Oakfield House Retirement Home

Oakfield House

Inspection report

Oakfield House Retirement Home
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Tel: 01227721107

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Oakfield House is registered to provide accommodation for persons who require nursing and personal care. It must not provide nursing care. At the time of this inspection 27 people were using the service.

This comprehensive inspection took place on 16 November 2016 and was unannounced.

A registered manager was in post at the time of the inspection and had been registered since 2010 under the current legislation. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff knew how to keep people safe and who they could report any incident of harm to. People's individual care needs were provided by a sufficient number of skilled and competent staff. An effective recruitment process was in place to ensure that staff were suitable to look after people who used the service. People's medicines were not always stored in a secure manner. Not all risk assessments were in place. This put people at risk of harm.

People's needs were met and supported by staff who knew the people they cared for well. People were supported to access health care services when required. Staff adhered to the advice healthcare professionals provided.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. Where appropriate, people's mental capacity had not been accurately determined. This meant that there was a risk of people being unlawfully deprived of their liberty. The registered Manager was aware of those organisations they needed to contact should any person require restrictions on their liberty. Staff had an awareness of the application of the MCA code of practice.

Not all staff had been provided with updates to their mandatory training. This meant that staff had not been updated on the subjects they had been trained on.

People's privacy and dignity was provided by staff in a respectful way. People could be involved as much as they wanted in the planning of their care. Advocacy services were available and people had relatives who could also have a say in the way people were looked after.

People were provided with various opportunities to help reduce the risk of social isolation. However, there was limited staff interaction with people other than during the provision of care. People were supported by staff to be as independent as possible.

People's concerns were acted upon before they became a complaint. People's concerns were recorded and

acted upon promptly.

The registered manager was supported by a head of care, senior care staff, care staff, housekeeping and domestic staff. Staff had regular mentoring, coaching and support from management.

Audits were not as effective as they should have been in identifying issues such as the safety of people's bed rails and the equipment people used. The identification, monitoring and mitigation of risks had not been effective. This put people at risk of harm. The impact on people's privacy as a result of surveillance equipment had not been assessed. This had the potential to infringe people's rights to a private life.

People's views about the quality of the service had been sought. People, their relatives and staff were able to make suggestions to improve and maintain the quality of the service that was provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Not all risks to people had been assessed. This put people at risk of harm.

People were supported to have their medicines as prescribed. However, the recording and security of medicines was not as safe as it should be.

A sufficient number of suitably recruited staff were in place to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always been provided with updates to their training. This meant that there was a risk of staff not be9ing made aware of current care practices.

People were at risk of being deprived of their liberty in an unlawful manner.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by staff in a caring, compassionate and sensitive manner.

Staff valued people's rights to privacy, dignity and independence.

People were supported to access advocacy services when required. Relatives were able to visit when people wanted them to.

Is the service responsive?

Good

The service was responsive.

People's individual care plans reflected how people's needs were met.

A range of opportunities were provided to support people to access and visit the community to help reduce the risk of social isolation.

People's concerns were listened to and acted upon before they became a complaint..

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits were not as effective as they should have been. This put people at risk of harm. The impact on people's privacy as a result of the surveillance equipment had not been assessed.

An open and honest staff culture was in place and staff were supported in their role.

People's views as to how the service was run and managed were listened to and acted upon.

Oakfield 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 unannounced inspection took place on 16 November 2016 and was undertaken by two inspectors.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we made contact with local health care professionals and Healthwatch. This was to help with the planning of the inspection and to gain their views about how people's care was being provided.

During the inspection we spoke with seven people and three relatives. We also spoke with the registered manager, a head of care, one senior staff member and two care staff.

We looked at four people's care records, medicines administration records and records in relation to the management of staff and the service.

