

# Mark Jonathan Gilbert and Luke William Gilbert

## Church View

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

We inspected this service on 22 and 30 November 2017. The first day of the inspection was unannounced.

At our last inspection on 18 and 22 August 2016 we found that systems and processes for assessing, monitoring and improving the quality and safety of the service people received were ineffective. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities). We also identified a breach in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). This was because medicines were not being managed safely. At this inspection we found improvements had been made and the provider was now meeting legal requirements. However the improvements made in relation to the quality assurance systems and processes need to become embedded into day to day practice and sustained.

This is the second consecutive time the service has been rated Requires Improvement.

Church View is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Church View accommodates up to 60 people in one adapted building where accommodation is arranged over three floors. The upper floors are accessed by way of stairs or a passenger lift.

The serviced had two registered managers one of whom had left the employment of the provider. The new registered manager had become registered in August 2017 and was in charge of the day to day management of the service. 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.

Since the last inspection the provider had implemented systems and processes for assessing the quality of the service. These had been effective in highlighting areas that the service needed to improve in but need to become embedded into day to day practice and sustained.

Improvements had been made in relation to the management of medicines which were stored appropriately and administered to people when they needed them. Medication administration records had been completed and were up to date and accurate.

Since the last inspection staff had completed the training the provider considered mandatory. Staff were also supported in their roles and had the opportunity to discuss their personal development and obtain nationally recognised qualifications in care. The registered manager told us further training would be provided for staff in relation to meeting people's specific needs.

Most people were satisfied with the opportunities for them to participate in activities they found stimulating and meaningful such as outings and group activities, however some felt they did not have much to do. The registered manager explained a wider range of activities would be available once they had recruited another activities organiser.

Some information was available to people in a format that was accessible to them such as pictures of food choices. However further development was needed to ensure other information such as the activity timetable was also available in an accessible format.

Most people felt most staff were kind and caring however we found some staff did not always refer to people and their care needs in a respectful and dignified manner. The registered manager took immediate action to address this however it is an area of practice that needs to become embedded into day to day practice.

People's needs were assessed and care was provided support in line with their wishes. People's independence was promoted and they were involved in the planning of their care. People could choose how they spent their time and were offered choices in relation to their care and treatment.

People were supported to eat and drink sufficient amounts and their dietary needs and preferences were catered for. People's health was monitored and staff responded when their health needs changed. People were cared for in a clean, hygienic and well maintained environment and staff had access to personal protective equipment.

People were supported by staff who worked within the principles of the Mental Capacity Act 2005 and met the requirements of the Deprivation of Liberty Safeguards. People's privacy was protected and information was stored securely. People were listened to and complaints were handled and responded to appropriately.

People were supported by sufficient numbers of appropriately recruited and suitable staff. People were safeguarded from the risk of abuse because staff were trained in how to recognise abuse and knew how to report it. Where concerns had been identified the local authority had been informed in line with local safeguarding protocols.

Health and safety checks were completed on a regular basis and the premises and equipment were well maintained. Risks to people's health and safety had been assessed and action taken to mitigate the risks. Accidents and incidents were recorded and analysed.

Management and staff worked in collaboration with other organisations to improve the service people received and achieve positive outcomes for them. Lines of delegation and roles and responsibilities were clear.

## 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.

People received their medicines when they needed them.

There were sufficient numbers of appropriately recruited suitable staff on duty to meet people's needs.

People were safeguarded from the risk of abuse.

People were cared for in a clean, hygienic and well maintained environment.

### Is the service effective?

Requires Improvement 

The service was not consistently effective.

People were supported by staff who were supported in their role but had limited access to training in meeting people's specific needs.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed.

People were supported by staff who worked within the principles of the Mental Capacity Act 2005 and the service met the requirements of the Deprivation of Liberty Safeguards.

### Is the service caring?

Requires Improvement 

The service was not consistently caring.

Staff did not always refer to people and their care needs in a respectful and dignified manner.

Information was not always available in formats accessible to people but was being developed.

People's independence was promoted.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy was protected and information was stored securely.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People had the opportunity to participate in group activities and outings.

People's needs were assessed and care was provided support in line with their wishes.

Complaints were handled and responded to appropriately.

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

**Requires Improvement** ●

The service was not consistently well led.

Systems and processes for assessing the quality of the service were effective but needed to become embedded into day to day practice and be sustained.

Lines of delegation and roles and responsibilities were clear.

Management and staff worked in collaboration with other organisations to improve the service people received.

