Bupa Care Homes (BNH) Limited

Clare House Care Home

Inspection report

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Date of inspection visit:
21 July 2016

Date of publication:
17 August 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out on the 21 July 2016. Clare House Nursing Home provides residential, nursing and respite care for older people who are physically frail. It is registered to accommodate up to 30 people. The service also provides end of life care to people with the support of the local palliative care service. On the day of our visit 24 people lived at the service.

On the day of our visit there was 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. We were also assisted by the deputy manager, who was also the clinical lead.

People said that they felt safe. Relatives of people felt their family members were safe. One person said, "I feel safe because if I needed help at night there is always staff available." Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse.

There were enough staff deployed at the service. We saw that people's needs were met by staff when they needed help. People told us that there were enough staff. One person said, "There is an abundance of staff."

Risks to people's safety were identified and appropriately managed. Staff were aware of the risks to people and what actions they should be taking that included risks around their care. Incidents and accidents were recorded and action taken to reduce the risks of these occurring. There were robust recruitment processes in place before staff started work.

People's medicines were managed safely and medicines were stored securely and in an appropriate environment.

People and relatives told us that they felt staff were competent in their roles. One person said, "I feel confident with them (staff)" with their clinical care." Staff had the training and experience they needed to meet people's needs. Staff's competencies were assessed regularly in one to one meetings with their manager.

People's human rights were protected because the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) was being followed. Where gaps had been identified around MCA assessments these were being addressed by the registered manager.

People had mixed views about the quality of the food at the service.although we found people were provided with adequate nutritious food to maintain their health. Comments included, "The food is quite good and tasty" and "The food is acceptable but not exciting." People at risk of dehydration or malnutrition had effective systems in place to support them including being regularly weighed and food and fluid charts

being put in place if needed.

People had access to a range of health care professionals. Advice given by health care professionals was followed by staff.

People and relatives felt that staff were kind and caring. One person said "The carers are just brilliant."

Staff interacted with people in a kind and compassionate manner and treated with people with dignity and respect. It was clear that staff understood people's needs and how to communicate with people. People and relatives were involved in decisions about their care.

People were cared for in a compassionate and dignified way at their end of life. The registered manager told us that more work was being undertaken to ensure that people's wishes about end of life care was obtained.

Detailed assessments of people's needs were undertaken and people felt they were getting good, responsive care. One person told us "My health has improved (since moving in) I am much more mobile because of the care I am getting." The registered manager confirmed that where there was information missing around the particular needs of people that this was would be addressed.

There was a lack of social interaction for people who were being cared for in their rooms and activities were not always person centred. However there were other activities that people participated in including, poetry, music, pet therapy, bingo, drawing, move and groove, donkey visit and church services. The registered manager told us that more work was being done to address the personalised activities. We have made a recommendation that this aspect of peoples care is improved.

People and relatives were aware of the complaints process and people were supported to make complaints if they needed to. Complaints were responded to appropriately.

People, relatives and staff said they were happy with the management and running of service. One person said, "I find (the manager) to be very approachable, pleasant, friendly and takes on board what you are saying." We saw during the inspection that the registered manager engaged with people positively and had a good amount of knowledge about the people living at the service.

There were systems in place that ensured that people and staff were involved in the running of the service and staff felt valued and appreciated.

There were a number of systems in place to make sure the provider assessed and monitored its delivery of care including audits, surveys and meetings with staff. Records were kept securely.

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 had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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.

There were enough qualified and skilled staff at the service to meet people's needs.

Staff knew about risks to people and managed them appropriately. People's medicines were managed safely

Staff were recruited appropriately. Staff understood what abuse was and knew how to report abuse if required.

Is the service effective?

Good

The service was effective.

Staff had an understanding of the Mental Capacity Act 2005. There were some gaps around people's capacity assessments but this was being addressed by the registered manager.

Staff felt supported and had received up to date training to make sure people were receiving safe and effective care.

There were mixed responses from people about the quality of the food. However people were given choices around mealtimes.

Peoples' weight and nutrition were monitored and all of the people had access to healthcare services to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and their dignity was respected.

