Churchfields Care Home Limited

Churchfields Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 20 June 2017 and was unannounced.

Churchfields care home is registered to provide accommodation for up to 35 older people who require nursing or personal care. At the time of the inspection there were 27 people living at the service.

There was a registered manager in post. 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. The registered manager worked closely with the deputy manager and the provider.

People supported by the service felt safe. Staff had a clear understanding on how to safeguard people and protect their health and well-being. People received their medicine as prescribed. There were systems in place to manage safe administration and storage of medicines.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe.

Churchfields care home had enough suitably qualified and experienced staff to meet people's needs. People told us they were attended to without unnecessary delay. The home had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they cared for.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005 and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

People's nutritional needs were met and people benefited from a good dining experience. People were given choices and received their meals in a timely manner. Staff treated people with kindness, compassion and respect and promoted people's independence and right to privacy. People received high quality care that was personalised to meet their needs.

People were supported to maintain their health and were referred for specialist advice as required. Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People were actively involved with the local community. People were encouraged and supported to engage with services and events outside of the home. Staff supported and encouraged people to engage with a variety of activities and entertainments available within the home. Activities were structured to people's interests and people chose what activities they wanted to do. The environment was designed to enable people to move freely around the home.

Feedback was sought from people and their relatives and used to improve the care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy. Staff told us complaints were used to make improvements.

Leadership within the service was open and transparent at all levels. There was a clear leadership structure which aided in the smooth running of the home. The provider had effective quality assurance systems in place which were used to drive improvement. The provider had systems to enable people to provide feedback on the care they received.

The registered manager informed us of all notifiable incidents. The registered manager had a clear plan to develop and further improve the home. Staff spoke positively about the management support and leadership they received from the registered manager.

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.

Risks to people were managed and assessments were in place to manage the risks and keep people safe.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

There were sufficient numbers of suitably qualified staff to meet people's needs.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who were being deprived of their liberty were cared for in the least restrictive way.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

Staff interacted with people in a positive manner. People were seen to be relaxed and calm in the presence of staff.

Staff knew how to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

People received activities and stimulation which met their needs and preferences.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's care plans were current and reflected their needs.

People's views were sought and acted upon.

Is the service well-led?

Good

The service was well led.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

Churchfields Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 June 2017 and was unannounced. The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service and the service provider. The registered 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. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We received feedback from three social and health care professionals who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed. We obtained feedback from commissioners of the service.

We spoke with six people and one relative. We looked at three people's care records and three medicine administration records (MAR). The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the home and getting their views on their care. During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the provider, the registered manager, the deputy manager and seven staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Churchfields. They told us, "Yes, I feel safe here. They [staff] are a friendly bunch. I have my bell with me here on the table in this lounge" and "Yes I feel very happy and safe here. No one is horrible and there seems to be a lot of staff". We asked one person who could not speak to us verbally if they felt safe and they gave us a resounding huge smile and touched the inspection team member's hand. The person was happy and appeared content with staff around them. One person's relative told us, "Yes I feel that [person] is very safe here. We did look at several others homes, some seemed too big and others I did not think the staff understood how to handle [person's] temperament. So far here they seem to have got it just right".

Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. These protected people and supported them to maintain their freedom. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person was not eating enough and at risk of losing weight. This person's risk assessments and care plans were reviewed promptly and the person was started on a fortified diet following the dietician's advice.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff said us, "We report any form of abuse to the manager and safeguarding team. We also inform the family".

During our inspection we saw people were supported by sufficient numbers of staff. Records showed the number of staff were well above what was required to meet people's needs. Staff told us, "We have very high staffing levels and it gives us time to give one to one care", "We have above average staffing levels" and "We have had a lot of improvements in the last year and one of them is staffing". One person told us, "There is always a lot of staff". One healthcare professional echoed, "They also have more staff which means they have time to focus on excellent person centred care". The provider told us they were investing in staff to ensure people's safety. They said, "I would rather we have more staff than less at any given time".

The service followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people. Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

People received their medicine as prescribed and the home had safe medicine administration systems in

place. The provider had a medicine policy in place which guided staff on how to give and manage medicines safely. We observed staff administering medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken the reason why. People understood the reason and purpose of the medicines they were given.

Churchfields looked clean and equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. Staff were aware of the providers infection control polices and adhered to them.

The provider had a business continuity plan and an emergency plan. These plans outlined the actions to be taken to ensure the safety of people using the service in an emergency situation.

Good

Is the service effective?