# Church View

## 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 was 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.

Our last comprehensive inspection of this service took place on August 2016. The overall rating for the service at that time was 'requires improvement'. Following that inspection the provider developed an action plan outlining the steps they would take to ensure they met the requirements of the law.

This inspection took place on 2 and 3 August 2017 and was unannounced.

The inspection team for the first day of the inspection consisted of two inspectors. One inspector completed the second day of the inspection.

Before the inspection we checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. The provider had 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 also wrote to 10 health and social care professionals involved in people's care to ask them for their views of the service and received a response from the local authority, the Clinical Commissioning Group (CCG) and one other healthcare professional.

During the inspection, we spoke with 12 people, one person's relative, a visiting healthcare professional, a visiting maintenance person, the registered manager, operations manager, regional manager, quality assurance manager, the provider, the deputy manager, the chef, a maintenance worker and 11 other members of staff including carers, senior carers and the activity organiser. As some people were unable to give us their views we carried out general observations of care and support including interactions between staff and people. In addition to this 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

observed the administration of medicines and lunch being served on both days of the inspection.

We reviewed eight people's medication administration records and reviewed a further seven people's care plans in detail. We also looked at people's daily records, minutes of meetings, health and safety records, accidents and incident records, complaints and provider's quality assurance and monitoring systems. We also looked at staff training, supervision and appraisal records and the recruitment files for five members of staff.

# Is the service safe?

## Our findings

At an inspection of the service in March 2016 we identified the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in relation to the management of medicines which placed people at risk. At our last inspection of the service on 18 August 2016 some improvements had been however the provider was still not meeting the requirements of the law. After that inspection, the provider wrote to us to outline the improvements they would make. At this inspection we found the provider had followed their plan and was now meeting legal requirements in relation to the management of medicines.

Improvements had been made in relation to the storage and recording of medicines. Medicines were being stored correctly and securely in line with legal requirements. Medicines that had a short shelf life such as eye drops, were dated when opened and destroyed within the specified timescales. Other medicines which were out of date or no longer needed were disposed of appropriately. The recording of medicines had improved. Medication administration records (MAR) were accurately completed and had been checked for accuracy and completeness. Medicines were administered by nurses who knew people well and whose competencies had been checked. We observed medicines were administered sensitively and appropriately.

People were supported to be safe without undue restrictions on their freedom and had choices about how they spent their time. We saw people moving freely around the service. Risk assessments were in place which considered the identified risks and the measures required to minimise any harm whilst empowering the person to undertake the activity. There were further systems to identify risks and protect people from harm. Risks to people's safety were assessed and reviewed. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as risks associated with mobility, developing pressure areas and the risk of choking. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place when needed.

Staff had a good understanding of what to do if they suspected people were at risk of abuse or harm, or if they had any concerns about the care or treatment that people received in the service. They had a clear understanding of who to contact to report any safety concerns and all staff had received up to date safeguarding training. They told us this helped them to understand the importance of reporting if people were at risk, and they understood their responsibility for reporting concerns if they needed to do so. There was information displayed in the service, so that people, visitors and staff would know who to contact to raise any concerns if they needed to. There were clear policies and procedures available for staff to refer to if needed.

Staffing levels were assessed when the needs of people changed, to ensure people's safety. We were told that permanent staff were contacted to undertake additional shifts in circumstances such as staff sickness and annual leave. On occasions that cover could not be provided by regular staff then agency staff were used. Staff had mixed views regarding whether staff levels were sufficient. One member of staff told us "It's enough." Another member of staff said that at times they were very busy and rushed explaining "We don't



stop, mornings are still too busy to spend time with people". Our observations were that staff did appear very busy but call bells were responded to quickly and we did not see anyone waiting for care they needed. Staff told us that the registered manager had arranged for an extra member of staff to work in a morning and this helped them to provide the care people needed.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The service had obtained proof of identity, references and employment histories.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm tests took place along with water temperature tests and fire drills, to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. There was a business continuity plan. This 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's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. Generic and individual health and safety risk assessments were in place to make sure staff worked in as safe a way as possible.

The service was clean, tidy and well maintained. Systems were in place for preventing cross infection including the use of colour coded cleaning materials, liquid soap and paper handtowels. Certificates had been obtained and checks had been carried out both internally and by external contractors to check the safety of equipment including the fire system, hoists, mattresses, electrics and gas. The food standards agency had awarded the home a rating of four out of a possible five stars for hygiene in August 2017.