On the day of inspection the provider was not able to access their staff training records. We gave them 48 hours to submit this information. We received these records within the timescales we gave the provider.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe because staff responded to requests for assistance promptly. One person told us, "They [staff] help me with washing and dressing and they do this carefully." Another person said, "I feel safe living here as there are plenty of staff." We observed that people had their individual walking equipment close at hand. One person told us, "I need a walking stick and they [staff] are always reminding me if I forget to make sure I use it." One relative said, "I feel my [family member] is safe here because there is always staff around." Where people required two staff members for their moving and handling we observed that this was done carefully and in consideration of the person's safety.

We found that not all risk assessments were in place. This was for areas such as equipment settings, skin vulnerability, bed rails, wheelchair use and accessing the community. Staff were able to tell us the checks they needed to undertake to make sure people were safe in their bed. This was as well as whilst using equipment and also in managing any person at risk of a pressure sore. However, these risks had not been formally assessed and documented and this put people at risk of harm. This was because there was no formal system in place for staff to follow to ensure that risks were reduced. For example in the equipment people used such as an adapted bed. The head of care and registered manager told us that they would act on this straight away.

Despite a lack of refresher training in some subjects we found that staff undertook safe moving and handling. Staff had a limited understanding of the different types of abuse. Staff were however knowledgeable about those organisations they could report any incidence of harm to should the need arise. Staff were aware of what to look out for should they suspect any person of being harmed. They described the potential changes in people's skin conditions, behaviours and moods. One member of care staff said, "If I noticed a person was quieter than normal I would investigate the reasons for this and report any concerns to [the head of care] or the [the registered manager]." Another staff member told us, "I would know straight away if they [people] were upset about something. You can tell if they aren't themselves. I would look for bruising when providing personal care and ask the person if they were worried about something." The head of care told us that they would definitely contact the local [safeguarding] authority or CQC if they ever had any concerns about people's safety. We found that people were kept safe.

Records of people's medicines administration records (MAR) we looked at showed us that that there were gaps in the recording. Staff told us that this was because staff had forgotten to sign but when they returned to work they would sign the MAR sheet. This meant that the records were not as accurate as they should have been. People and staff confirmed that people had however received their medicines. Records of staff training showed us that staff had been trained to safely administer medicines. One staff member said, "I had medicines administration training in January 2016 and I had my competence assessed. I had to complete a [competence] book which is marked independently. If you don't pass this you have to undergo more training."
We found that medicines were safely disposed of. We observed that staff gave people the time they needed to take their medicines as well as explain what they were for. However, staff had made contact with people but they did not wash their hands before they attended to the next person's medicines administration. This

presented a risk of cross contamination and infection spreading. We also found that the medicines storage trolley was not always correctly secured to the wall. The registered manager told us that they would action this straight away. This was confirmed by them the day after our inspection. One staff member said, "I had medicines administration training in January 2016 and I had my competence assessed. I had to complete a [competence] book which is marked independently. If you don't pass this you have to undergo more training." We heard how staff asked people if they would like the pain relief that was prescribed to be given when they required it. Another person told us, "I used to take my own [medicines] but I am happy that the [staff] do it so much better for me." One of the home's GPs told us that "they had confidence that prescribed medicines were administered safely."

Staffing levels were assessed through a combination of needs assessment and the knowledge of the head of care and registered manager. Where two staff were needed for people's safe moving and handling the required staffing was in place for this. We found that a sufficient number of staff were in place to meet people's assessed needs. Staff told us that, unless any staff rang in sick or were delayed due to the weather or traffic, there was always enough staff to look after people's needs. One staff member told us, "We can always ask off duty staff to cover or existing staff to work extra shifts. It [staffing] is never a problem." The registered manager told us that most staff were local and that this helped maintain a safe and consistent staff team.

People told us and we observed that requests for care were responded to promptly. One person told us, "I am safe as there are always [staff] about. I couldn't ask for anything better." Another person said, "I called using my [call bell] this morning as I wanted a drink and [staff] came quickly." One relative said, "Every time I pop in there is always staff to greet me as well as making sure [my family member] is safe." Another relative said, "I can't fault the staffing levels. [My family member] would soon tell me if things weren't right."

