Comfy Care Homes Limited

Rockfield Residential

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

This inspection took place on 25 February 2016 and was unannounced. We previously visited the service on 15 April 2014 and found that the registered provider did not meet all of the regulations we assessed. The registered provider submitted an action plan on 8 June 2014 to tell us how the would become compliant. We carried out a follow up inspection on 5 August 2014 and found that the registered provider met the regulations we had assessed.

The home is registered to provide accommodation for up to 17 people whose main need is in relation to their mental health. On the day of the inspection there were 15 people living at the home. There is a variety of accommodation at the home; some people have a small flat and some people have a bedroom. The home is situated in the seaside town of Scarborough in North Yorkshire, close to the sea front and town centre amenities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at the home.

People told us that they felt safe whilst they were living at Rockfield Residential. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. Staff also told us that they would not hesitate to use the home's whistle blowing procedure if needed.

Staff confirmed that they received induction training when they were new in post and told us that they were

happy with the training provided for them. Staff had received training on the administration of medication and people told us they were happy with how they received their medicines.

People told us that staff were caring and that their privacy and dignity was respected. They said that they received the support they required from staff and that their care plans were reviewed and updated as needed. People's nutritional needs had been assessed and people told us they were very happy with the food provided.

There had been no formal complaints made to the home since the previous inspection but there was a process in place to manage complaints should they be received. There were systems in place to seek feedback from people who lived at the home, relatives and staff.

Care staff, people who lived at the home and a health care professional told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote safety and optimum care to people who lived at the home. Staff told us that, on occasions, the outcome of surveys and audits were used as a learning opportunity for staff and for the organisation.

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.

The home adhered to robust medication policies and procedures to ensure that people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service that met their individual needs.

Staff had received training on safeguarding adults from abuse and this meant they were aware of how to refer any concerns to the safeguarding authority.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and people told us they liked the meals at the home. Some people prepared their own meals, with assistance from staff when needed.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

People told us that their privacy and dignity was respected by staff and we saw evidence of this on the day of the inspection.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, as well as their preferences and wishes for care.

People were encouraged to follow their chosen lifestyle and take part in their chosen activities.

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager or one of the care staff if they had any concerns.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care and support.

Rockfield Residential

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 25 February 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider and information we had received from the local authorities who commissioned a service from the registered provider. The registered provider was asked to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with two people in private and chatted with others. We also spoke with two members of staff and the registered manager. Following the day of the inspection we spoke with a health care professional.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, including quality assurance, maintenance and medication.

Good

Our findings

People told us that they felt safe living at Rockfield Residential. One person told us, "Yes, there is always someone overnight – if I'm scared or need someone to talk to." We asked staff how they kept people safe and their comments included, "We take advice from outside agencies", "We are open and relaxed and there is trust between us" and "Our training." A health care professional confirmed that staff were skilled at promoting people's safety and that the registered manager always let them know if 'something out of the ordinary' had occurred. This allowed health care professionals to monitor people's safety.

We saw there were policies in place on safeguarding adults from abuse and whistle blowing. The safeguarding policy included information about safe recruitment, staff training and recognising and reporting abuse. The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. Staff were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the registered manager or any member of staff. Staff told us they were confident that their colleagues would report any poor practice, and that they would not hesitate to use the home's whistle blowing policy if needed. One member of staff told us, "We are not here to protect our colleagues but the service users."

The registered manager told us that there was only a small number of incidents at the home; she believed this was because staff spent time talking with people and this meant that any issues did not escalate. We saw that alerts had been submitted to the safeguarding adult's team when an incident had occurred, and that the appropriate notifications had been sent to the Care Quality Commission. These documents were accompanied by detailed reports of any incidents that had occurred and the outcome of any investigations that had been carried out, and were stored securely.

We saw that care plans listed the risks associated with each person's care and support needs, including the risks associated with poor nutrition and the risks associated with each person's vulnerabilities. Most people had a mobile phone so they could keep in touch with staff when they were out; this minimised the risk of people being involved in incidents when they were out in the local community or the risk of them going missing.