## Is the service effective?

### Our findings

At the last inspection on 18 and 22 August 2016, we identified areas of practice that needed improvement. This was because we identified issues in respect of staff training not being up to date. At this inspection we found improvements had been made.

At the last inspection we found that several areas of training identified by the provider as essential had not always been completed. At this inspection staff told us the training they received had improved and felt they had the skills they needed to carry out their roles effectively. Training schedules confirmed that essential training such as moving and handling, dignity and respect and safeguarding had been provided. Staff were also supported to complete the care certificate and obtain nationally recognised qualifications in care. The care certificate is a nationally recognised qualification designed to provide staff new to care with the skills and knowledge they need to provide safe and effective care. However we also found that staff had limited access to specific training around the needs of people who lived at the service such as dementia and end of life care. The registered manager told us that now staff were up to date with the training the provider considered essential, additional training to meet people's specific needs would be provided.

Staff told us and records confirmed that they received regular supervision meetings throughout the year and said they felt supported by the management team. When new staff commenced employment they underwent an induction and shadowed more experienced staff until they felt confident to carry out tasks unsupervised. They also had a planned annual appraisal.

People's nutritional needs were met. The home used outside caterers who provided meals to suit all diets and meet people's individual cultural needs. Special diets were catered for, such as fortified meals and drinks. Tasting sessions of meals had been carried out which were used to help people choose the meals they would like on the menu. People chose from the options on the menu the day before. People who ate a normal diet were positive about the food on offer. However people who ate a soft textured diet were not. The registered manager told us, and records confirmed that a survey of people's views on food had been carried out recently and had been mainly positive. However they also acknowledged that the survey had not specifically targeted people who required a soft textured diet. Following the inspection the registered manager confirmed that a survey of people's views of the soft textured food would be completed and people's feedback would be used to implement changes to the menu.

On the first day of the inspection we observed that people who required different diets were served at different times. People receiving a normal diet were served first and people who needed a soft textured diet or required staff support to eat were served last. The impact of this was that some people had to wait a long time for their food to be served. For example one person sitting at a table of four was served their food half an hour after the first person on the table had been served by which time the other people at the table had finished their meals. The registered manager told us that this was unusual and the serving of food had not been raised as an issue by people on the surveys they had completed or picked up as an issue through observations of mealtimes. A healthcare professional who provided us with feedback supported this view and commented that 'People had been offered choice of menus and appeared to receive meals in a timely

manner; snacks were also offered throughout the day in addition to appropriate refreshments'. The registered manager told us they would make improvements in relation to the serving of food and ensure people sat together would be served at the same time. On the second day of the inspection we saw that these changes had been implemented. The impact of this was that people were not kept waiting for their food and the mealtime experience was more enjoyable, relaxed and sociable. This is an area of practice that needs to become embedded and sustained.

Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. Where people had been identified at risk of weight loss, food and fluid charts were in place which enabled staff to monitor people's nutritional intake. People's weights were recorded monthly, with permission by the individual. Where people had lost weight, we saw that advice was sought from the GP.

People received consistent support from specialised healthcare professionals when required, such as GP's and community nurses. Access was also provided to more specialist services, such as chiropodists and speech and language therapists (SALT) if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. People told us that they felt staff looked after them if they were unwell. One person explained, "They get the doctor" and said staff followed the doctors instructions. We spoke to a visiting health professional who told us they had no major concerns regarding the service people received. They also explained the service was taking part in a couple of pilot schemes to improve health care for people living in residential care and said that staff generally followed advice given.

Each person had their own bedroom with wash basin. Adapted toilets, bathrooms and shower rooms were available for people to use with support if needed. Communal space was all on the ground floor and consisted of a small lounge / dining room and a very large room that had sitting areas, dining tables and a conservatory. Since our last inspection this room had been rearranged to provide smaller sitting areas providing a more intimate environment for conversation. Adaptations were available within the home to support people with their mobility and personal care. This included specialist beds, a lift, hoists, call bells and grab rails. Corridors and doorways were wide enough for people using a wheelchair to move around easily.

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 be 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 or authorisations to deprive a person of their liberty were being met and found that they were being very well managed. A register was maintained of people who currently had a DoLS in place and for whom a DoLS application had been made. The registered manager had a system in place for regularly checking with the relevant authorities the status of applications.