The provider told us in their PIR, "We undertake DBS [Disclosure and Barring Service checks for any criminal records] checks on all staff, and obtain references before they start work." Records we looked at and staff we spoke with confirmed that this was the case. One staff member told us, "I had to provide my driving licence, proof of address, [evidence of] my qualifications, my CV [curriculum vitae] and sign to say that I was in good health." Another staff said, "I had to provide my passport, two written references and complete employment history in my CV." This showed us that there were systems in place to help ensure that only staff deemed suitable were employed.

Requires Improvement

Is the service effective?

Our findings

We found that a comprehensive assessment of people's care and support needs had been undertaken and plans formulated on how to meet these. The aim of this was to help ensure the skills that staff had were in line with people's needs. For example, moving and handling, mobility support, nutritional and health care. If required staff could have training on additional subjects including catheter care, dementia care and diabetes awareness. One relative told us, "They [staff] all seem to know what they are doing. I ask questions and they can always get me the answer I am looking for."
The head of care told us the mandatory subjects new staff had to compete as part of their induction. Records showed that these included but were not limited to moving and handling, food hygiene, infection prevention and control, safeguarding, health and safety and fire safety procedures.

The lack of refresher training limited staff's ability to be aware of current safeguarding and moving and handling information. One staff member told us, "I have had some training on the Mental Capacity Act 2005 (MCA) and dementia care." However, we found that following staff's induction a programme of refresher training was not in place. A staff member told us, "The only refresher training I have had this year is first aid." A third staff member said, "I can't remember when I last had updates to my moving and handling training [as this had been over 12 months]." Records viewed confirmed that updates to staff training had not been provided. This meant that good practice in care and staff's knowledge about care was not as up to date as it could have been such as updates for moving and handling and safeguarding training. The registered manager also told us that although new staff were not expected to complete the Care Certificate (a national standard of training in care) they did undertake a comprehensive induction based upon this standard and the needs of people using the service.

The registered manager and their head of care confirmed to us that staff were supported on a day to day basis. Staff were supported with formal supervisions. One member of staff told us, "My supervisions are very much two way and an opportunity to discuss my job, what is working well and anything that I need support with." Another staff member told us, "It doesn't matter what the problem or issue is [the head of care] is always there, even if this at midnight. I get the support I need." A third staff member said, "[The head of care] has a wealth of experience and knowledge about care. I am always supported positively and encouraged. Nothing I ever discuss is dismissed. I am made to feel valued." In addition to formal one to one support staff had regular staff meetings where they could raise any issues about what was working well and updates to any people's care. This was as well as any additional support such as qualifications or developments at the service.

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. We checked whether the service was working within the principles of the MCA.

We found that lawful arrangements were in place for those people who had set up a Power of Attorney for subjects such as health and welfare and financial affairs. One person told us, "My [family member] does all that for me. I trust them as well."

We found that all staff we spoke with were aware of the MCA. However, we found that their knowledge had not been embedded as some people's mental capacity had not been accurately determined. For example, some people had relatives who had agreed to restrictions on their freedom although they had no legal right to do so. No record was in place if this was in the person's best interests or if this was the least restrictive method. One staff member said, "If we have to make decisions for people they have to be in the person's best interests. We would involve the GP, social worker, relatives and staff if this was the case." A basic assessment of people's ability to understand their choices had been completed but this had not been regularly reviewed as people's capacity to make informed decisions had changed. The lack of a mental capacity assessment for each decision a person could or couldn't make meant that people were at risk of being deprived of their liberty unlawfully. We found however that for some people who may lack mental capacity to make some decisions, no formal mental capacity assessment had been undertaken. This meant that the restrictions on people's liberty may not have been in their best interests or in the least restrictive manner.