We saw that accidents and incidents had been recorded appropriately. Accidents had been audited each month; there had been none in January 2016 and one in February 2016. There was a record of the accident, the condition of the person concerned and the treatment given, and records showed the person was

checked throughout the night and given Paracetamol for pain relief.

Only senior staff were responsible for the administration of medication and the training records we saw confirmed that these members of staff had completed appropriate training; both of the members of staff who we spoke with confirmed they had undertaken medication training. Staff also told us that they had competency checks by the registered manager to ensure that they retained the skills to carry out this task safely.

People's care plans included details of their physical and mental health conditions and their current prescribed medication. People told us they understood why they were taking their medication and that they received their medication at the right time. One person said, "I always get my medicine when I need it" and went on to tell us the times they took their medication.

There was a policy on the storage, handling and administration of medicines as well as the Rockfield Residential policy on drug administration and medicines, and a policy on self administration of medicines. There was also a copy of good practice guidance on the administration of medicines in care homes produced by the Care Quality Commission.

We saw that medication was stored securely; the trolley was fixed to the wall in the medication room and it was locked when not in use. The trolley remained in this room and people came to the room to request their medication.The temperature of the medication room was checked and recorded each day to ensure medication was stored at the correct temperature. Medication was supplied in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The blister packs were colour coded to indicate the time of day the medicines needed to be administered. No-one had been prescribed medicines that required storage in a fridge. None of the people who lived at the home had been prescribed controlled drugs (CDs). These are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We saw that there was a storage cabinet and a CD record book should someone be prescribed CDs.

We checked the folder where medication administration record (MAR) charts were stored and saw that each person had a laminated sheet in place that recorded the name of their GP, the name of the GP practice, their next of kin, their medical conditions and any known allergies. There was a list of sample signatures for staff so that records of administration could be checked. We saw that most handwritten entries on MAR charts had been signed by two members of staff, although two entries had only been signed by one person. The risk of errors occurring when information was transferred from the original packaging to the MAR chart would be reduced if the task was carried out by two members of staff. We saw that there were a small number of gaps in records; two were in respect of supplements and one was a tablet. We checked and the person had taken this medication but the member of staff had forgotten to sign the MAR chart. The registered manager showed us a laminated sheet that they used to check when each person had taken their medication; on this occasion this system had not been effective. Codes to record the reason why medication had not been taken had been used appropriately.

Some people had been prescribed 'as and when required' (PRN) medication and the MAR chart had only been signed when this medication had been administered. We saw that care plans included protocols that described when people would require this type of medication. When a medication had been stopped, or when a course of medication had been completed, the date was recorded on the MAR chart and signed.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. The arrangements in place for returning unused medication to the

pharmacy were satisfactory.

We received information of concern following the day of the site visit. This was in respect of the medication handed to people or their relatives to be used during visits away from the home. If these visits were planned, the registered manager was able to ask the pharmacist to provide a blister pack for the period of time concerned. However, if the visit was 'short notice', tablets were given to people in sealed, dated and labelled envelopes; one for each tablet for each time of day it was due to be administered. We discussed this with the registered manager and they agreed to take advice from the home's pharmacist so that a more robust system could be introduced.

We checked the recruitment records for two members of staff. We saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw that some references were not dated. This made it difficult to evidence that the references were received prior to people starting work at the home. The registered manager told us she would ensure references were dated in future. Staff told us they had been through a thorough recruitment process when they were employed at the home, and had not been able to work until all of their safety checks were in place.

We noted that a record of interview questions and responses had been retained for future reference, and that a checklist was used to score the applicant's responses. This meant that only people considered suitable to work with vulnerable people had been employed at Rockfield Residential.

On the day of the inspection there was the registered manager and a support worker on duty. The registered manager told us that they were short staffed; there were usually three members of staff of duty during the day, including a domestic assistant. People who lived at the home, staff and a health care professional confirmed that there were usually three members of staff on duty. We saw that, even though they were one member of staff short, people had their needs met. There were two staff on duty overnight; one who was awake throughout the night and one 'sleeping'. The staff rota was colour coded and this enabled people to see 'at a glance' who was on duty. We checked the staff rotas for a two week period and saw that staffing levels had been maintained. People who lived at the home told us there were enough staff on duty. One person told us, "There are enough staff, even during the night. That makes me feel safe."

