Karamaa Limited

The Gables

Inspection report

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23 November 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on the 22 and 23 November 2016. At the last inspection on 3 June 2015, the service was found to be requires improvement under the responsive and well led domains. At this inspection we found there had been some improvement.

The Gables is a care home which provides accommodation with personal care for up to 24 older people. At the time of our inspection 24 people were living at the home.

The provider is also the 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 and associated Regulations about how the service is run.

There were audit systems in place to monitor the quality of the care people received, however they were not always effective at identifying some of the issues we had raised with the registered manager and required some improvement.

People and relatives told us they felt the home was a safe environment for people to live in. Staff spoken with could confidently identify the different types of abuse and explained how they would report abuse. People were protected from the risk of harm and abuse because staff knew what to do and were effectively supported by the provider's policies and processes. Risks to people were being monitored and staff identified risks to people and explained how those risks should be managed. Staff had a good understanding of the risks and the action that was required. The plans and risk assessments were reviewed and updated on a monthly basis and/or when people's needs changed.

Most of those spoken with felt there was a requirement to increase care staff levels. We saw all staff were busy but were available to provide support to people when needed. This included support for people to eat, drink and move around the home safely. Requests for assistance from people were responded to promptly. The provider's recruitment processes ensured suitable staff were recruited.

People received appropriate support to take their prescribed medicines and senior care staff maintained accurate records of the medicine they administered to people. Medicines were stored securely and consistently at the recommended temperature given by the manufacturer and were safely disposed of when no longer required.

People were supported by suitably trained staff that told us they received training and support which provided them with the knowledge and skills they needed to do their job effectively. People and relatives felt staff were knowledgeable on how to support people effectively and that staff possessed the necessary skills.

We found mental capacity assessments had been completed for people who lacked the mental capacity to consent to their care and welfare. The provider had taken suitable action when they had identified people who did not have capacity to consent to their care or treatment. Applications had been made to authorise restrictions on people's liberty in their best interests.

People were able to choose what they ate and drank and were supported to maintain a healthy diet with input from dietary specialists. People were supported to receive care and support from a variety of healthcare professionals and received appropriate treatment if they were unwell.

People's care records contained information relating to their specific needs and there was evidence that the care plans were updated when people's needs changed. People and relatives told us they were involved in developing and reviewing their care plans. People were supported by caring and kind staff who demonstrated a positive regard for the people they were supporting. Staff understood how to seek consent from people and how to involve people in their care. We saw staff interacting with people in a friendly and respectful way and that staff respected people's choices and privacy.

People were supported to lead active lives and, where appropriate, to access the local community. In addition, people were supported by staff that provided activities on a daily basis. People told us they had no complaints but were confident it they did, that the management team would deal with it effectively. Complaints that had been raised were investigated and where appropriate action plans had been put in place.

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 told us they felt safe. People were safeguarded from the risk of harm because staff were able to recognise abuse and knew the appropriate action to take.

Risks to people's health and safety had been identified and were known to the staff. This ensured people received safe care and support.

People were supported by suitably recruited staff.

People were supported by staff to take their medicines as prescribed by their GP.

Is the service effective?

Good

The service was effective.

There were arrangements in place to ensure that decisions were made in people's best interest. Staff sought people's consent before they provided care and support.

People were supported by suitably trained staff.

People enjoyed the meals provided and were given snacks and drinks at regular intervals, or when requested. People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration.

People received support from healthcare professionals to maintain their health and wellbeing when it was required.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and respectful.

People's independence was promoted as much as possible and staff supported people to make choices about the care they

received.

People were supported to maintain relationships with their friends and relatives.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People received care and support that was individualised to their needs, because staff were aware of people's individual needs.

People were engaged in group or individual social activities to prevent isolation.

People knew how to raise concerns and were confident the provider would address the concerns in a timely way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to assess and monitor the quality and safety of the service, although they were not consistently effective and required some improvement.