## Is the service caring?

### Our findings

People told us that most staff were kind and caring, their comments included; "They are okay, all in order". "Lovely we get on well." "Great, helpful, they are there for you." "Most are good". However they also told us "A couple are indifferent; just want to do it as quick as they can." "One or two I don't like." Staff practices did not always demonstrate respect for people. For example on the first day of the inspection some staff referred to people when talking about people as a room number. A member of staff referred to supporting people with eating their meals as "Do the feeds". Different types of soft or blended meals people required were referred to as 'categories' rather than the type of meal people required. We also heard a member of staff who was supporting a person in a wheelchair say "I've got the new one; I'm just going to put them in a chair". The registered manager told us all staff had received training in dignity and respect and knew they should not refer to people in this way. They gave assurances that this issue would be addressed. On the second day of the inspection we did not hear any institutional language and staff spoke about and to people in a dignified and respectful manner. However this is an area of practice that needs to become embedded into day to day practice and sustained.

We looked at how the provider ensured information was made as accessible as possible to people. On the first day of the inspection the menu was displayed in small writing on a notice board in the dining area. There was also a picture of the main meal on offer to people who ate a normal diet. However it did not contain the alternative meals available or the meal options for people who required a soft diet. The manager explained they had ordered a range of menus in an accessible format from their catering supplier. On the second day of the inspection we saw that pictures of the meals on offer had been collated into a folder which could be shown to people to aid their understanding of the food choices. Menus detailing the meals on offer were also displayed on each table. Staff told us this was an interim measure until their catering suppliers menus arrived. We also saw the timetable of the activities on offer was only available in written format. The activities organiser told us they went round to each person to inform them of the activity on offer each day and ask them if they would like to join in. The registered manager told us there were plans to increase the amount of information, including the activities timetable, available in an accessible format, and this was an area of practice they had identified as needing to improve.

People were supported to have choice and control over their lives. People were free to do very much what they wanted throughout the day and could choose what time they got up, when they went to bed, how and where to spend their day and what they wanted to wear. Staff told us some people liked to get up late and have a late breakfast or eat their meals in their rooms or in a quiet room with their relatives and this was accommodated. Arrangements were in place for independent advocates to be contacted for people who could not express their wishes and did not have any family or friends to support them to make decisions about their care.

People were supported to be independent. We saw staff encouraging people to do as much as they could for themselves. One person told us staff had been very supportive in helping them re-gain their mobility skills with a view to moving to their own home. They told us "The girls are fantastic they are behind me all the way". Staff informed us that they always encouraged people to carry out personal care tasks for themselves,

such as brushing their teeth and hair.

Positive relationships had developed with people. Staff took their time to talk with people and showed them that they were important and they demonstrated empathy and compassion for the people they supported. We noted staff spoke clearly and slowly to people living with dementia, using short sentences, making eye contact with them and giving them time to respond. They let people speak for themselves throughout discussions and let them speak about how they were feeling and gave them the time to listen to what they were saying.

People were able to maintain relationships with those who mattered to them. With the exception of protected mealtimes, visiting was not restricted and guests were welcome at any time. People could see their visitors in the communal areas or in their own room.

Information was stored securely in locked cupboards and on computers that were password protected.

## Is the service responsive?

### Our findings

We observed people engaged in a range of individual activities such as reading the paper, watching the television, listening to the radio and talking with others as well as a group of people sitting playing bingo with staff support. The activities organiser and registered manager told us, although not recorded staff also spent one to one time with people in their rooms. Records of group activities confirmed activities such as bingo and film nights took place on a regular basis. The registered manager told us that the times activity staff worked had been altered to afternoons with flexibility to work evenings or weekends to better suit people's needs. This flexibility had allowed for people to be supported going on outings they enjoyed such as to the theatre, for a pub lunch and the aquarium. The activities organiser told us they were responsive to people's likes and dislikes and changed the planned activity for the day if people wanted to do something different instead.

Some people told us that they did not feel there were a lot of activities for them to participate in. The registered manager explained that until recently the service had employed two members of staff who supported people with activities for five afternoons a week. They told us one of these staff members had left which had meant the amount of activities had reduced. They also assured us the range of activities on offer would increase again once they had recruited to the post. Minutes of a resident and relatives meeting held in October confirmed that additional activities were being provided in the run up to Christmas including a visit from a local school, Christmas bingo and a Christmas party.