We checked that the premises were being maintained in a safe condition. We saw maintenance certificates for gas safety, the fire alarm system and fire extinguishers. A risk management company had completed a fire safety risk assessment on behalf of the home. Weekly fire tests were carried out to ensure the alarm system remained in full working order, and monthly fire drills were being carried out to ensure that people who lived at the home and staff were aware of the action to take in the event of a fire.

We saw that there was a folder in place that was kept by the fire panel. This included an emergency plan that advised staff what action to take in the event of a fire. It included details of emergency contact numbers, staff contact details and personal emergency evacuation plans (PEEPs). These are documents that record the assistance a person would need to be evacuated from the premises, including the level of assistance they would require from staff. We discussed how it would be useful to include information about other emergencies that could occur in the emergency plan, such as flood, loss of utilities and an outbreak of infectious disease.

We noted that the premises were clean throughout and that there were no unpleasant odours.

Good

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 MCA 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. The people who lived at the home had the capacity to make their own decisions and discussions with the registered manager and staff indicated that they understood the principles of this legislation and how it applied to people who lived at Rockfield Residential.

Deprivation of Liberty Safeguards (DoLS) are part of the MCA legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. 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. We saw that the registered manager and staff had completed training on DoLS as well as mental health awareness.

We saw that staff asked for people's permission or consent before they started to support them. People who lived at the home confirmed this. One person said, "Staff always ask first – I am in control." Support plans recorded a person's consent to staff administering medication on their behalf and having their photograph taken for medication records. The person concerned had been asked to sign these records.

A support worker told us they helped people to make decisions by giving people alternatives, and asking them what they thought 'would be best'. They said that, if they gave advice, they explained to the person the reason why. Another support worker told us that they "Could only advise people" about decisions and choices. They said they would talk to people and present them with various options but in the end the person was free to make their decision. We noted that one care plan recorded that the person sometimes became anxious, and this was usually due to them making unwise choices.

A care plan we saw recorded that the person was unhappy about having hourly checks during the night; these were introduced because the person have left the premises during the night un-noticed. We discussed this with the registered manager who told us that they had consulted with the person's psychiatrist, social worker and family members, and that the person concerned had agreed to these checks. The registered manager told us they would ensure this was recorded as a best interest decision.

We asked people if they thought staff had the skills they needed to carry out their roles and to assist them

with their care and support needs and they responded positively. Their comments included, "They are the right kind of people", "I'm happy living here – I'm quite settled" and "Staff have the right skills."

We saw that new staff completed thorough induction training prior to becoming part of the staff rota. The staff rota clearly recorded when new staff were 'shadowing' experienced staff, and the rotas we saw showed that these members of staff were always supernumerary. Staff confirmed that they had undertaken thorough induction training; one member of staff said, "I received a copy of the staff handbook, read information folders and then shadowed some experienced members of staff." Another member of staff told us, "I shadowed other staff for three to four weeks – we have to cover a selection of all shifts." The registered manager told us that there were plans in place for each member of staff to commence the Care Certificate; this would be induction training for new staff and refresher training for existing staff. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

Training records identified that staff had completed training on fire safety, food hygiene, infection control, equality and diversity, safeguarding vulnerable adults from abuse, mental health awareness, DoLS, first aid and moving and handling. Five staff had completed training on learning disability awareness and three staff had completed training on The Care Act. In addition to this, eleven staff had completed a National Vocational Qualification (NVQ) at Level 2, and five staff had completed this award at Level 3. The registered manager had achieved NVQ Levels 4 and 5. Staff told us they were happy with the training provided for them, and had completed a variety of training courses in the last year. These included safeguarding vulnerable adults from abuse, equality and diversity, medication and food hygiene. This meant that staff had received training that gave them the skills to carry out their roles effectively.

