Leicestershire County Care Limited

Hadrian House

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

We inspected the service on 7 June 2016 and the visit was unannounced. We returned on 13 June 2016 and this was announced.

Hadrian House is a purpose built care home that provides care without nursing for up to 40 people. At the time of our inspection there were 38 people using the service.

The service had 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.

People felt safe and staff knew how to protect them from abuse and avoidable harm. The service had safeguarding and whistleblowing procedures in place. Staff were aware of their responsibilities in these areas.

The registered manager investigated accidents and incidents to reduce future risk. Where people were assessed as being at risk there were plans in place that were available to staff to minimise risk.

There were emergency plans available to support people in the event of emergencies such as fire and loss of services.

People felt there were enough staff available. The provider's recruitment processes were robust and included checking prospective staff before they started to work at the home.

People received their medicines at the right times. The provider had safe arrangements for the management of medicines.

People received support from staff who had the appropriate skills and knowledge to support people. Staff had received regular training in areas relevant for the people they supported.

Staff knew about their roles and responsibilities. Staff received an induction when they had started in their role and on-going support from the registered manager.

Staff understood the relevance of and acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when they supported people.

People liked the food that was offered to them. They were supported to choose a healthy diet and their preferences and special dietary needs were known by staff.

People had access to healthcare professionals to maintain good health. Staff monitored people's wellbeing and acted promptly where concerns were identified.

Staff developed caring relationships with people and understood people's needs and preferences. People's dignity and privacy was promoted by staff.

People's care plans were focused on their individual needs. People were supported to maintain their independence. They were able to follow a range of hobbies and interests. People using the service and their relatives knew how to raise concerns and their views were acted upon.

Where people could, they had been involved in and had contributed to the planning and reviewing of their care and support. Where this had not been possible, relatives had been included.

People's support plans were individual to them and written in detail so that staff would know how to offer care and support.

People using the service, their relatives and staff were involved in developing the service. The provider acted upon their feedback. The registered manger and senior staff monitored staff care practice.

The provider had effective procedures for monitoring the quality of the service and took action to make improvements in areas identified by them as requiring improvement.

The registered manager was described as approachable and supportive.

Staff were clear about their roles and responsibilities. They knew how to raise concerns if they had needed to about the practice of a colleague. Staff were able to make suggestions for how the service could improve.

The registered manager understood the requirements of their role. They had carried out quality checks to monitor and improve what the service was offering people.

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 were protected from risk of abuse and avoidable harm. The provider had effective recruitment procedures and enough staff were deployed.

People were supported to take their medicine safely.

Is the service effective?

Good

The service was effective.

Staff sought people's consent prior to providing their support. People were supported by staff who had received appropriate training.

People were satisfied with the food available and had access to healthcare services to support them to maintain their health.

Is the service caring?

Good

The service was caring.

People received support from staff who cared and who were aware of their preferences and what was important to them.

People's dignity and privacy was protected and promoted.

People were involved in choices about their care and support and had opportunities to make their choices known.

Is the service responsive?

Good

The service was responsive.

People's support and their plans focused on them as individuals in line with their preferences.

People had access to a range of activities.

There was a complaints procedure in place. People felt confident

to raise their concern.

Is the service well-led?

Good

The service was well-led.

People knew who the registered manager was and felt that they were approachable.

People using the service, their relatives and staff were involved in developing the service.

The provider had effective arrangements for monitoring the quality of the service.

Hadrian House

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 inspection took place on 7 June 2016 and was unannounced. We returned announced on 13 June 2016.

The inspection was carried out by an inspector, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who used this type of service. The specialist advisor was an RGN (a registered general nurse) and had experience in the care of older people in community settings, tissue viability, moving and handling and palliative care.

Before our inspection we reviewed the information we held about the service and information we had received about the service from people who had contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch, who have the right to enter and view services, for their views of the service.

Due to technical difficulties the provider did not complete a Provider Information Return (PIR) when initially requested but made arrangements for it to be completed shortly before we visited. This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed a range of records about people's care and how the service was managed. This included five people's care plans and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service, as well as the policies and procedures that the provider had in place. We spoke with the registered manager, the compliance and care standards officer for the service, three senior care workers, two care workers, the cook and a visiting peripatetic worker.

We spoke with seven people who used the service and two relatives of other people who used the service. This was to gather their views of the service being provided.

Good

Is the service safe?