People told us that that their nutritional and hydration support needs were met. Including those for people at an increased risk. Where people were at an increased risk of malnutrition we saw that advice had been implemented from community health care professionals such as a dietician or district nurses. One staff member told us, "For people who require a low sugar content diet as well as those with allergies the chef makes sure that the information we give them is implemented." We found that the chef had a list of people's preferences as well as any allergies such as shellfish. This was through the provision of home cooked produce offering people a healthy balanced diet. One person told us, "The food is always lovely. I have a choice and there is always plenty to eat." We observed that the lunchtime experience for people was relaxed, calm and people were engaged in general conversation about lunch, the weather and each other. We found from records viewed and people we spoke with that as well as the daily food choices people could have something else if they preferred. People were provided with food of different consistencies where this was required. Updates from the speech and language therapist had been incorporated into care plans and staff adhered to this guidance. Another person said, "The food is always good here and plenty of it." Another told us there was, "always lots of choice."

People's healthcare needs were met by prompt requests for health care professional support. People and their relatives told us that the provision of health care support was always provided when requested. One person said, "If I feel unwell I just say and [staff] call the [community] nurse or my GP." A GP told us, "[Name of registered manager] is mostly in the home when we visit and this can be at varied times throughout the day. He will always be happy to interrupt what he is doing to talk to the doctors that visit (unless there is a clear overriding reason)." And, "Robin has always taken on board advice that we have given, and acted promptly to any suggestions or decisions that we make regarding a patient's care." A relative told us, "When [my family member] moved in we had a choice of keeping our GP which [our family member] did." We saw that people's care plans contained relevant guidance for staff including that for people whose skin condition meant that they needed to move the person in a certain way. People were assured that their healthcare needs would be responded to. Staff at a local GP practice informed us they had no concerns regarding staff supporting people's healthcare. People could be confident that their health care needs were met.

Good

Is the service caring?

Our findings

People and staff described the service to us as a place that was, "homely", "friendly" and "inviting". The provider told us in their PIR, "We treat it as [people's] home and we are here to maintain it and meet their needs in a discreet, and caring manner as would be expected by a caring family member. We promote dignity, self-esteem, individuality and compassion and respect. We found this to be the case. People's care plans described people in a respectful manner and people confirmed that they, or their relative, had been involved in developing their care plan. People received care that was dignified, compassionate and caring. However, we found that the impact on people's privacy as a result of surveillance equipment had not been assessed. This had the potential to infringe people's rights to a private life. The registered manager told us they would address this point. A GP told us [the staff at] Oakfield House, in my view, provides more than just the expected level of good and safe care. They provide personal care and my feeling is that many of the residents in the home feel that they are part of a "family" in the home."

We received positive comments from other health care professionals we contacted about the quality of people's care. One told us, "The [registered] manager and staff treat people with respect as if they were family members. They [people] always appear well cared for, they are clean, well dressed and presented." One person told us, "The [staff] are all very nice, very caring and they respect my independence." A relative told us, "[My family member] has settled in well and the staff have all been very helpful and pleasant. [My family member] would soon tell if they weren't." At lunchtime we heard staff asking people, "Shall I put this [serviette] on to keep you clean?" and, "Would you like me to cut that [food] up for you?" This showed us that staff were respectful and attentive in the way they provided people's care.

We saw that staff knew the people they cared for well and that they were able to describe people's needs to us in detail. For example, the newspaper people liked, their preferences including when they liked to get up, having a bath or shower as well as the person's favourite film or actor. We also observed how staff supported those people who were cared for in their rooms. As well as how they payed attention to detail such as making sure the person always had a cup to drink from. Throughout our inspection we saw that staff treated people with compassion. We heard staff asking, "Would you like me to do anything for you." And, "Are you comfortable and are you warm enough?" People told us about how well they were looked after. One person said, "I know them [staff] as good as they know me. I like my daily newspaper every day and this is what I get. I do the crossword as well and they [staff] respect my [independence]." A relative told us, "My [family member] is [age] and has, for some aspects of their care, to completely rely on the staff. It is reassuring to know that when I leave that [family member] is going to be well cared for."