The records we saw confirmed that staff had completed appropriate induction and on-going training and that training certificates were issued to evidence training achievements.

Staff told us they attended regular one to one supervision meetings with the registered manager. They told us that they were able to "Say what they thought", make suggestions and discuss their training needs at these meetings. One member of staff told us, "The manager is very fair and approachable."

People told us that staff were aware of their special dietary needs and their likes and dislikes. They told us that staff helped them to eat healthily, for example, if they needed to gain weight or had diabetes. They told us they had plenty of choice and we saw this on the day of the inspection. One person who lived at the home told us, "We have enough choice – we are spoilt."

A member of staff told us that there was a board in the kitchen that recorded people's likes and dislikes and any special dietary requirements, such as diabetes or 'no dairy'. On the day of the inspection people were offered a choice of soup or various sandwiches. The menu board recorded that the evening meal would be Spaghetti Bolognese and the alternatives listed were a jacket potato, salad or a sandwich.

We saw that one person had a food intake chart in place. This did not include actual amounts the person had eaten. We discussed this with the registered manager and they told us that this was completed to check when the person agreed to eat a meal and when they declined and that they had been asked to record this information by health care professionals.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

When we read people's support plans we gained a clear understanding of each person's medical condition, the reason medication had been prescribed, how the person was able to manage aspects of their physical and mental health condition themselves and the level of support they required from staff and health care professionals.

We saw that any contact with health and social care professionals was recorded, including the date, the reason for the contact and the outcome. This information indicated that care professionals such as the GP, psychiatrist, community nurse and social worker were involved appropriately in supporting people to reach optimum health. A health care professional told us that the registered manager and staff asked for advice appropriately, and then followed any advice given. They said, "They definitely follow advice. This has improved over the last year or so. If there is an incident, they telephone us for advice. They are also good at keeping us informed, such as if anything out of the ordinary occurs."

The registered manager told us that one person regularly refused to take their medication. The registered manager had an agreement with mental health services that they would telephone every three days with an update about medication. This allowed health care professionals to decide on the best course of action to take and to provide advice to staff at the home.

Support workers told us that, if someone needed to see their GP, they would ask them if they wanted to ring the GP themselves, or if they wanted the support worker to ring on their behalf. The people who lived at the home told us that they would go to the GP surgery themselves; one person said they would make the appointment themselves and another person said staff would make the appointment for them.

We noted there were steps up to the front door of the premises and steps and stairs to the first and second floors of the premises. People who lived at the home told us they did not have any problems mobilising around the home, although a member of staff told us that, if people became very overweight, they might start to have problems managing the steps and stairs. There was no passenger lift or stair lift and there was no space for either within the home. There was a bathroom and a shower room and this meant that people could choose whether to have a bath or a shower.

Good

Our findings

We asked people who lived at the home if they felt staff really cared about them, and they all responded positively. Staff told us they were confident that the full staff team cared about the people they were supporting. One member of staff said, "We would soon pick up if a new member of staff wasn't right for the job." A health care professional confirmed this. They told us, "Staff genuinely care. I can pop in to speak to them if I need to, and I speak to them regularly on the phone. They are a lovely bunch of staff."

We saw that interactions between people who lived at the home and staff were positive; it was clear that there was rapport between them and that staff understood people's particular personalities, behaviours and support needs. We saw people approaching staff to tell them where they were going and what they were going to do, and asking for advice. We noted that staff listened to people's comments and offered appropriate advice. One person requested new batteries in their hearing aid and we saw that staff dealt with this request promptly. A health care professional told us, "There are so many people with different illnesses. They do a really good job. They have empathy with the people they support." They went on to say, "I called in recently. We were discussing some of the people who live at the home and all of the staff 'chipped in'. It was clear they knew people really well."

We asked people who lived at the home if staff respected their privacy and dignity and they confirmed that they did. One person said, "They make me feel comfortable when they help me." People also told us that staff maintained their confidentiality if this is what they wished. One person said, "Staff would keep things private and confidential." Staff told us that they ensured a person's dignity was maintained when they assisted them by closing doors. They said, "We may stand outside and ask people to shout if they needed any help, and we might 'take a step back'." This showed that staff were respectful of people's privacy and dignity.