Although staff told us they felt supported, they felt communication could be improved with the provider.

People were happy with the care and support they received.

The Gables

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 unannounced inspection took place on 22 November 2016 with a return announced visit on the 23 November 2016. The inspection team consisted of one 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 service. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health difficulties.

We asked 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. The PIR was returned within the required timescale. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us and any other information we had about the service, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

We spoke with 10 people, seven relatives, the registered manager, three social and health care professionals, the deputy manager and seven staff that included care, kitchen and domestic staff. Because some people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to four people's care and seven medication records to see how their care and treatment was planned and delivered. Other records we looked at included two staff recruitment and

training files. This was to check that suitable staff were recruited, trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service and a selection of the provider's policies and procedures, to ensure people received a quality service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us the home provided a safe environment for people to live in. One person said, "It suits me here, I like it, I like the company and I feel safe." Another person told us, "I feel very safe living here." A relative said, "I don't have any concerns about [person's name] safety." There were a number of people living at the home who were not able to tell us about their experience. We saw that people looked relaxed and comfortable in the presence of staff and that staff acted in an appropriate manner to keep people safe. For example, one person attempted to get up and leave their arm chair without using their walking frame, a staff member immediately followed the person and suggested they use their frame to make sure they remained safe when walking.

Staff were able to explain to us in detail what could constitute abuse and how they would recognise the signs of distress in people. One staff member told us, "We know people very well and would know if there was something upsetting them." Staff we spoke with knew how to escalate concerns about people's safety to the provider and other external agencies for example, the local authority and Care Quality Commission (CQC). A staff member we spoke with told us, "Without hesitation, I'd tell the local authority or CQC if I needed to."

The Provider Information Return (PIR) stated 'Care planning and risk management processes include the deployment of a comprehensive initial needs assessment. Applied in a person centred way.' Records we looked at and observations we made corroborated this and we found that risk assessments had been completed and were individualised for people. We saw equipment such as pressure relieving cushions were in use to support people who were at risk of developing skin damage. One staff member explained, "We use body maps, we inspect skin during personal care and document if there are any concerns and then pass on [the information] to the senior." Another staff member told us, "We get to know people; we talk to them, we look at their care plans and also talk to their relatives." There were a number of people who had been identified at risk of falls. Where applicable, referrals had been made to the appropriate professionals, equipment and walking aids were accessible to people and we found risks to people's welfare were managed effectively.

Safety checks of the premises and equipment had been completed and were up to date. Staff explained what they would do in the event of an emergency. For example, what action to take in the event of a person choking. The provider safeguarded people in the event of an emergency because they had procedures in place and staff knew what action to take.

Most of the relatives and all the staff we spoke with told us they felt there was a need to recruit additional care staff particularly in the morning. One staff member told us, "We do struggle in the morning, we could have 12 people to get up and only two carers because the senior is responsible for administering the medicines and should not be interrupted." They continued to tell us, "Buzzers are going off and people all want to get up at the same time. We used to have another person for a few hours in the mornings which really helped but that has been stopped." We saw a sign requesting the senior staff member was not interrupted when administering medicines. However, this had not been our experience. When we arrived

on the first day of our inspection we saw the staff member had to take telephone calls and answer the front door when they were administering medicine. We were told the two staff working upstairs should have taken the phone calls and answered the door but we did not see this happen. When we spoke with staff they told us it was not always possible for them to leave and answer the door or the phone, particularly if they were already supporting someone with their personal care or to get up. We were assured by the registered manager this was not a usual day and normally it was 'much quieter.' We noted on the second day of our inspection it was more relaxed with only a small number of visitors.