Staff were able to describe to us the circumstances they needed to be mindful of to help ensure that people were provided, and received, privacy, dignified and respectful care. One person said, "They [staff] never just walk in they always knock and ask me." One care staff told us, "Some people can't hear too well so I make sure they know it's me. I then check to make sure it is okay to go in. I get all their [person's] clothes ready and only [assist] the person with the things they can't do [for themselves]." Another staff member said, "[Care] all about giving people respect, never assuming that they can't do something and giving them the time they need." Our observations confirmed that people's care was provided in a friendly and unhurried environment

where laughter and fun flourished.

The provider confirmed in their PIR that relatives, family and friends were able to visit at any time and that refreshments were always offered. People were free to come and go from their home as they wished. People were observed to make sure that they let staff know if they were going out and on their return. This was to ensure that people received the care they needed. We found that advocacy services (this is a service for people who needed someone to speak up for them or on their behalf) were available. Information was provided to people and their relatives on how to access this.

Good

Is the service responsive?

Our findings

The provider told us in their PIR, "We undertake a thorough pre admission assessment of all [people], we talk to them, their representatives / families and any associated [health] professionals to ensure that we can meet their immediate needs and that of the foreseeable future. We put into place before admission/arrival, any special care products they may require and review these regularly." We found and saw that people, their relatives or appointed representative, had been consulted and involved in determining the person's care needs. A detailed life history record helped staff to determine those subjects that people had an interest in. One person told us, "My [care plan] is over there [pointing to the booklet]. My [relative] generally lets me know if anything has changed especially if I have asked for something such as hanging my pictures on the wall." One relative told us, "When [my family member] first started we were asked lots of questions such as [my family member's] favourite foods, mobility, preferences for a bath or shower, health conditions, medicines and quite a few others [subjects]." One person told us, "I like doing [puzzles] and [there is] someone else who likes [the same puzzles] as me."

The registered manager told us that care plans were reviewed formally every 12 months with a monthly review covering day to day changes. More urgent reviews were undertaken anything require prompt attention. This was for subjects including people's dietary requirements, prescribed medicines as well as the provision of adapted cutlery or plates. One person said, "My [relative] advocates for me. They have power of attorney for all my needs so they make sure the [care plan] accurately describes what I want and need." We found that the care plan matched the needs of the person it described. We found that in the care plans we looked at there was little recorded of what the person could do for themselves. Care tasks had been recorded, but not the level of involvement by the person. This limited staff's ability to be aware of people's independent skills as well as any changes in these.

At lunch we saw that staff responded promptly where people required assistance such as with cutting up their food. People told us that they were satisfied with how their individual needs were met. We did however see that there were periods in the day where people were not as occupied as they could have been. For example, we saw staff walking through the lounge without speaking or engaging with any of the people who were seated there. One person told us, "I do get bored sometimes. I do join in when there activities but there isn't anything today apart from the TV." Another person said, "It is very quiet today but we do have time to spend talking with the [staff]." We saw that a variety of events had been organised and planned such as a craft club, visit by the hairdresser, a reflexologist exercise class as well as opportunities for people to attend a day centre to play cards, dominoes and do jigsaw puzzles. Other people did however tell us that they were happy to stay in their room. One person said, "I can ask to be taken downstairs in my wheelchair if I want to join in." Another person said, "I like to read and there are lots of books I like." A third person told us that, "The [staff] have a chat [with me] as they work."

People and relatives told us they would speak with the [registered] manager or head of care if they ever had any concerns. Information was provided to people on the complaints process as well as this being displayed on notice boards. This however did not include all the organisations that were responsible for investigating complaints. The registered manager told us that they would update their poster to accurately reflect the

relevant organisations. We found that people's concerns were swiftly addressed before they became a complaint. The registered manager and staff team were proactive in acting upon people's suggestions such as for personalising people's rooms with people's own possessions. Records confirmed the proactive responses to people's requests.

Requires Improvement

Is the service well-led?