Our findings

People told us they felt safe living at Hadrian House and with the care staff who cared for them. One person told us, "Oh yes I do feel safe." Another person said, "The staff are all very good, I feel safe." A relative we spoke with said, "I know [person's name] is safe. The staff are very good. I have no concerns."

The staff members we spoke with described what they do to keep people safe. They had a good understanding of abuse and knew their responsibilities to keep people safe from avoidable harm and abuse. Staff could describe the different types of abuse as detailed in the provider's safeguarding policy and knew to report concerns immediately. All the staff we spoke with knew they must report any concerns to the person in charge of the shift or the registered manager. One staff member told us, "I haven't ever seen anything but I know what to do and I know that [registered manager] would deal with anything." Staff told us they had received training in the safeguarding of adults and records confirmed this.

All of the staff we spoke with told us that they understood whistleblowing and that they could raise concerns with external professional bodies such as the local authority or Care Quality Commission (CQC). The registered manager understood their responsibility for reporting allegations of abuse to the local authority and the CQC.

People could be sure that accidents and incidents were being managed well. Staff told us that they had received training in first aid. They also told us how they recorded any accidents or incidents so that there was a record of what had happened and what action was taken to reduce future risk. Where accidents had occurred the registered manager investigated them and action was taken to reduce further incidents wherever possible.

A person told us about a health concern they had and explained they had fallen a few times. We asked if they had any equipment to alert carers if they fell. They told us they did not. We asked a staff member about this. They told us what action they had taken to maintain the person's safety. Accident records indicated that the person's falls had reduced. This showed the action taken by the service had improved the person's safety.

People were assessed where there were risks to their health and well-being. These were centred on the person's individual needs and provided staff with a description of identified risks. The assessments gave clear guidance on how people should be supported in relation to this risk. These included assessments about moving and handling people safely, continence and people's risk of falls. Risk assessments were reviewed annually unless a change had occurred in a person's circumstances.

We had previously received information of concern about a person's behaviour that may affect other people using the service. We looked at this person's risk assessments in detail. They showed that the concerns had been addressed and action taken to reduce the risk posed to other people using the service. Staff we spoke with were aware of what action they needed to take to keep people safe.

There was a plan available for staff to follow for a range of emergency situations that could have occurred. For example, a fire or the loss of gas or electricity. We saw that regular checks were being undertaken to make sure that staff knew what to do in an emergency. Fire evacuation training had been provided to the staff team and regular practices had been carried out during 2016. Checks were being carried out on the hot water in the home to ensure it was safe and people were not at risk of scalds.

We also asked the compliance and care standards officer to investigate whether the gaps on the stair bannisters posed any risk to people due to their size. We did note that there was restricted access to the stairs. During the inspection the estates manager visited the service and confirmed that changes would be made to reduce any potential risk.

Some of the shower rooms and toilets had large pictures depicting what room it was. However, we noted that this type of signage was not used throughout the service. Clear signage could make moving about the service easier for people who were living with dementia to identify where they were. Some bedrooms had the name of the occupant but there was nothing personal on the doors that could assist someone with dementia to locate their own room. We discussed this with the compliance and care standards officer who told us that they would look at why this had not happened. During our second day we saw a staff member adding information to people's doors.

People told us they thought there were enough staff to help them when they needed help. One person said, "I press my buzzer at 7.20 in the morning so that they know I am ready to have my shower." Another person told us, "I sometimes press my buzzer at night because I worry a lot and think there's someone outside. The carers always come and reassure me." A relative told us, "There are always staff about, they do work hard. They are always there though when you need them."

We saw staff deployed throughout the day to meet people's needs. Staff we spoke with had mixed views about staffing levels. We were told that most of the time they were probably enough staff. However, if people's needs changed or two people needed the hoist at the same time, it did strain the staffing levels to ensure everyone else was safe. We brought this to the registered manager's attention who told us they used a dependency level assessment tool to establish staffing levels. They would review this to ensure they had sufficient staff to meet people's needs.

People were cared for by suitable staff because the provider's recruitment procedures were robust. We looked at the files of four staff members and found that appropriate pre-employment checks had been carried out before they started work. This meant that people could be assured they were being cared for by appropriately recruited staff.

People told us they received their medicines when they needed them. One person told us, "I used to have tablets but not now. The doctor said I could leave them for a while and see how I get on." Another person was able to tell us what tablets they took and confirmed that there had never been any problem with them.

The provider's medicines management policy was based on the latest guidance about medicines management. Medicines were stored safely and there were effective arrangements for the disposal of medicines that were no longer required. We were told that only staff who were trained to give people their medicines did so and their competencies to continue to do so were regularly assessed. Records we saw supported this.