People spoken with told us they received support when they needed it. One person said, "They [staff] respond promptly if I call for help." One relative told us, "I think there are enough carers." Another relative said, "[Person's name] has been at the home for a number of years and although I think there is a need for more staff in the mornings, the care is over and above." We did bring the concerns relatives and staff had discussed with us about staffing levels to the attention of the registered manager. They explained to us how they deployed staff and how this was reviewed. They confirmed they did have an additional staff member for a few hours in the morning but found there was not always a consistent amount of work for them to do and they left and a decision was taken not to replace them. However, the registered manager said they would monitor and review the situation. We found that although staff were constantly busy, alarm activations and requests for support were responded to by staff in a timely manner.

The provider's PIR stated, staff were recruited after 'pre-employment checks and at least two satisfactory references were completed.' We saw the provider had a recruitment process in place to make sure they recruited staff with the correct skills and values. This included criminal checks through the Disclosure and Barring Service (DBS) and the checking of employment and character references. The DBS check helps employers to make safer decisions when recruiting and reduces the risk of employing unsuitable people. Although we found in one file, one requested reference had not been followed up. When we discussed this with the registered and deputy managers, we were shown evidence to support the staff member had completed a supervised induction, had received training and there had been no concerns with their performance.

People we spoke with told us they had no concerns about their medicines and confirmed they received their medicines on time and as prescribed by the doctor. We saw medicines at the home were stored in medicine trolleys and when the trolleys were not in use they were locked and kept securely in separate areas. The senior carers were responsible for administering medicines and for auditing and completing the Medical Administration Records (MAR) sheets. We reviewed seven people's MAR sheets and found there were people who required medicine to be given 'as and when'. We found protocols that provided guidance for staff when people required pain relief were in place. One person we spoke with told us, "I would ask for painkillers if I needed them and I would get them quickly." We also conducted an audit of five peoples' medicines and found the medicine stocks balanced with the medicines that had been administered to people.

Good

Is the service effective?

Our findings

People spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "The carers are nice people and are well trained." One relative said, "My relative has lived here for years and during the last two years, things have improved with some really good core members of staff; since the deputy manager has been in charge, things are much better." The staff we spoke with said they were supported by the management team and received the necessary training to support them in carrying out their roles. One staff member told us, "The training has much improved." Another staff member told us, "The training is all good". Staff members spoken with told us they were happy with the training they received from the provider. We saw that training and refresher training for staff was reviewed. Staff new to the service explained how they completed their training induction and spent time shadowing another staff member before being permitted to work unsupervised.

Staff we spoke with had told us supervisions were held approximately every three months. One staff member confirmed, "I had my supervision two weeks ago." We saw from the staff records we looked at that supervision had taken place. The deputy manager and staff explained how they held daily 'handovers' to discuss people's support needs and were confident to approach the senior management team if there were any concerns.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
At this inspection we checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The Provider Information Return (PIR) stated, 'We ensure that staff are trained in the MCA/DoLS requirements so they have an understanding.' All of the staff we spoke with demonstrated knowledge of DoLS and identified people who they felt could be put at risk if they were not restricted, for example, from leaving the home unsupervised. One staff member explained, "DoLS is when a person is being restricted because they are not aware of the dangers so it is in their safety and we have to consider their best interest and give support." We saw that some people were closely supervised and had been subjected to a restricted practice, in their best interest, to prevent injury to themselves or others. Applications had been made to the supervisory body and the provider was meeting the legal requirements of the MCA.

The 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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible. Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "We talk to people and ask them, you can tell if they understand by the reaction on their face." One person told us, "They [staff] do ask me first before helping me if it is okay." A relative said, "They [staff] do ask [person's name] permission." We saw staff encouraged and offered people choices and sought people's permission before supporting them.

People we spoke with told us and we saw they were offered choices at every meal and had access to drinks. We saw one staff member asked everyone what they wanted for lunch and explained to people what the choices were. Staff encouraged people to walk to the dining room for their lunch. We were told that this was encouraged because it put emphasis on the lunch time experience and therefore something different and encouraged people to move from their chairs. We found the staff were organised while lunch was served to people. Staff provided one to one support where people required it. We saw staff encouraged people to eat, offered more food to those who had finished and meals looked well presented. We saw that people who chose not to eat in the dining room received their meals without delay and that meals were plated and covered to keep the food hot. People spoken with told us they enjoyed the food and since the appointment of a new chef the food was 'much nicer'. We saw that staff supported people to access snacks and drinks throughout the day. One person said, "I like a biscuit with my cup of tea."