Our findings

People received effective support from staff who were trained and felt confident in their roles. Newly appointed care staff went through an induction and probationary period which gave them the skills and confidence to carry out their roles and responsibilities. The induction training was linked to The Care Certificate standards. The Care Certificate is a set of nationally recognized standards to ensure all staff have the same induction and learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This included training for their role and shadowing an experienced member of staff. New staff were mentored for six weeks. One member of staff told us, "Induction was lovely. Staff were all welcoming. I was supernumerary for two weeks until I knew the residents".

Staff told us they had the training they needed when they started working at the service and were supported to refresh their mandatory training. Staff completed training which included safeguarding, infection control, manual handling and fire safety. Staff were supported to attend specific training courses to ensure they had the skills to meet people's needs. Staff told us they could request training and it would be provided. One member of staff told us, "We requested syringe driver training and it was arranged". Another member of staff said, "During my one month review, I requested to progress to NVQ 5 and the provider is providing that".

Staff told us they felt supported and had regular supervisions (one to one meeting) with their line manager. Supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. They said, "We have one to one supervisions where we discuss generally how we are doing and training needs" and "I find supervisions really good as we can talk about our wellbeing". Staff were also supported to develop and reflect on practice through yearly appraisals.

People's care records showed relevant health and social care professionals were involved with their care. People were supported to stay healthy and their care records described the support they needed. One person commented, "Yes, we can go to see the dentist. They took that lady over there to get her fitted with new dentures and now she can eat so much better". The provider facilitated weekly GP visits to review residents as needed. Health and social care professionals were complimentary about the service. One healthcare professional told us, "Governance meetings happen biannually and involve, nursing staff, GP and management. Safeguarding, seasonal incentives, deaths and admissions are discussed". People's care records showed details of professional visits with information on changes to treatment if required.

People told us they enjoyed the food and were able to make choices about what they had to eat. Comments included; "I like most of the food and like cauliflower cheese", "I don't like cereal, so they cook me scrambled egg" and "The carers are regularly offering us hot and cold drinks and the food is quite good here. And if there is something we do not like they will make us a salad or jacket potato for example".

People's dietary needs and preferences were documented and known by the chef and staff. The home kept a record of people's needs, likes and dislikes. The home chef knew people well and was aware of their dietary needs. The chef told us, "If residents do not like anything on the menu, they can have an omelette, ham salad or jacket potato. I liaise with the nurse about residents who need pureed food. I keep one copy

and the nurses have their copy". Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. The home contacted GP's, dieticians, speech and language therapists (SALT) as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. Drinks and snacks were available to people throughout the day.

During lunch time we observed people having meals in the dining room, lounge and in the garden. The atmosphere was pleasant. There was conversation and chattering throughout. People chose where they wanted to have their lunch and did not wait long for food to be served. People were given meal choices. People were supported to have meals in a dignified way by attentive staff. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace. We saw staff asked people if they wanted more and this was provided as needed. Some people chose to have meals in their rooms and staff respected that. People had the same pleasant dining experience despite where they were.

The provider had a policy and procedure to manage extreme weathers like heat wave. On the day of our inspection, there was a heat wave and staff and residents wore very light clothing. People were offered ice lollies and cold drinks constantly. Staff encouraged people to stay in the shade and wear sun hats. The provider had invested in window and doors which kept the home cool in hot weather and warm in cold weather. It felt cool and comfortable in all the areas of the home.

The provider facilitated champions within the home who promoted evidence based good practice. There were champions in nutrition and infection control as well as a clinical lead nurse. These champions were staff that volunteered for the roles and were passionate about the areas they chose to champion. The champions were supported to undertake additional training and raised awareness in their topic area and shared their knowledge within the team.

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager and staff followed the MCA code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity to make certain decisions, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests. For example, where people refused personal care and had no insight on why they needed it. One member of staff told us, "Everybody is assumed to have capacity to make their own decisions, even unwise ones".

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Staff knocked on people's doors and sought verbal consent whenever they offered care interventions. Staff told us they sought permission and explained care to be given. For example, when people were supported with eating and drinking.

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 hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home met the requirements of DoLS. People who had DoLS in place were being supported in the least restrictive way. Staff had been trained and understood the requirements of the MCA and the specific requirements of the DoLS.

Good

Is the service caring?

Our findings

People received care and support from staff who were caring, compassionate and kind. People told us staff were caring. Comments included; "The carers are lovely", "The staff look after us and they are kind" and "All the staff here are amazing. We always have a laugh".

We observed staff talking to people in a polite and respectful manner. They interacted with people as they went about their daily work stopping to say a few words to people as they passed by. People were given options and the time to consider decisions about their care. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of light humour throughout the day. People received care and support from staff who had got to know them well. The relationships between staff and people receiving care demonstrated respect and dignity.