Staff told us they tried to encourage independence and encouraged people to carry out tasks that they were able to do independently, and only helped with tasks that the person found difficult. We observed this to be the case on the day of the inspection.

Staff had completed training on independent advocacy. Everyone who lived at the home had capacity to make their own decisions but there was information available about advocacy services, Independent Mental Capacity Advocates (IMCAs), the local Crisis team and other support services should people wish to contact these services independently. Care records evidenced that one person was supported by a solicitor.

Discussion with the registered manager and staff and our observations on the day of the inspection indicated that people's had diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Our findings

Assessments were undertaken to identify people's support needs and records evidenced that this information had been gathered from the person themselves, their family (when appropriate) and from health and social care professionals involved in the person's care. People told us that they had been involved in developing their support plan. One person said, "I know there is a care plan and staff talk to me about it, but I have never looked at it." Information gathered in assessments was used to develop support plans that outlined how the person's assessed needs should be met. Support plans were reviewed and updated approximately each month so they were an up to date record of each person's current needs.

It was clear from reading support plans that care was focused on the person concerned. The support plans we looked at were written in a person-centred way and recorded the person's individual needs and abilities as well as choices and likes / dislikes. There was a record of the person's preferred name, their life history, their hobbies and interests, the people who were important to them, their medical conditions, their prescribed medication and the support they received from health and social care professionals.

We saw that support plans focused on what people were able to do, not what they could not do. For example, support plans recorded, "[Name] washes and dresses independently. Needs prompts to have a bath and change their clothes" and "[Name] uses public transport, has a mobile phone, is able to shop and uses shops and cafes."

We saw there were some minor omissions in support plans, such as a PEEP for one person and the family history for another person. The registered manager told us that this person had declined to share details of their family history with staff. They assured us that other missing information would be added immediately.

Care staff recorded information about each person during the morning, afternoon and overnight shift. We saw the notes prepared for and read out at handover meetings. These included details of the staff on duty each shift, a report on how each person had been throughout the day and details of any appointments or other duties for staff that day. Staff told us that these meetings helped them to keep up to date with people's changing needs as they had the information they needed to provide responsive care as people's needs changed.

People told us that staff shared information with them and communicated with them appropriately. One person said, "Yes, the staff would tell me anything I needed to know."

A new member of staff told us they had received ample information during their induction period to help them to get to know people, such as their routines and their likes and dislikes. They said that they had read people's support plans but had also spent time talking with people, and that this had helped them to get to know people.

We saw that people were supported and encouraged to maintain contact with their family and friends. A member of staff told us that most people had a mobile telephone and this helped them keep in touch with family and friends independently. One person was supported to visit their home town on a regular basis and another person told us, "People can come to see my any time."

There was evidence that meetings were held for people who lived at the home. A member of staff told us that people had been asked at a recent 'resident' meeting if they were happy with the activities on offer at the home, and they had said they were happy with things as they were. People told us that they enjoyed going on the seafront for a walk, dominoes, meditation, colouring and flower arranging / plants. There was evidence of people's hobbies and interests in ther bedrooms and people told us they had enough to do to occupy themselves. We saw that people had an activity programme for the week in their care plan; activities included going out for a walk, reading, watching TV and overnight visits.

We looked at the minutes of the most recent meeting for people who lived at the home. The minutes recorded that two people had told staff they would not be attending the meeting, but they passed on their comments to staff prior to the meeting. Activities were discussed and one person said they would like some dominoes and some new bingo equipment and another said they would like some more board games. We asked the registered manager if any action had been taken in response to these suggestions and she told us that they had purchased a chess set and some new bingo equipment.

People told us they were asked if they were happy with the support they received and that they had completed satisfaction surveys. We saw a copy of a survey that had been given to people to complete in December 2015. Questions were asked about staff training / competency, query handling, the presentation of the home, meeting service user requirements and the effectiveness of management. The survey recorded, "If your response is 'poor' or 'very poor' please expand in order for us to implement effective corrective action, although we saw that all of the responses received were 'good' or 'very good'.