People were able to express their opinions about the service and were involved in the decisions about their care.

Care was centred on people's individual needs.

Visitors were welcomed to the service.

People were supported in a caring and dignified way at the end of their life.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities were not designed to suit everybody's individual needs.

Care plans were mostly detailed around people's needs; we identified some gaps around specific care planning around diagnoses of people.

People knew how to make a complaint and who to complain to.

Is the service well-led?

Good

The service was well-led.

There were appropriate systems in place that monitored the safety and quality of the service.

Where people's views were gained, this information was used to improve the quality of the service.

People and staff thought the registered manager was supportive and they could go to them with any concerns. The culture of the service was supportive and staff felt valued.

Clare House Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 21 July 2016. The inspection team consisted of two inspectors and an expert-by-experience in care for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. Due to the short notice of the inspection we did not ask the provider to complete 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 reviewed notifications that had been sent in that gave us information about important events that had taken place.

During our inspections we spoke with the registered manager, the deputy manager, four people that used the service, four relatives and five members of staff. We looked at four care plans, three recruitment files for staff, medicine administration records, supervision and appraisal records for staff, and mental capacity assessments for people. We looked at records that related to the management of the service. This included minutes of staff meetings, surveys with people and staff and audits of the service. We observed care being provided during the inspection particularly at lunch.

The last inspection of this service was on the 12 August 2015 where we found one breach of regulations.

Good

Is the service safe?

Our findings

People said that they felt safe. One person said, "I feel safe because if I needed help at night there is always staff available" whilst another person said, "Having staff around helps me feel safe." Relatives felt their family members were safe and that they had peace of mind when they left the service. Another relative said that the security around the service was good which helped them feel their family member was safe.

Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. One member of staff said, "We are like a family here, If any staff saw anything wrong we would bring it up with the manager." There was a Safeguarding Adults policy and staff had received training in safeguarding people. There were flowcharts in the offices to guide staff and people about what they needed to do if they suspected abuse and a poster on display in the reception to guide people on how to report any concerns they had.

People's needs were met because there were enough staff deployed at the service. People told us that there were enough staff. Comments included, "There is an abundance of staff", "When I wake at night I always know there is someone (staff) here to help me" and "I press the bell (staff) respond quickly." We observed that staff provided support to people when they needed it. One person asked a member of staff for assistance to use the bathroom and this was responded to quickly by staff. The registered manager told us that there needed to be six carers and one nurse in the morning and five carers and one nurse in the afternoon. During the night there needed to be one nurse and two carers. We saw from the rotas that these levels were always met. One member of staff told us "There are enough staff on duty"; they said that they had enough time to spend with people. Another member of staff said, "Yes there are enough staff, although it can be busy at night." This may be the case on occasions but from what people told us it did not affect how quickly staff responded to peoples needs at night.

Risks to people's safety were identified and appropriately managed. People told us that risks to them were managed well. One person told us that staff ensured the service was clear for them to be able to walk around with their frame. Another member of staff understood the choking risk to someone and how to manage this. Risks had been assessed and managed appropriately to keep people safe. This included the management of pressure sores, catheter care, bedrails and medicines. Risk assessments were also in place for identified risks such as malnutrition and choking with clear guidelines on the action that should be followed by staff. Staff were aware of the risks to people and what actions they should be taking. Incidents and accidents were recorded and action taken to reduce the risks of things occurring. For example one person had fallen out of bed and a crash mat had been put in place by their bed to reduce the risk of injury.

People had access to specialist equipment such as wheelchairs, walking frames, and specialist beds where needed. We noted that communal areas, stairs and hall ways were free from obstacles which may present a risk to the person. We saw that walking frames were kept within easy reach of people when they needed to use them.

People would be safe in the event of an emergency because appropriate plans were in place. In the event of

an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and keep them safe. Staff were knowledgeable on what to do in the event of an emergency. There were personal evacuation plans for each person that were updated weekly and sooner if needed and a copy was kept in the reception area so that it was easily accessible. We saw these had been updated to include people that had just moved in to the service.

