safeguard people from the risk of abuse:
• The provider had effective safeguarding systems and all staff spoken with had a good understanding of

what to do to make sure people were protected from harm or abuse. Staff had received appropriate and effective training in this topic area from the local authority.
• Staff knew how to recognise signs of abuse and act upon these, including referring any incidents to the local authority.
• There were policies and procedures for whistleblowing and safeguarding, as well as policies in relation to emergencies, fire safety, medicines, bullying and harassment. Staff told us they felt protected to whistleblow. A whistleblower is a person who informs in confidence on a person or organisation seen to be engaging in an unlawful or immoral activity. A care staff member said, "I would not hesitate to raise concerns if I had any."

Staffing and recruitment:
• There were sufficient staff to support people safely. A person said, "I ring for help occasionally; the system works very well, and I have never had to wait very long."
• Staff supported people when needed and in a safe way. A family member told us, "I feel my [relative] is very safe. They come downstairs and they always have someone with them for reassurance. There is always staff visible in the lounges."
• Staff told us there were no concerns with staffing levels. A staff member said, "We have some new staff starting, we have had staff leave so that has meant we have had agency staff." Another staff member said, "It can be busy but the manager or deputy will help out."
• An on-call system was operated for night time for emergency situations such as hospital admission or if someone is unwell. There were examples of how this worked. For example, the registered manager had been called in recently when someone had become unwell and needed to go to hospital. This ensured there were still enough staff in the service to keep people safe.
•The provider continued to undertake checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Using medicines safely:
• Staff were trained to handle medicines in a safe way and completed a competency assessment. This ensured their knowledge was up to date.
• People told us they received their medicines safely. One person said, "I prefer staff to give me my medicines, I get them every day, I don't have to worry." Another said," It's a weight off my mind, I get what I need and the doctor sees me regularly."
• Medicines were stored, administered and disposed of safely. Each person had a medicine administration record (MAR). We found these were accurately completed and showed people received their medicines as prescribed.
• Staff obtained people's consent and ensured they had a drink when given their medicines. They were discreet in checking the person's medicine had been swallowed and were patient and understanding.
• Medicines prescribed on an 'as and when required' basis (PRN) had protocols in place which informed staff of when the medicines were required. The registered manager informed us that the PRN and homely remedy guidance was currently being reviewed and training sought as they had identified they needed to improve their guidance. The optimizing medicine team was currently working with the GP's who were involved with the service and they were midway through their review of Mountside Residential Home.

Learning lessons when things go wrong:
• The provider carried out regular monitoring of accidents, incidents, complaints and issues raised by staff and people who use the service and their relatives. We saw that these had been evaluated to see if there were any ongoing trends and what learning opportunities there were to reduce reoccurrences. For example,

it had been recognised that there were some people who had an increased number of falls. The management team had appointed a falls champion. The senior care staff member kept a detailed log of all falls, both witnessed and unwitnessed. There was evidence of involvement of the GP, falls team and an occupational therapist. There had been a decline in re-current falls and this showed that lessons had been learnt.

Preventing and controlling infection:
• Mountside Residential Care Home remained clean and free from malodour.
• Staff continued to have access to personal protective equipment (PPE) such as disposable gloves and aprons. Good practice seen throughout the inspection.
• Domestic staff were employed to support with daily cleaning.
• Daily environment checks and weekly room checks were carried out to ensure infection control was maintained. These included checks on areas such as, food preparation areas, laundry areas and bedrooms.
• Staff were required to complete training in food hygiene, so they could safely make and serve meals. Records confirmed this. The service had a rating of 'five' (the highest rating) from the Food Standard's Agency, who are regulators for food safety and food hygiene.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

At our last inspection in June 2018, this key question was rated "requires improvement". This was because the training programme needed to be developed to ensure all staff had the necessary skills to meet the needs of the people who lived at Mountside Residential Care Home.

At this inspection, we found the service had taken steps to develop the training programme to ensure staff had the necessary skills to meet people's needs. Therefore, the rating for this key question has improved to Good.