The senior staff member responsible for administration on the day of the inspection told us that they had attended training on medicines management and had regular competency assessments from the registered

manager to ensure they remained safe. They could describe how to safely administer medicines which showed they understood the provider's policy. We observed part of a medicines round and saw that staff followed the correct practice. They explained to people what their medicines were for and observed that the medicines were taken before signing the records of medicines administration. If a person refused their medication this was recorded. A relative we spoke with told us that staff always watched a person take their medicine before they moved on.

Staff told us that two people had a covert medicines plan. (This means that adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.) The care plan described how the person should receive their medicines. All the staff we spoke with were aware of who needed their medicines administered this way and how it was done. Both the medicines administration records and the person's care plans showed that appropriate guidance and permissions had been obtained from the GP. This showed that staff followed people's medicine plans.

We did note that there were significant number of slings for moving people by a hoist, stored in a bathroom. We were told that these were for communal use. For infection prevention purposes slings should be used on an individual basis and stored in the individuals room.

We were also told that one person had extended spectrum beta-lactamase (EBSL). (EBSL are resistant to many penicillin and cephalosporin antibiotics and often to other types of antibiotic. Resistance makes these infections more difficult to treat. It is therefore important that good infection control procedures are practiced.) There was no easily accessible personal protective equipment in the room or on entry to the room. This meant that staff could not easily protect themselves and other people from cross infection.

Good

Is the service effective?

Our findings

People were supported by staff with the right skills and knowledge. One person told us, "They seem to know what they are doing, they go on lots of courses." A relative told us, "The staff are very good, they know how to support my [person using the service].

Records showed and staff confirmed that they had attended relevant training. A staff member told us, "We have loads of training. [Registered manager] is always checking we are up to date and asking if we want any training. We do a lot of distance learning and it is very good. It makes you think and you have to find out the information to complete the work book." Staff were also able to give examples of things they had learnt on their training. For example, how they cared for people who were living with dementia and how best to support them to reduce any distress they may feel. The registered manager told us that all staff receive the same training, this included office staff and the maintenance man. This was evident when we saw a person walking with staff then lower themselves to the floor. All staff including the maintenance man knew what to do. We looked at this person's care plan and it was clear that staff had followed the plans instructions.

People were being supported by staff who knew their responsibilities. The registered manager had made arrangements for all new staff to complete an induction. One staff member told us, "I had an induction it covered lots of training. I shadowed a more experienced member of staff and was also given time to read people's care plans. I found it very helpful."

Staff told us and records confirmed that they met with the registered manager regularly. One staff member said, "I meet with the manager every few months. They observe my practice and we have meetings. If I have any concerns I know I can talk with her. If she observes something she doesn't think is right she will tell us and we get help and more training if we need it." Records showed that staff were encouraged to discuss concerns and how they could improve their practice. This meant staff received the support they needed to be able to be effective in their role.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). We saw that the registered manager had made the appropriate applications to the 'supervisory body' (the local authority) where they were seeking to deprive someone of their liberty. We also saw that these applications had been reviewed within the timescale and had been renewed. Staff had a good understanding of MCA and DoLS. They were able to give examples of when it might be necessary to apply for a DoLS, such as if a person continually tried to leave the building. This ensured that people were not being deprived of their liberty or human rights unlawfully.

We checked whether the service was working within the principles of the MCA. We saw that each person had a care plan that included information about asking the person what they wanted and that reminded staff to seek the person's consent. We saw that where possible people or their representative had been involved in creating and reviewing their care plan and consented to their support.

People told us that the staff offered them choices and that they were involved in making their own decisions. One person said, "I can choose what I do. If I want to stay in bed a bit longer I can. If I want to eat my breakfast in bed I can. If I want to sit in a different lounge I can. It's very good like that here." A relative told us, "[Person using the service] struggles to make their own decisions but staff are very good they do ask them and try to give choices where they can make them."

All the staff we spoke with told us they would offer choice. One staff member said, "Some people you need to show them to help them make a choice. Like with their clothes, you would show them a choice of a skirt and top or at meal times show them the meals to help them make a decision." We also heard staff offer people choice throughout the day as well as ask for consent to provide support. For example, when staff needed to use a hoist to assist a person to transfer.

People were happy with the choice and amount of food and drink they received. One person told us, "The food here is quite good" whilst another person said, "The food is all right, but I've not got a big appetite." A relative told us, "The food seems good, my [person using the service] likes it. They always have a drink at hand, I know the staff are always encouraging people here to drink."