People were protected from being cared for by unsuitable staff because there were robust recruitment processes in place. All applicants completed an application with their full employment history. The provider ensured that the relevant checks were carried out that ensured staff were suitable to work at the service and included criminal records checks and references. Staff files included a recent photograph, an up to date professional registration certificates for nurses and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or are barred from working with adults at risk. Staff confirmed that they were unable to start work at the service until these checks had been undertaken.

People's medicines were managed safely. Medicines were stored securely and in an appropriate environment. Staff authorised to administer medicines had completed training in the safe management of medicines and had undertaken a competency assessment where their knowledge was checked. We saw one member of staff administer medicines, we heard them explaining to the person what the medicine was and gave them time to swallow the medicine before they left them.

There were appropriate arrangements for the ordering and disposal of medicines. Staff carried out medicines audits to ensure that people were receiving their medicines correctly. We checked medicines administration records during our inspection and found that these were clear and accurate. Each person had an individual medicines profile that contained information about the medicines they took, any medicines to which they were allergic and personalised guidelines about how they received their medicines. There was PRN (as required) guidelines for staff that ensured that people received their medicines when they needed it.

Good

Is the service effective?

Our findings

People and relatives told us that they felt staff were competent in their roles. One person said, "I feel confident with them (staff)" with their clinical care. One relative said, "I feel staff are competent and know what they are doing."

People received care from staff that had the training and experience they needed to meet their needs. Staff were kept up to date with the required service mandatory training. The training included fire safety, moving and handling, health and safety and food hygiene. Staff told us that the training provided was effective and helped them in their roles. One member of staff said, "The training is really good, it provides useful reminders." We asked the registered manager to provide us with evidence of the training that the clinical staff had received however they told us that updated training had not taken place. For example there was no evidence of updated wound care training, catheter care or end of life care training. The registered manager told us after the inspection that all nurses would be completing individual revalidation programmes and clinical training to ensure that their knowledge and skills were updated. We saw that the training had been booked in the near future. The nursing team were supported by a clinical lead who observed practices with staff and recorded any development needs. We observed good practice (including clinical) by staff on the day of the inspection, particularly in relation to moving and handling, infection control and wound care.

We saw that staff's competencies were assessed regularly in one to one meetings with their manager and in yearly appraisals. Discussions included any additional training the member of staff may need. One member of staff told us "We talk about training, performance, problems, how I'm doing. It's about every three months." Another member of staff said, "It's useful to have a discussion with your manager."

People's human rights were protected because the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) was being followed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Most of the people who lived at the service had capacity to make decisions. However there was some information missing specific to particular decision that needed to be made. For example, we were told by the registered manager that one person lacked capacity and had been refusing their medicines. There was no specific MCA assessment around this particular decision or detailed evidence around why this person was not having medicines covertly. However there was guidance from the GP that the person's medicine was not crucial and a decision had been made not to give the person the medicine. One member of staff said "People have varying capacity, you should judge capacity of people at the time" The manager told that consent to care capacity assessments were undertaken but accepted that in some cases these needed to be

more decision specific. They knew what improvements needed to be made and has started to takle action. We were told by the registered manager that DoLs applications had been submitted to the local authority where appropriate in relation to restrictions placed on people, such as the locked front door.

There were mixed responses from people about the quality of the food at the service. However people were getting enough nutritious food and drink to maintain their health. Comments included, "The food is quite good and tasty," "It's not the same as at home", "The food is okay" and "The food is acceptable but not exciting." However this person did say that the chef was starting to introduce more things to the menu. One person felt that meals were served too early in the evenings but said that they were able to get snacks later in the evening. People confirmed that they were always given a choice of the meal that they wanted and were offered an alternative if they didn't like the meal.

The lunchtime meal was managed well by staff who clearly knew what they should be doing and who they should be supporting. Those people that had meals in their rooms were served first by staff. People were seated where they wanted to and staff were seen and heard to give choices to people. Those on a soft diet had this set out on their plates separately and the meals looked appetising. People who needed support were given this at a pace that was appropriate to them.

People at risk of dehydration or malnutrition had effective systems in place to support them.
The chef had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plate guards and adapted drinking cups. Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs. The chef was provided with regular updates on people's needs to ensure that they were being provided with the correct meals.