Our findings

We found however that the audits that were in place were not effective and that some audits, such as of medicines administration, were not in place. The registered manager told us and we found that their pharmacist checked the medicines recording and management. Areas we found where audits had not identified the risks that we found included: a lack of robust risk assessments and the security of the medicines cabinet. This was as well as the recording of medicines administration and a lack of an assessment on the impact on people's privacy and the safety of equipment people used. This showed us that the governance arrangements were not robust and put people at risk of harm. This was as well as a lack of the impact on people's privacy having not been assessed where surveillance cameras had been introduced.

Regular meetings were held with people, their relatives and staff. Other less formal occasions were used as an opportunity to gauge people's satisfaction as to the quality of their care such as in day to day conversations. We saw that the registered manager spent time around the home asking people if everything was alright, if they needed anything and if the person was satisfied with their care. All of the people, relatives and staff we spoke with told us that the communication from the registered manager was very good and that they felt listened to. This was also confirmed by health care professionals. One person said, "[Name of registered manager] is good at getting things done."

People were supported to keep community contacts and to remain in touch with friends and family. This included visits by religious representatives from various faiths with a regular service being held for people who wanted this. People who wished could practice their faith more regularly such as being enabled to see a priest. One person told us, "I can go out when I want. I go for walks as well as a bit of shopping." Another person told us, "My [relative] takes me out for dinner and to places of interest." The registered manager told us that staff also took people to church or a day centre where people could meet their peers and friends. This showed us that people were helped to access the community and reduce their risk of social isolation.

Staff were aware of the whistle blowing policy and when to use it. One staff member said, "If I ever need to whistle blow about any unacceptable standards of care I would. We are a team and anyone who steps outside the rules would be picked up quickly and reported." The head of care told us that whistleblowing was something that they would not hesitate to do and that they were confident that their staff would be fully supported. They told us that this was because the registered manager was "just so supportive".

People, relatives, staff and health professionals all praised the registered manager for their openness, integrity and being such an approachable person. We received positive comments from a GP service that supported the people living at Oakfield House. They said, "I think the best compliment that I can make for the care at Oakfield is that, when the time comes, I would be more than happy to book myself into the home." One person told us, "[Name of registered manager] is a nice man. He is always asking me how things are and if he can help." Another person told us, "All the [staff] are very pleasant. They help each other."

A GP had recently responded to the provider's quality assurance survey by saying, "This is a very well run

home with experienced, very professional and very caring staff. I would not hesitate to recommend it to both patients and family/friends." Another health professional had written, "Nice clean home, staff are friendly and polite." A relative had said, "Very happy with the care that my [family member] receives." Another relative had commented, "Absolutely delighted with Oakfield House. [Family member] is very happy and very well looked after. Please don't change anything."

Staff were provided with opportunities such as at a daily handover meeting with the head of care or registered manager to discuss and review each person's care. This was as well as being able to make suggestions at staff meetings and other informal day to day meetings with the registered manager. One staff member told us, "I also have a more formal supervision with [head of care]. Generally we speak with each other so often that it is rare that something unexpected needed to be discussed." All staff told us that their meetings and supervisions were very much two-way and an opportunity to reflect on what had worked well and if any improvements were needed.

The registered manager was supported by a team of staff, which included a head of care, senior care staff, care staff, a chef and housekeeping staff. The registered manager told us that the key challenge in running the service was getting the right staff. They said, "We do recruit locally as much as possible so that staff did not need to travel far." The registered manager told us that they needed staff with integrity and the right attitude. We found from records viewed, speaking with staff and our observations that this was the case.

One member of care staff said, "If someone ever moves in who has a new [care] need the [registered] manager or head of care arranges training for this." We found that most staff had been employed at the service for several years and this had benefitted people by the provision of consistent standards of care. We were told by the head of care and found that the support staff were enabled to do their jobs effectively. One staff member told us, "It is such a family friendly service. The head of care is open to suggestions and spends time working with us." The head of care told us that they called in at night or during the weekend. This was to make sure that staff were maintaining the expected standard of care. Staff confirmed to us about the 'spot checks' that they had been supported with and that the head of care was always prepared to listen and act if this was required.