People told us they would speak to support staff if they were not happy and that they were confident they would be listened to. One person said, "I could speak to the staff – they would keep it confidential. There is always someone to speak to." One person mentioned some support workers by name who they would be happy to speak with. People also said they would be happy to speak to the registered manager. They told us, "She would listen and she would try to put it right." The registered manager told us that they had a comments book although it was rarely used, as people preferred to share information verbally.

Staff told us that, if someone complained to them, they would record the facts such as the date and who was involved. They would pass this information to the registered manager and they were confident the person would be listened to and the issue would be dealt with professionally.

We checked the home's complaints log and saw that there had been no formal complaints made in January or February 2016, although there were systems in place to record and audit any complaints if they were received.

Good

Our findings

The registered provider was required to have a registered manager as a condition of their registration, and the service had a manager who was registered with the Care Quality Commission. This meant that the registered provider was meeting the conditions of their registration.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection. We found that these were easily accessible, well kept and stored securely, including people's support plans and other documents relating to people's care and support.

We saw that the home's mission statement was displayed in the registered manager's office. This stated, "A relaxed homely atmosphere, where individuals are encouraged towards confidence in themselves and social integration with a view to a level of independence to suit personal needs." We asked the manager to describe the culture of the service. She told us, "We promote a relaxed atmosphere. People don't have to do anything they don't want to do. We promote a family feel." A support workers told us, "People have freedom and we give them encouragement. They are happy – the home is not institutionalised." Other staff described the home as "Relaxed" and told us that they worked well as a team. A health care professional told us, "When I last visited, the service users and staff were sitting around the dining table together having a cuppa. They didn't know I was calling so this was not for my benefit." This demonstrated the relaxed family atmosphere of the home.

The home was associated with the Independent Care Group (ICG) and this helped the registered provider and manager to keep up to date with developments in the care sector, good practice guidance and changes in legislation.

We asked support staff if they thought the home was well managed. They told us, "[Name] is approachable. She is always at the end of the phone. She has a relaxed but thorough style" and "[Name] listens to what we have to say. She listens to our ideas. She is very approachable. She is firm but fair – the residents are always her priority." A health care professional told us, "[Name] is a really good manager. She gets her point across to staff but has a nice way of doing this." A person who lived at the home told us, "The registered manager

and deputy are easy to talk to. All the staff are good – we work together well."

The registered manager told us that they did not distribute surveys to staff, as they had staff supervision meetings every six weeks and staff meetings approximately every three months. They felt that this gave staff enough opportunities to share their views. A member of staff confirmed that staff meetings were held and told us that they liked to attend them, as it was "Good to sit down and talk." Another member of staff told us that they had 'open' discussions at staff meetings. We saw the minutes of the staff meeting held on 3 December 2015. The topics discussed included team work, the structure of shifts, supper, food diaries, the 'on call' rota and cleaning. Staff were also asked if they thought there were any areas where the service could.improve.

The registered manager told us that they had previously issued questionnaires to people's relatives but had received very little response. They told us they continued to share information with families by telephone "Even when there were poor relationships between people who lived at the home and relatives."

Numerous audits were being carried out by the registered manager and staff. We saw a health and safety audit that included a 'slips, trips and hazard spotting' checklist. The most recent audit had been carried out on 25 January 2016 and included the action needed to reduce the risk of the build up of ice on footpaths to the home during the winter months, and the use of 'wet floor' signs inside the home. The most recent medication audit had also been completed on 25 January 2016; this included the record of a 'medication count' that was found to be correct and information about a missing photograph due to the fact that the person concerned had refused to have their photograph taken. Audits were also taking place on the prevention and control of infection and we saw that any areas that required action had been noted and dealt with.

Staff told us that any issues of concern would be discussed openly and they were certain that any learning would be identified, including whether any improvements were needed to make sure the same issue did not occur again. One member of staff said, "We would look at whether a risk assessment was needed, could we have done things differently and whether this home was the right place for the person to live – we would share our ideas."