People were weighed regularly and advice sought from health care professionals if staff had any concerns. Those that needed had food and fluid charts completed to assess how much the person was eating and drinking. Drinks were within reach for people that were in bed and staff regularly offered drinks to people that required support. However we did raise with the registered manager that one person in their room was not being encouraged to eat as much as they could have been. The meal was placed in front of the person and staff left the room to support other people. Although the person was able to eat independently their care plan stated that they needed to be encouraged to eat. The person did not eat much of their meal. The registered manager told us that they would ensure that staff stayed with the person to encourage them to eat. There were no concerns with the person's weight.

People had access to a range of health care professionals, such as the GP, opticians, community dentist, physiotherapist and the palliative care team from the local hospice. The GP visited regularly and people were referred when there were concerns with their health. We saw that the care plans included actions taken by the health care professionals and staff providing care based on their recommendations. People confirmed that they had access to health care; one told us that they kept a diary of all of their future health appointments and said that staff supported them to attend.

Good

Is the service caring?

Our findings

People and relatives felt that staff were kind and caring. Comments included "We have a good relationship with staff", "The carers are just brilliant" and "They (staff) are very good at understanding my moods, they sit and talk to me."

We observed staff interacted with people in a kind and compassionate manner. We saw they responded promptly to people who were requesting assistance. They did so in a patient and attentive way and we noted some warm and friendly exchanges between staff and people. One member of staff observed that one person was struggling to pick their cup up; they went over straight away and turned the handle around so it was easier for them to pick up. On another occasion during lunch staff noticed that the flowers on the table were in the way and the person could not see the person opposite. The member of staff moved the flowers for them. We saw staff comfort people when they looked upset.

Staff were seen and heard to speak to people with dignity and respect. One person told us, "Staff always treat me with dignity, they respect my wishes." They told us that when personal care was given staff would always shut the door and pull the curtains. Another person told us that staff asked them what they wanted to be called which they said they appreciated. Through the day staff would discreetly ask people if they wanted to have personal care. We asked staff how they would treat people with dignity and respect and comments included, "I always ask people before doing things, if I'm taking someone to the bathroom I will always asked them first" and "I always knock on doors and close them for personal care. If someone is using the toilet I leave them with the bell and wait outside. I will cover people with a towel when we're washing them so they're exposed as little as possible."

It was clear that staff knew people well and knew how to communicate with people. One person was brought a cup of tea with biscuits by a member of staff. The person said to us, "It's the little things like that; (the carer) knows my favourite biscuits." We heard one carer kindly supporting someone in their room with their breakfast, saying, "I've got your eggs that you asked for and a nice cup of tea, let me make sure it isn't too hot for you, the egg is nice and runny, perfect for you." One person, who was unable to verbally communicate, indicated to staff that they needed them and staff understood what it was they wanted. People were all dressed appropriately and appeared well cared for. Staff told us that they enjoyed working at the service. One member of staff said "We work well as a team here, I like helping residents with their needs."

People were able to make choices about when to get up in the morning, what to eat, and what to wear. One person said, "If I'm asleep in the morning when they come in they (staff) know to just leave me, mornings are not my best time." Another person told us that they could go to bed when they wanted. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. The service was clean and rooms were personalised with family photographs and other personal effects. People told us that they felt that they could do what they wished with their rooms.

One person told us that when they moved to the service the registered manager and staff helped them come to terms with leaving their home and offered help with bringing their belongings to the service. They ensured that their room was near their family member who also lived there.

People and relatives said they felt involved in the planning of their care. Where care plans were reviewed this was done in consultation with the person and the family where appropriate. People said that staff always asked them about how they wanted their care to be provided. One person told us, "I have just had my care plan to check that I'm happy with everything." We did raise with the registered manager that some care plans lacked some information about people's histories, particularly for those who could not communicate as well. Having this background information for people would help staff with things that they could discuss with the person. The registered manager told us that they would address this.