Staff support: induction, training, skills and experience:
• The provider has progressed the training provided since the last inspection.
• Staff had regular training to ensure they had the right knowledge and skills to carry out their roles. Staff training included safeguarding adults and children, moving and handling and medicine training.
• There was a combination of e-learning and face-to-face training.
• Staff training records reflected the information provided by the registered manager and confirmed that staff had been supported to gain the Health and Social Care diploma.
• People told us, "Staff know what they are doing and look after me well." A second person told us, "Staff know what they are doing, really good and kind." A third commented, "Staff are on the ball, they pick up when I'm not myself and get the doctor if I need it."
• The staff spoke positively about the training sessions they had received. One staff member told us, "The training is really good, we get the opportunity to discuss what training we need and the manager listens."
• Records showed staff supervision had taken place regularly and the staff we spoke with felt supported.
• Staff received an induction and shadowed experienced staff before they worked with people on their own. The Care Certificate was used as part of the induction process as good practice. The Care Certificate is an identified minimum set of standards that health and social care workers adhere to in their daily working life.

Staff working with other agencies to provide consistent, effective, timely care:
• The service worked well with a variety of health and social care professionals. Those we had contact with were positive about the service. One told us, "They have come a long way. They are now proactive and this has had a positive effect on people."
• There had been joint working with the falls team and occupational therapist to encourage independence and prevent falls.
• Arrangements were in place to share information between services as appropriate. For example, the service had a hospital passport whereby relevant information about a person was always available should they be taken to hospital in an emergency.

Supporting people to live healthier lives, access healthcare services and support:
• A range of professionals from primary and hospital health services were involved in assessing, planning, implementing and evaluating people's care and treatment. This was clear from the record of appointments in the care documentation.
• People were assisted with access to appointments with external professionals and when diagnostics tests like blood samples or x-rays were needed.
• Professionals that visited people at the service included GPs, district nurses, dietitians, Speech and language therapists (SaLT), podiatrists, physiotherapists, and social workers.

Supporting people to eat and drink enough with choice in a balanced diet:
• The meal times were a social and enjoyable occasion for people. Nearly everyone ate in the dining room sitting with their friends. The dining room was light, pleasant and dining tables were laid ready for use.
• People's food preferences were considered when menus were planned. Comments from people included, "Good food, always tasty," "They offer us a choice and I can have something different if I don't want what's on the menu," and "We have been asked to do a survey because there have been a few problems with the heat of food but the manager listens."
• There were appropriate risk assessments and care plans for nutrition and hydration.
• Choking risk assessments were completed where a risk was identified. Referrals to a speech and language therapist (SALT) were made when necessary.
• People had correctly modified texture diets where there were risks of choking. This included soft, pureed or fork-mashed meals. Appropriate plans were in place to use high calorie ingredients to fortify meals. This prevented weight loss.
• People's drinks were thickened when needed, to prevent the risk of choking on fluids.
• The registered manager had a 'tracker' which noted people's weights and malnutrition scores. These could be traced over time to check whether there were any risks and flag staff to request a dietitian's input.

Ensuring consent to care and treatment in line with law and guidance:
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 make specific 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

• The registered manager informed us of the people who had been referred for a DoLS authorisation. The service had completed appropriate assessments in partnership with the local authority and any restriction on the person's liberty was within the legal framework. We found that the service had submitted notifications to the CQC when DoLS had been authorised.
• Staff received training in the MCA and DoLS. They understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty. The staff we spoke with confirmed this. One staff member told us, "It's about people having the capacity to make choices and their own decisions."
• Records showed people signed to consent for their care and treatment.
• Staff had a good understanding of equality and diversity and there were policies for staff to refer to. The policy provided clear details about the groups covered by the Equality Act 2010; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation and, that these are now called 'protected characteristics'. Staff were confident people's equality, diversity and human rights were protected and they were aware that as employees they were also

protected.

Adapting the service, design, decoration to meet people's needs:
• The building had been adapted and an extension added in 2014.
• There was a rolling plan of redecoration for the older part of the building. The new extension had a large outside area and terrace which people could access in good weather. Large communal lounges and seating areas gave people a choice of areas to use. For example if they wanted to sit quietly or had visitors and the main lounge was busy, there were further areas in the extension that could be used.
• There was level flooring throughout the ground floor, with one slight ramp that allowed people to be as independent as possible with walking aids.
• Lifts and stair lifts provided access to all parts of the service. This allowed people to choose where they spent their time.
• There were sufficient communal bathrooms with both showers and baths offering people a choice. Ensuite facilities were also available.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well-treated and supported; equality and diversity:

• People continued to receive kind and compassionate support from staff.
• People were observed to be treated with kindness and were positive about the staff's caring attitude.
• Throughout our inspection, people and families provided consistently positive feedback about staff and the service. Visitors told us, "Very kind and caring, I have never had any worries," and "Oh what kind people here." People told us, "Even when busy they are kind and helpful," and "Very nice team of staff, there have been new faces but that's normal I suppose."
• Relatives confirmed how care workers would work to people's personal instructions and cared for them in the way they chose.
• People's equality and diversity was recognised and respected. People were encouraged to maintain their independence and live a life they wanted. People who lived with the beginnings of dementia were treated in the same way as people who were not living with dementia. They were offered the same opportunities to join activities and chose where they spent their time. One staff member said, "Everybody is treated the same way." One person told us, "I prefer to stay in my room, but I do go down to the lounge when my daughter visits -we do jigsaws." Another person told us they liked to spend their time in a lounge on their own to watch television and staff respected this.

Supporting people to express their views and be involved in making decisions about their care:
• People and families continued to be involved in reviews. Some people could tell us that they were involved in planning their care. One person told us, "They involve me in care decisions and I can speak to staff about anything."
• Records confirmed regular meetings were held with people and their relatives or friends had the opportunity to attend. Multi-disciplinary meetings were held and people were involved in these meetings to discuss their needs and make decisions about the care.
• People told us they had been involved in planning their move to the service. One person told us, "I came here in November last year. It was my decision but the staff here made it an easier decision because they listened to what I needed and didn't push their ideas on me."

Respecting and promoting people's privacy, dignity and independence:
• People's right to privacy and confidentiality remained respected. One person told us, "Staff respect my privacy, they always knock on my door before coming in." Another person said, "They are very courteous and always make sure I'm properly dressed." A visiting professional commented, "I've never had any concerns about the staff, they respect people's privacy when I come to the home to visit and I see people in their room or in the clinical room."

• Staff continued to promote peoples' independence, one person told us, "Staff encourage me to do things, for myself and help if I need it. I can choose when I get up and go to bed, what I eat and what I get up to, I like to be in the lounge with my friends." Another person said, "Staff help me to stay independent and I do things for myself. Staff help me with my hair and baths, but I'm pretty good for my age I think."
• Staff continued to treat people with dignity and respect and provided support in an individualised way.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

At our last inspection in July 2018 improvements were needed to ensure care plans were updated and reflective of people's needs.

This inspection found the service had taken the necessary steps to improve and sustain improvements to providing person centred care. Therefore, the rating for this key question has improved to Good.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• The support people received was individual to their needs and was delivered in a person-centred way.
• Care plans were comprehensive and contained information about people's diverse physical, social and mental health needs. Their history, likes, dislikes, sensory needs and any preferences for the delivery of their care was recorded. A care administrator had worked alongside care staff to develop care plans and ensure they were updated. At present they were working on introducing end of life care plans in conjunction with PEACE plans (Proactive Elderly Persons Advisory Care' plan). The PEACE plan is a document to help health care professionals deliver the best care to frail, older people with life-limiting illnesses.
• Reviews took place to ensure people's needs were being met to their satisfaction and involved of their family or legal representative. Where people had specific health care needs, these were clearly identified and showed how people should be supported. Staff could explain where and how this support should be provided.
• Where an advocate was needed, staff supported people to access this service.
• People's needs were attended to quickly, although a small number of people told us they had to wait sometimes for staff, especially those on the upper floors. One person said, "When I ring my bell, they are sometimes quick, but sometimes lots of us ring at the same time. They seem to come quick at night.
•People could pursue social and leisure interests and enjoyed one to one and group activities provided by the service. One person told us, "The activity person thinks of no-one but others, they are one in a million."
• Activities took place every afternoon and they included external entertainers and pet therapy.

Improving care quality in response to complaints or concerns
• Processes, forms and policies remained in place for recording and investigating complaints.
• There was a satisfactory complaints policy.
People also had access to a 'service user guide' which detailed how they could make a complaint.
• People told us they knew how to make a complaint. One person said, "I know how to make a complaint; I would go to the manager." A second person told us, "I've got no complaints about anything and feel happy living here." A third commented, "I got information about this at the beginning and I would tell the manager if I was making a complaint but I've no complaints and I'm happy to be living here. It's a nice place, my room is lovely and I have my personal items."
• We saw complaints and concerns were very minimal. The service had one complaint logged by a person

using the service and the registered manager had acted on this.