On the first day of our inspection it was very hot and some people were sat outside. We heard staff regularly ask people if they needed more to drink.

We saw the midday meal being served and people were given a choice. Where people had cultural or religious dietary requirements these were met. People who required softened or pureed diets received these and they were presented in an appetising manner. We spoke with the cook who knew who had special dietary requirements. Information was displayed in the kitchen with a photograph of the person and their dietary needs. These were updated regularly. This meant the cook had the information they needed to ensure people received the nutrition they needed.

Where people required support to eat their meal this was done discreetly and at the person's pace so they were not rushed. A staff member told us, "We had training on how to help people eat their meals. How it feels to have someone stand over you shoving a spoon in your face. It isn't nice. We know to sit next to the person and only offer more food when they are ready." Staff recorded what food people had eaten and where there were concerns about this, appropriate action was being taken. This information was also shared with staff during handover so they could monitor people and ensure they were offered snacks or alternative meals. Where people had lost weight this was reported to senior staff who contacted the GP and suitable food supplements or a referral to the dietician was made. This meant that people could be assured they would be supported to eat and drink enough.

On the first day of our inspection the dining room was very busy and there were a number of people with walking aids. This meant that access in and out of the dining room was difficult for some people. We were told that due to the sunny weather, more people than usual were eating in the downstairs dining room and usually some people ate in the upstairs dining room. We did note it was less busy during the second day as people were eating in the upstairs dining room.

People were being encouraged to maintain their health and to access healthcare services when they needed

to. One person told us they had an NHS hearing aid and they managed the batteries by themselves. They also said "Last week I had a stomach problem and had to have some antibiotics." Another person explained "I am waiting to have a cataract taken off my left eye." A relative told us, "They are very good they call the GP if [person using the service] doesn't feel well. They always let me know if they aren't feeling well."

We saw that people were being supported to visit specialists when they experienced poor health. For example, on the day of our inspection a person had a visit to the hospital. A relative told us, "If [person using the service] needs to go to the hospital or see a doctor they always send a care assistant with them. It's reassuring in case they need to go to the toilet. Also come in to see the doctor with me as two heads are better than one. I may not always remember so they can hear what the doctor has to say as well."

Records showed that people were supported to access routine healthcare appointments such as the chiropodist, optician and GP and specialist support where it was identified. For example, where staff had observed a person's behaviour change they had referred them to the mental health team. Staff told us how they monitored people's well being. One staff member said, "You get to know people really well and you know if so and so is a bit off colour. It might mean they have a urine infection. So we would monitor and pass it on to the senior for handover to keep an eye on them. If they don't look better we would call the GP and we do it quickly as things can change quite quickly. I would rather call a GP or district nurse out than not and they then got worse." This shows that the provider has systems in place to monitor and maintain people's health.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by staff. One person said "They're all right, I get on with all of them", whilst another said, "They're all very good and kind". A person explained "The carers are very nice to me they do anything I ask them to do." One person did say "The majority of the staff are very kind, they're not all tip-top but you have to take the good with the bad." They did not expand on this comment. Another commented, "The girls are very kind to me, they're always there to help if necessary." A relative said, "All the staff come across as caring, very friendly. They call people by their first name. They are always polite. They always intervene if other residents become challenging. They do it right, make sure both are ok. Usually take them off to get a cup of tea." They added, "You just have to ask and you get an answer they are always helpful." Another comment we received from a relative was, "Even the maintenance man is involved, he talks to the men about football."

People could be sure that staff listened to them and talked to them in a way they could understand. This was because there was clear information about this in people's support plans for staff to follow. Where people had difficulties communicating verbally, we saw that staff took time to listen and understand to ensure they were able to make their views known. One staff member told us, "We have a resident who can't talk very clearly but we know how to ask questions and we understand their reply."

People's care plans included preferences and personal histories. This enabled staff to provide support in a way that was caring. For example, we observed a staff member talking to a person and commenting they weren't wearing any jewellery that morning. They said that the person had some lovely pieces and would they like the staff member to go and get some. The person said they did. The staff member said they would get it and be five minutes. The staff member returned promptly with some jewellery and asked the person if the choice was alright. The person was clearly happy that the staff member had fetched their jewellery for them.

Where people became distressed staff were prompt in taking practical action to comfort them. For example, a person was calling out and a staff member knelt down next to the person to ask what was wrong. This was done with compassion and the person became calm.