We saw that people's care plans included information around what they wanted. For example one person liked to have the radio on in their room and the specific channel and we saw that this was done. Information was also included in the care plans for those people who couldn't communicate verbally. There was guidance for staff on how best to communicate with people including the gestures people made and what this meant.

People were cared for in kind and dignified way at their end of life. Staff did work with the local hospice team around how to support the person to be pain free. However the care plans for people were generic and not detailed around the person's wishes. We raised this with the registered manager who said that additional training had been planned around end of life care wishes for people. Despite this, relatives had fed back to the service how they felt their loved ones had been cared for at the end of their life. Comments included, "Words alone cannot express our appreciation for the way you looked after (the family member) in the past weeks", "The family would like to say a huge thank you to everyone who cared for (their family member) especially to those who ensured he was not alone at the end" and "Our (family member) was treated with great dignity and gentleness in her last days of her life."

Requires Improvement

Is the service responsive?

Our findings

There were occasions where staff were not always given appropriate information around people's needs. We saw that there were people who had diabetes and although their blood sugars level were checked there was no detailed guidance for staff on what their safe blood sugar levels should be. There was no guidance for staff on the signs to look out for should they become unwell. However after the inspection the registered manager advised us that care plans for people with diabetes were now in place. Staff we spoke to were not aware of diagnosis of two of the people who lived at the service. One member of staff said, "That would have explained a lot about their behaviours" whilst another member of staff said, "That would have been useful to me to know." The clinical lead had identified the gaps in the care plans and was arranging for additional training for this to be addressed.

Most people that we spoke with were not enthusiastic about the activities that were on offer. One person said that they didn't want to get involved and preferred to stay in their room. Another person said, "I don't think there is enough to do, I would like more activities to suit me."

Activities on the day were not person centred and people did not appear stimulated. Some people were reading the paper but no conversation was promoted from this by staff. People were doing art work making cards but the stickers being used were very small and difficult for people to see.
People who remained in their rooms did not receive sufficient one to one interaction from staff (apart from to provide care) and were at risk of social isolation. Although there were records of activities taking place in people's care plans, these were not always person centred. One person's record stated that they were visited in their room on three occasions over one month for a 'brief chat'.

There were a core group of people who spent their time in the activity room who were offered activities including, poetry, music, pet therapy, bingo, drawing, move and groove and church services. We saw that occasional trips to place of interest were organised. One member of staff said, "There isn't enough for people to do in their rooms, different people like doing different things."

We recommend that detailed information about people's preferred hobbies and interests is gathered with the intention of providing suitable activities that meet peoples needs and reduce the risk of social isolation. There was other detailed guidance for staff in the care plans. Where people had a wound they were provided appropriate care from the staff. There was a description of the wound, a clear photograph and entries regarding how often dressings should be changed. The Waterlow score, which is a tool for identifying skin integrity problems, was reviewed monthly. One person was being nursed on a specialised bed and the pressure relieving mattress was set at the correct setting to prevent pressure sores. Air mattress checks were conducted as well as repositioning of people that ensured people were not in the same position for too long.

People and told us that before they moved in the registered manager undertook an assessment of their needs. Relatives also confirmed this. People said that staff responded well to their needs. One person said "My health has improved (since moving in) I am much more mobile because of the care I am getting."

Detailed pre-admission assessments had been completed for people and used to develop and initial plan of care. There were detailed care records which outlined individuals' care and support included personal hygiene, medicine, health, dietary needs, sleep patterns, safety and environmental issues and mobility. Any changes to people's care was updated in their care record and ensured that staff had up to date information. Staff always ensured that relatives were kept informed of any changes to their family member and relatives confirmed this.

Staff told us that they completed a handover session after each shift which outlined changes to people's needs. The information related to a change in people's medicine, healthcare appointments and messages to staff. Daily records compiled by staff detailed the support people received throughout the day. Care plans were reviewed every month to help ensure they were kept up to date and reflected each individual's current needs. Where a change to someone's needs had been identified this was updated on the care plan as soon as possible and staff were informed of the changes. 'Take 10' meetings took place each day where the person's up to date needs were discussed with senior staff and then discussed with all other staff at the handover.