The provider's PIR stated. 'We have processes in place which monitor the nutrition and fluid intake of residents with staff using information to specify specific intervention for the individual concerned.' Staff we spoke with confirmed people were assessed to meet their individual dietary needs and ensured people received a healthy and balanced diet. We saw that people's dietary needs and preferences were recorded in their care records and, where appropriate, their food and fluid intake was closely monitored and reviewed every month. People who had been identified as at risk of losing weight had input from healthcare professionals, for example, Speech and Language Therapists for support (SALT). A SALT is a healthcare professional that provides support and care for people who have difficulties with communication, or with eating, drinking and swallowing. We saw additional food supplements to sustain and improve people's weight were administered as prescribed.

We saw visiting professionals attended to people to assess and review the person's care and support needs. For example, a GP, chiropodist, district nurses, opticians and social workers. People told us they were regularly seen by the GP and community nurses. One person said, "I have seen the doctor." Staff spoken with were knowledgeable about peoples' care needs and how people preferred to be supported. A relative said, "They [staff] call the doctor when it is necessary." A visiting healthcare professional explained the staff were knowledgeable of the person they were visiting. We saw from the care records we looked at that people were effectively supported to maintain their health and wellbeing with additional input from health and social care professionals.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring and kind. One person said, "They [staff] are all lovely and kind." Another person told us, "I have a laugh with the staff, the best thing about being here is the company." A relative told us, "The staff are all caring and lovely, they [staff] know how to look after [person's name]." Another relative said, "The staff are decent people." A staff member told us, "I prefer to work in smaller homes to the larger ones, they are more personal and you get to know people well." Another staff member said, "I like it here, it's small and homely, we can get to know residents well. We spend time one to one with them."

We saw one person being supported by a member of the local place of worship to pray. We also noted that one bedroom door did not have a number on it and asked the registered manager why this was. They explained it contained a number that in the person's culture was deemed to be unlucky so it had been removed to avoid upsetting the person. People we spoke with told us the staff listened to them. Staff explained how they supported people who could not express their wishes, for example, once they got to know people, they could tell by facial expressions and body language whether the person was happy with their care. Staff spoken with explained they would make sure they would deliver care in a way the person was happy with. If the person was not happy, staff told us they would leave the person for a while, then return later to check if the person had changed their mind. People we spoke with told us staff treated them with kindness and empathy. We saw staff understood people's communication needs and gave people the time to express their views

We saw people exercised choices with regard to their daily routines; such as the time they got up, went to bed, and what leisure activities they enjoyed. For example, one person told us, "Getting up and going to bed is flexible I can choose." We asked staff how they encouraged people to maintain their independence. One staff member said, "We try to encourage people to do as much as they can. It might be combing their hair or washing their face." Staff demonstrated patience and understanding when people needed encouragement and reassurance. For example, one person was confused as to where they were and throughout the day we heard all of the staff patiently explain where the person was and that they were safe. Although the person was unable to retain the information at no time did they become anxious or upset, they were reassured and joined in with the bingo.

We saw that staff protected people's dignity and privacy when providing personal care. We heard staff discreetly prompt people so that their personal care needs were met in a sensitive and private manner. One person told us, "Personal care is offered rather than just given." People's personal appearance had been supported. One person told us "I see the hairdresser." A relative told us, "They [staff] encourage mum all the time, I've never seen them [staff] stop or discourage anyone from doing something." Staff ensured confidentiality was maintained and were discrete when talking to professionals on the telephone.