People's dignity and privacy was respected. We saw that staff knocked on people's bedroom doors before they entered and asked people how they wanted their care and support to be provided. For example, we saw a staff member discreetly ask people if they needed support to eat their midday meal. People were asked if they wanted an apron to protect their clothes during the meal. We also saw staff assisting a person using the hoist. This was done carefully with staff covering their legs with a blanket to promote their dignity. They explained at each stage of the process what they were doing to provide reassurance. Staff showed a caring approach by being both interested in people they were supporting and respecting them as individuals.

People had the privacy they needed. There were a variety of lounges in the service, people were able to choose where they sat including a small pleasant garden. Staff told us that the smaller lounges were being

decorated with themes. For example they had a garden room, which overlooked the local playing fields and was decorated in a light and airy manner. Another lounge was decorated to resemble a pub. Staff told us this was so the men felt they had a place that was for them. People were able to see their visitors in their bedrooms. Staff told us when healthcare visitors came to see people they could see the person either in their bedroom or the treatment room.

Relatives told us they could visit any time. One relative said, "When my [person using the service] was in hospital we couldn't visit any time but here I can. I come at least four times a week and I am always made to feel welcome."

People were supported at the end of their life to have a comfortable, dignified and pain free death. Records showed that where people were at end of their life they received care that promoted their dignity. Healthcare professionals were called in a timely manner to ensure the person was pain free. We saw that advanced decisions to refuse treatment were available in people's care plans and these were signed by the person's doctor. The decisions were discussed with the people or close family and there was a clear reason for the decision.

Good

Is the service responsive?

Our findings

People told us that they received care that was personal and responded to their needs. One person said, "I think I was asked what help I might need. My daughter answered a lot." Another person told us, "I can't recall but they must have as they seem to know what they are doing." People were assessed prior to moving to the service. The pre admission assessment looked at the person's abilities, what they were able to do for themselves and where they needed support and how many staff were needed. In this way the registered manager was able to establish if the service was able to meet the person's needs. Where possible people were able to contribute to their care plan.

Care plans were written in such a way so that staff would know how to provide personalised care. For example, one care plan described how the person preferred to be dressed and have their hair done. There was a personal history document in people's care plans. Where possible this had been signed by the person and had information about their childhood, memories and family history. This is recognised by the Alzheimer's society as good practice to know the person behind the illness. Staff told us that they were key worker for people. They would get to know those people very well, including little things that were important to the person such as the type of toiletries they like. One member of staff told us, "We know all the residents well but we know people we are key worker for particularly well. We make sure their care plans are up to date. If they need anything it is the key worker who sorts it out." This meant that the provider had systems in place to ensure people received individualised care.

Staff told us that they read people's care plans and these helped understand what support people needed. A member of staff said, "I would read a person's care plan but we also talk to them and that's when you find out lots of interesting things. There is a person I am key worker for and they have dementia and can't remember things they did this morning but can tell me all about their early childhood. It is really interesting. It means you know if things might upset them or make them happy."

Records showed that care plans were reviewed and amended as people's needs changed. A relative told us, "I speak to the staff or the manager and I am kept up to date with any changes."

People told us that they do a variety of activities. One person said, "I have been out in the past and we have made things, but not for a while." Another person told us "If I ask the carers to take me to Asda they will take me to do some shopping." They also told us, "You can do as you like, play cards or games." Another person told us, "I like to knit and make squares for blankets for the local hospital." They added, "We have quite a bit of entertainment but I don't go, I can't be bothered." A person told us that they liked to read books and "Sometimes my daughter comes to take me out shopping." The hairdresser was in the first day of the inspection and we saw that some people had taken advantage of that service. One person said "I'll go and see her tomorrow, she comes in two days a week." A relative told us, "We have had trips in the past, they organised a Christmas meal, which was nice."

The service is currently without an activities organiser but the registered manager told us that they are in the process of recruiting a new person. Staff told us that when they can, they like to take people out either to the

local shops or the local park. Records showed that staff had taken people out in the past. We also heard staff discuss a person requesting to go to the local shops when the rain stopped. During the first day of our inspection there were no activities taking place. During the second day we saw people assist staff folding napkins and later taking part in a game.

People and their relatives knew how to make a complaint should they need to. One person told us, "I had to make a complaint about a carer who was rushing me when I was trying to wash myself." They were happy that their complaint was taken seriously and that staff member did not provide support to them anymore. A relative told us they would feel confident to make a complaint if they needed to. They told us, "I have never had to complain. I have needed to ask questions but not complain."