End of life care and support:
• Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment.
• This included having 'anticipatory medicines' available, so people remained comfortable and pain free.
• End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage or could not participate in these conversations, with the person's permission, discussions had been held with family and those closest to them.
• One was approaching their end of life. Their care documentation had reflected that care had been adjusted for this stage of their life. It emphasised the need for constant monitoring of pain and of ensuring that food and fluids should be offered regularly in small amounts. We discussed the gold standard framework for end of life care and the management team confirmed that they were planning to introduce this learning within the home.

Requires Improvement

Is the service well-led?

Our findings

Aspects of leadership and management did not consistently assure person-centred, high quality care.

At the last inspection in July 2018, we rated this key question as requires improvement because whilst improvements were seen the improvements were not yet embedded in to practice. At this inspection, we found steps had been taken to drive improvement; however, these improvements were still not fully sustained or embedded. Therefore, this question remains Requires Improvement.

Understanding quality performance, risks and regulatory requirements:
• Since the last inspection the provider and registered manager had implemented some improved quality assurance processes. These included audits of care plans, staff files, complaints, safeguarding concerns, incidents and accidents, and quality satisfaction surveys. However, as discussed, the systems had not identified some of the shortfalls we found. For example, whilst there were systems to record medicine errors, these had not been always being followed. The care plan audits had not identified that one person did not have a care plan for the management of their diabetes despite the GP identifying their blood sugars were high.
• The action plan we received following our last inspection set out a variety of systems and checks the provider proposed to put in place to ensure good governance. We spoke with the provider and the registered manager who advised there were still areas of improvement to be implemented but were proud of what had been achieved since the last inspection. This included providing activities specific to peoples' needs and continued refurbishment of the premises.
• There had been a safeguarding investigation and the senior management team had worked closely with safeguarding officials and commissioners to address the concerns. They had worked hard to make improvements and had kept relatives informed of what had happened and the actions that would be taken in response.
• A relative commented that there had been improvements and they were happy with how things now were at the home. The relative identified areas that in their view had improved recently, such as staff engagement.

Working in partnership with others:
• The service had worked hard over the past year in improving partnership working with key organisations to support the care provided and worked to ensure an individual approach to care. Some visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "Staff listen and are knowledgeable about the people they support."
• The service worked with other local health and social care professionals, community and voluntary organisations.
• There were connections with social workers, commissioners and the community team for people who lived with dementia.

Managers and staff being clear about their roles:

• There was a management structure in place, which gave clear lines of responsibility and authority for decision making about the management and provided clear direction for the staff.
• Staff had clearly defined roles and were aware of the importance of their role within the team.

Engaging and involving people using the service, the public and staff:
• There was a positive workplace culture at the service. Staff said they had been able to raise concerns and felt listened to. Staff worked well together, and there was a shared spirit of providing a good quality service to people. One staff member said, "I really like working here, we have worked hard, and we are a caring team."
• Staff had team meetings and discussed various topics such as any changes in people's needs or care, best practice and other important information related to the service. The registered manager sought feedback from the staff through regular meetings and day to day communications. The team discussed various topics in the meetings including the support and care of people who use the service, policies and procedure, tasks and actions to complete, any issues and ideas.
• Regular feedback was sought from people who used the service and their relatives or advocates. This was used to inform the provider how well the service operated. These surveys were collated and the survey outcomes shared with people, families and staff. The actions to be taken were also shared. One visitor said, "We give feedback all the time and are more than happy with things, very caring and kind staff."

Continuous learning and improving care:
• The registered manager told us that they used accidents, incidents, complaints and safeguarding as learning tools to improve the service. This was confirmed by the documents seen and from the staff we spoke with. One staff said, "We monitor all falls and injures, we then contact the falls team for advice and this has really helped and reduced falls." The lessons learnt were used to enhance staff knowledge and to improve on the service delivery.
• Accidents and incidents were documented and recorded. We saw that incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
• People, family and staff felt they could talk to the registered manager and staff at any time and the regular meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One person said, "I can talk to the staff they really care."
• The provider was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The service had notified us of all significant events which had occurred in line with their legal obligations. The rating achieved at the last inspection was on display at the home and on the provider's website.
•All staff were keen to emphasise the service would advocate for people if required. For example, in respect of ensuring medicine reviews took place. This meant people were only on the medicines currently required as opposed to taking those which were no longer relevant or the best for the person.