People told us that their family members were made welcome. We saw there was a constant arrival of visitors. A relative told us "Lunch time is protected but any other time you can visit and always made to feel welcome." Due to the design of the home, there was limited communal space for relatives to meet their

family members in private. However, we saw there were opportunities for relatives to meet in the person's bedroom, giving people the opportunity to meet with their relatives in private. We were invited into some people's bedrooms and found them to be maintained by the provider and individualised with pictures and belongings that were important to the person.

Good

Is the service responsive?

Our findings

At the last inspection in June 2015, the provider had been found to be requiring improvement in relation to people's care plans. The plans were not consistently personalised to the individual's support needs. At this inspection we found there had been improvements made.

The Provider's Information Return (PIR) stated 'We intend to introduce a key worker for all our residents … and develop comprehensive care plans for each resident.' One staff member told us, "We now have a keyworker system which I think works well." Another staff member said, "Care plans are reviewed monthly for the residents we are keyworker for." One relative explained, "I was asked for a biography of [person's name] life which was put with their care plan." People we spoke with told us they had been involved in discussions about their care. Relatives we spoke with confirmed they were involved in their family member's care and support. One relative told us, "I'm not involved with the care plan but I am aware my mum is consulted and kept up to date." Another relative said, "I am 100% confident that the advice from the home will be right for [person's name]. From admission onwards, I have had much involvement with the care plan."

We saw individual care plans were in place which reflected people's support needs. Staff we spoke with were knowledgeable about people and their support needs. Staff demonstrated that they understood how to engage with people who may have some memory loss or difficulties expressing themselves. Staff demonstrated in their answers how they supported people. We found that care records detailed people's medical conditions. Staff told us that they had the guidance and instructions they needed to meet people's specific needs. This showed that people's preferences were known by staff which enabled people to have their care delivered in a way that met their individual needs.

We heard from people and their relatives that staff were responsive to people's requests. Relatives we spoke with told us they were kept informed about any changes if people became unwell. A relative told us, "We are kept up to date with any changes to [person's name] health needs." Staff told us that they had daily handovers to keep them up to date with people's changing needs and updated on any significant risks so that they could respond to people's care needs.

There was a dedicated activity coordinator that planned and delivered a programme of activities for people. We saw there was one to one and group activities. Feedback from people and their relatives about how people's leisure and social needs were responded to was positive. One person told us, "The entertainment and activities are excellent, I enjoy them very much." A relative said, "[Person's name] is very happy here and enjoys the activities the home offers." We saw people who chose to, took part in a chair exercise, bingo and singing. Another person said, "There's always something going on." Our observations of the activity staff showed them to be very interactive with people; lively, encouraging and inclusive.

People we spoke with told us they had no complaints. One person said, "I have never complained but if I did, I'd speak with the staff." Two relatives we spoke with did tell us they had raised some concerns over the loss of personal items and laundry processes damaging their relative's clothes. They explained they had

raised the issues with the provider. We saw from the complaints records, the issues had been investigated and action taken had been recorded. The registered manager explained there had been some problems with the laundry but this had now improved. This was supported with conversations we had with relatives. One relative told us, "They [people living at the home] do look much more presentable than they have done in the past." A social care professional explained there had been some issues with people wearing other people's clothes but the situation had improved over the last couple of months. We spoke with the domestic staff and they showed us how they separate and place clothing in people's individual containers. They confirmed there had been some problems but there had also been an improvement.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in June 2015, the provider had been found to be requiring improvement with regard to leadership and monitoring the quality of the service being provided to people. At this inspection we found there had been an improvement but further improvement was required.

We saw a range of audit checks were carried out to monitor the quality and safety of the home. This included audits on the arrangements for people's medicines, risk assessments, recruitment, care records and health and safety. However, some improvement was required with regard to the provider's recruitment processes. For example, one recruitment file contained no evidence to show discussions had taken place about gaps in employment history; although we were assured discussions had taken place but had not been recorded in the file. We also found there was no evidence to show one employment reference had been sought. The deputy manager explained they had approached the former employer but had encountered some setbacks. The deputy manager told us they would try to contact the former employer again. We also noted audit checks had not identified some of the pressure relieving cushions were worn. We were told all the cushions would be checked and where appropriate, would be replaced.