Although not everyone could recall being involved in the planning of their care it was evident that they and their relatives had been involved in the assessment of their needs and the development of their care plans. We saw that people's needs had been assessed before they started using the service and care plans had been developed to meet those needs, in a structured and consistent manner. Paperwork confirmed people and their relatives were involved in the formation of the initial care plans and consulted when changes were made. Care plans contained personal information, which recorded details about people and their lives. Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence needs, personal care and details of people's hobbies, interests and how they preferred to spend their time. Information was clearly documented regarding people's healthcare needs and the support required meeting those needs and had been reviewed with the person and or their relatives on a regular basis. Relatives and residents meetings were also held at which people were invited to give their views and raise any areas of concern. Minutes of these meetings showed that action had been taken to address any concerns raised.

Care plans detailed people's communication needs for example if they needed to wear hearing aids or spectacles. We observed staff responded appropriately to people's different communication needs. For example by bending or kneeling down so they were at the same level of people who were sitting down, making eye contact with people and speaking slowly and clearly to people with dementia or hearing difficulties. One member of staff showed us that they had used pictures with one person to establish how they felt. Although we did not see them communicating with the person in this way the staff member was knowledgeable about how the person communicated.

End of life care was provided and arrangements were in place for other healthcare professionals to be contacted to provide support if needed. Some people had made advance decisions and these were recorded in their care plans. We saw compliments had been received from family members in relation to the end of life care their relative's had received.

People told us that if they had a concern or complaint they would feel confident to raise it. They said that they would approach the manager or a senior member of staff. Information about how to raise a complaint was displayed in the lift. Records confirmed that complaints raised had been recorded, investigated and responded to appropriately.

## Is the service well-led?

### Our findings

At our inspection March 2016 we found that systems and processes were ineffective at assessing, monitoring and improving the quality and safety of the service people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection 18 and 22 August 2016 we found although some improvements had been made to the overall management of the service and the systems for monitoring and improving the quality of the service, further improvements were needed to ensure the provider was meeting the requirements of the law. At this inspection these improvements had been made and the breach had been met however the improvements made needed to become embedded into day to day practice and sustained.

Since the last inspection the systems introduced for monitoring and improving the quality of the service had improved. The quality of the service provided was monitored by speaking to staff, relatives, visiting professionals, and examining records. The registered manager and provider's senior management team also completed a series of audits at the home. For example there were regular audits of medication, care plans, incidents and accidents, staffing levels, building maintenance, laundry, health and safety and fire safety. Accidents and incidents were reported, monitored and patterns analysed, so appropriate measures could be put in place when needed. The registered manager and a member of the senior management team showed us audits had been used to highlight areas of good practice and areas they needed to improve in for which action plans had been completed. The registered manager also produced a weekly home managers' report, which the senior management team used to analyse trends and improve standards at Church View and across the providers other services.

The systems in place to monitor people's satisfaction had improved. Satisfaction surveys which allowed people to give their views were regularly undertaken. The management were able to show us what action was taken in response to people who were not completely satisfied. For example we saw evidence that the provider had responded to people's feedback in relation to the quality of food and provided taster sessions so that people could choose the meals they wanted to be included on the menus. We also saw that the time of day activities were provided had been altered so that more activities could be provided. The registered manager told us further action would be taken to gain people's views on the issues people had raised with us specifically about the quality of the soft textured food, the kindness of staff and the provision of activities.

Since the last inspection the registered manager had left the provider's employment however an application to remove them from the register had not been submitted. Following the inspection the provider wrote to us to inform us that this issue was being addressed. A new manager had been employed and become the registered with the Care Quality Commission CQC on 10 August 2017. The new registered manager was supported by a deputy manager who was also a registered nurse. The registered manager told us they were supported in their role by the senior management team who visited the service on a regular basis. They also attended meetings with the senior management team and the managers of the providers other services at which they could discuss any issues they may have and share good practice.

Staff told us that they thought the new registered manager had improved the service people received by



introducing structure and paperwork that helped them to be more organised. They also said that they felt listened to by the registered manager and senior managers within the organisation. They explained although change could take some time, their views were sought and often acted upon. For example training had improved and an extra member of staff had been introduced in a morning.

Staff members were aware of the line of accountability and who to contact in the event of any emergency or concerns. There were open and transparent methods of communication. Staff attended daily handovers and regular team meetings. This kept them informed of any developments or changes to people's needs. Staff commented and we saw that they worked well together. We also saw that the service worked well with other agencies. For example the deputy manager and nurses attended regular meetings with local healthcare professionals involved in people's care in order to ensure people received 'joined up' care. Minutes of these meetings were maintained and detailed any decisions made, any action needed to be taken and by whom.

The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Staff were aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. We saw that policies, procedures and contact details were available for staff to do this.