People and relatives were aware of the complaints process and people were supported to make complaints if they needed to. People told us they would raise concerns about the care they received with the registered manager if they needed to. One relative told us that as soon as they raised any concerns with senior staff they were addressed straight away. There had been two complaints at the service since the last inspection. We saw an appropriate response from the registered manager with actions to improve the quality of care in the future.

Good

Is the service well-led?

Our findings

People and relatives told us they were happy with the management and running of service. Comments from people included "This is a happy place", "I'm happy here, I wouldn't have come in here otherwise", "I find (the manager) to be very approachable, pleasant, friendly and takes on board what you are saying." Staff were also positive about the management of the service. Comments included, "If I need to know anything I can always ask the manager. I think of (the manager) as being firm but fair", "I feel supported by management, the home is managed well, (the manager) is nice."

People told us that the registered manager was visible in the service and was often walking around to make sure people were okay. The registered manager arrived at the service after we arrived, they ensured that they went and spoke to people before introducing themselves to us which showed us that their focus was on the people that lived there. We saw during the inspection that the manager had an open door policy, and that people and staff accessed their office through the day. The registered manager engaged positively with people and had a good amount of knowledge about the people living at the service.

The registered manager was aware of the challenges and what improvements needed to be made and was taking action to improve people's experiences.

People and relatives were involved in how the service was run. There were regular 'residents' meetings and minutes of these were made available to people. People told us that they attended the meetings and matters discussed included menus, maintenance, housekeeping and nursing needs. As a result of the meetings actions plans were produced and addressed. For example people raised that they wanted new items on the menu and the chef had started to introduce new things. A new television had been purchased for the lounge as a result of this being raised. People were involved in the decoration of the dining rooms, they chose the paint colour and wall art. People wanted a breakfast area in bright yellow to signify day to help orientate in time and place and the other end of the room to be more of a bistro style eating space. We saw that this was all in place.

Staff also attended regular meetings, these included 'Heads of Department' meetings, clinical meetings and general staff meetings. Discussions included changes in policy, staff changes, the environment and training. One member of staff said, "There's good rapport and team work here. We all work together to help each other" whilst another said, "We have team meetings every month. We can bring anything up and we're guided in the right direction." Staff said that they felt valued, one said, "I feel like my opinion matters" whilst another said, "The managers are carers will ask if I'm okay." The registered manager had introduced 'staff surgeries' where staff could go and see the registered manager to discuss any worries or concerns that they may have. Staff told us that they were appreciated and there was recognition for staff individually and for team working at the service when they performed well.

There was a system to manage and report incidents and accidents. Staff told us they would report concerns to the registered manager. We saw incidents and safeguarding's had been raised and dealt with where relevant notifications had been received by the Care Quality Commission in a timely manner. Incidents were

reviewed which enabled staff to take immediate action to minimise or prevent further incidents occurring in the future. We saw accident records were kept. Each accident had an accident form completed, which included immediate action taken.

There were a number of systems in place to make sure the service assessed and monitored its delivery of care. Various audits were carried out such as health and safety, medicines and maintenance. The regional manager also undertook monthly quality assurance checks and emailed appropriate actions to the registered manager for them to address. In addition to this there were plans to focus on the lack of activities within the service to make them more 'meaningful' and plans to improve the activity area to include a coffee corner with a counter, and drinks making facilities and snacks which people can take themselves. In the short time that the clinical lead had been at the service they had identified the need for more detailed care plans. They told us that they were in the process of developing their action plan to address the shortfalls. People's records were kept in a secure way.

People's, relatives' and staff feedback about how to improve the service was sought. Surveys had been carried out and an analysis of their surveys was being undertaken by the provider. People and relatives confirmed that they were sent surveys each year and were asked for feedback regularly. We saw that new uniforms were being trialled as a result of feedback from surveys received from staff.

Staff understood the values of the service. Comments from staff included, "We're here to keep people safe, happy and to get the best out of them. The manager always promotes that it's not an institution, it's their home and they have the same rights as we do" and "We try to make it as homely as possible for people, it's a happy home. I've said that to people in the past when I've recommended it to them."

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 had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.