The provider had successfully applied to become the registered manager and had also appointed a deputy manager to support them. The Provider Information Return (PIR) had stated, 'The Registered Manager deploys a team based approach when providing leadership, direction and organisational governance for the service; she and the deputy manager lead by example.' We saw staff had reasonable access to visible leadership in the home where they could seek guidance and advice. Although, on the first day of our inspection, it was clear the registered manager had not been made aware of the number of appointments that had been arranged for re-assessments of people's needs and best interest reviews. The registered manager explained to us they had not made the appointments and had they known, some of the meetings would have been re-arranged to reduce any potential disruption to people living at the home. It is reasonable to expect the registered manager should be aware, or made aware, of who is visiting their home. Where appropriate, arrangements should have been in place to accommodate the additional professional visits organised by the deputy manager and to reduce the potential impact on staff. For example, to ensure the senior staff member administering medication was not disturbed. It was acknowledged, that during the first day of our inspection, the number of professionals and visitors arriving at the home was 'unprecedented.' We found on the second day, the home was more relaxed and the senior staff member had completed their medication round without interruption.

All the people and most of the relatives we spoke with were complimentary about the service. One person told us, "This is a happy place to be." We were told the deputy manager was approachable. Another person said, "She's approachable, so is the staff." A relative told us, "Both managers are very good, they always seem to be here." Staff we spoke with us told us they felt valued by the deputy manager but this was not always how they felt when speaking about the provider. Staff explained they felt the provider did not always listen to their concerns and that the registered manager was not always on site to provide guidance and support. We raised these concerns with the registered manager who explained they had taken some personal time. They continued to explain the deputy manager was always able to reach them by telephone

and there had never been any problems. We found that people were happy to approach and speak with the registered manager and our discussions demonstrated the registered manager was knowledgeable of peoples' care and support needs.

People and most of the relatives told us that they could speak with members of the management team and confirmed there was an 'open door' culture to the office. We saw that people and relatives approached the deputy and registered managers and other staff freely during our visit. Staff we spoke with told us they were able to raise concerns at staff meetings which were held regularly but felt that communication could be improved. We saw the provider had introduced a new method of communication, on a trial basis, through a closed 'chat room' only available to staff members through social media. The feedback we received to this had been positive.

People and relatives told us they had been asked for their views on how the service could be improved. One person said, "We have frequent residents meetings where you can put your views in." A relative told us, "To be honest, the staff are always asking is everything ok, so I can't really remember if I've filled in a survey." We saw evidence to support the provider had issued satisfaction surveys where an analysis of the information received had been reviewed and where appropriate action taken. We saw the results of satisfaction surveys were displayed on the wall at the home.

Staff told us they would have no concerns about whistleblowing and felt confident to approach the management team, and if it became necessary to contact Care Quality Commission (CQC) or the police. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations. Whistleblowing is the term used when an employee passes on information concerning poor practice.

It is a legal requirement to notify the Care Quality Commission of any significant incidents or accidents that happen as this helps us to monitor and identify trends and, if required, to take appropriate action. We had been notified about significant events by the provider and saw that where appropriate, investigations had been conducted in partnership with the local authorities to reach a satisfactory outcome.

The most recent CQC reports and ratings were prominently displayed in the hallway area of the home. The PIR we requested had been completed thoroughly and submitted on time. The information had been completed by the provider. It contained information relevant to the service and the improvements they planned to make. These were consistent with our findings and what we were told by people, relatives and staff. At the end of our inspection we provided feedback on what we had found. The feedback we gave was received positively with clarification sought where necessary. This showed a willingness to reflect and learn in order to sustain and continue to improve the quality of service provided to people.