Staff told us how they would support people if they needed to complain. One staff member told us, "I would listen to them and if I couldn't deal with it I would speak to the manager." The complaints procedure was available in the foyer of the service and all complaints were recorded with the action taken by the registered manager.

There were systems in place to receive feedback from people. There was a monthly questionnaire for people who use the service. Staff would ask people a range of questions to ensure they were happy with the service. The registered manager would review these and where people made comments about their care, changes would be made to improve the service. We also saw that the a new menu had been introduced and the cook was recording where meals had been liked and where they hadn't. They told us once they had all the comments in the menu would be changed to reflect people's preferences. This showed that the provider had systems in place to listen and learn from people's experiences, complaints and concerns.

Good

Is the service well-led?

Our findings

The service promoted a positive, open culture that was person-centred. People were very positive about the registered manager. One person said, "Oh yes, I can't remember, she's got a funny name but she's very nice." Another person confirmed that the registered manager was very nice whilst another said "I like the manager, she's ever so kind". A relative told us they found the registered manager very approachable. Staff members we spoke with were all positive about the registered manager.They told us that they were approachable and supportive. We saw that compliments had been received praising the registered manager and the staff team.

People's feedback was consistently positive. The service had a 9.5 out of 10 rating in www.carehome.co.uk for the work it does with people using the service. That rating is based on people's feedback to www.carehome.co.uk. Since January 2016 there have been 10 comments all positive and all saying they would recommend the service.

There was a statement of purpose available to people and it described what people should expect from the provider. It included how the provider would assess people's needs, how to complain and facilities provided by the service.

The registered manager and staff were able to describe what the expectations were for the service. This included the aim of delivering a service 'to provide people with a good quality life'. The staff team understood and worked towards shared goals.

Staff also knew how to report poor practice of their colleagues should they need to. One staff member told us, "If I saw anything I didn't like I would report it. If there were issues with the manager I can contact the compliance and care standards officer. If nothing was done I would speak to social service or CQC" We saw staff had access to the provider's whistleblowing policy and procedure. It included details of other organisations staff could report concerns to if they needed to.

Staff told us they had opportunities to give their suggestions about how to improve the service. A staff member said they were able to suggest things either in their supervision or in team meetings. They said, "We can bring ideas to the manager and sometimes they are taken up, not always."

We were told that feedback about the service had been sought by the provider. The registered manager told us that questionnaires had been sent in the last 12 months to people about the quality of care offered to people. People we spoke with could not recall receiving a questionnaire. A person said, "They may well have done but I can't remember." We saw a copy of the analysed results of the survey and these included what action the provider planned to take as a result. This showed that the provider had systems in place to listen to people's views.

The registered manager told us that improvements to the service were carried out following audits and speaking to people. For example the lounges were decorated as a result of feedback from staff and given

themes and general refurbishment had started as a result of the 2015 survey.

People were being supported by staff who were monitored regularly by the registered manager. The registered manager told us that they would work alongside staff to ensure they were working to a consistent standard. The registered manager told us, "If I see anything that isn't right I will carry out impromptu supervision. Staff know then what is expected." We saw that the registered manager took staff through the provider's disciplinary procedure as and when necessary. This meant that the registered manager was aware of the culture of the staff team and dealt with any negative or poor practice promptly.

The registered manager was aware of their responsibilities to ensure that they informed us of events at the service such as unexpected deaths, serious injuries and allegations of abuse. This was important because it meant we were kept informed about events at the service and we could check whether appropriate action was taken in response to those events.

We saw that the registered manager was being supported by the wider organisation to deliver the care and support as detailed in the provider's mission statement and statement of purpose. For example, the compliance and standards officer carried out a monthly scrutiny of the service. This checked that the registered manager had appropriate arrangements in place to deliver the service effectively. We saw that training, care plans and the environment had all been audited. Actions had been identified and we saw that the registered manager had addressed these. This meant that the provider could be assured that the registered manager was effective in their role.

The registered manager undertook audits of quality. This included audits on the medicine records, care plans, daily records, risk assessments and policies and procedures. We saw that the registered manager monitored records to make sure that they had been completed correctly and signed. They told us that if they found areas that had not been completed correctly they would follow this up with the individual staff member. For example, senior staff told us if a medicine record was not completed correctly the staff member would be called back onto the shift to sign the paperwork. This meant that that provider had procedures in place to monitor and improve quality.