Staff had a calm approach and made sure people were comfortable. People told us staff treated them respectfully and maintained their privacy. One person said, "When they [staff] hoist me, they make sure that my skirt covers all areas and they tell me what they are about to do". People received care in private. We saw staff knocking on people's doors and asking if they could go in. Staff told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing. One member of staff told us, "We explain and ask for consent of the help you are giving. During wash, we cover top half when washing bottom half".

Staff knew people's individual communication skills, abilities and preferences. Care plans contained information and guidance on how best to communicate with people who had limitations to their communication. For example, one person's care record stated, 'If face lights up and smiles, it means I'm content'. We saw staff communicating with this person and offering care. The person was smiling, relaxed and clearly comfortable with staff.

People's independence was promoted. Staff told us that people were encouraged to be as independent as possible. Staff said, "We don't take tasks away they can still do" and "We always have time to allow people to do the few things they still can for themselves". People told us they were supported to be independent. Comments included; "I have a walker which I use when I go out into the garden. Around the home I try to be more independent and do not need to use it", "They let me be as independent as I can, but they are also on the lookout to make sure that I am ok" and "Yes I am as independent as I can be". We saw people using mobile call bells whilst in the communal areas and gardens. This allowed them to do what they chose knowing they could call staff for help if needed.

People had the opportunity to express their wishes with regard to the care they would like to receive at the end of their lives. Some people had made advanced decisions and others had made living wills. Details were contained in their care plans so that staff were able to follow people's wishes. Staff told us they involved people and relatives in decisions about end of life care and this was recorded in their care plans. For example, one person had an advance care plan, end of life care plan (a plan of their wishes at the end of life)

and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Staff understood the importance of keeping people as comfortable as possible as they approached the end of their life. They told us how they would maintain people's dignity and comfort and involve specialist nurses in the persons care.

On the morning of the inspection, a resident had died. We saw staff supporting the family calmly in a compassionate way. Staff were obviously sad but still managed to be professional. One healthcare professional commented, "A resident lost his wife in the last few months and I was moved by the support offered to him by the staff, visiting him during their break times". The provider always ensured a member of staff attended the funeral for any resident who passed away.

Good

Is the service responsive?

Our findings

People's needs were assessed before they came to live at Churchfields to ensure their needs could be met. People, their relatives and other professionals had been involved in these assessments. This information from the assessment informed the plan of care. For example, one person liked dogs and they enjoyed patting dogs during activities. Another person liked music and records showed they enjoyed attending music sessions and listening to music in their room.

Care plan records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about where they wanted to spent their time or when to go to bed. People and their relatives confirmed they were involved in planning and review of their care. One person told us, "I talk to staff about my care plan and they explain things". One person's relative said, "Yes, I am involved with her ongoing care and I talk to the GP and nurses regularly".

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes and the service sought appropriate specialist advice. For example, one person developed an infection and was put on new medicines by their GP. Staff updated the person's care plan to reflect those changes.

Handover between staff ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff shared information about any changes to care needs, activities attended, planned appointments and generally how people had spent their day. This meant staff received up to date information before providing care, maintaining consistency. One member of staff told us, "We have daily handovers and afternoon catch up meeting".

Staff told us and records confirmed the provider had introduced a keyworker system. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.

People had access to a range of activities which they could be involved with, including group and one to one activities. For example, pet therapy, art therapy and musical entertainers. Once a week people went to a nearby pub for a coffee morning and village hall monthly to watch a film. The provider employed an activities coordinator who was passionate about their role. They told us they linked activities to people's interests and hobbies. They said, "I have a file so that I can document how it helps the residents, physically and emotionally. I have another file that I document what activity each resident has attended and whether they like it or not and what else they would like to do".

There was a large, well-kept garden with good access for wheelchairs. Paved areas were smooth and furniture was in place for people to sit and enjoy the garden. On the day of our inspection we saw residents

preparing a variety of sandwiches of their choice for their afternoon 'Pimms and picnic'. Everyone seemed to be having great fun. One person said, "I love doing this because I have made friends here. I would have been so lonely at home".

People's views and feedback was sought through residents and relatives meetings, yearly surveys as well as through quality monitoring questionnaires. Records of family meetings showed that some of the discussions were around what changes people wanted, people's opinions were sought and action was taken to respond to issues raised. People and their relatives told us they attended the resident/relatives meeting. One person's relative told us, "I have had to raise an issue at the relatives' and residents' meeting recently and the management have taken it on board". The provider published a bulletin which kept people and staff up to date with changes within the home.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People told us, "I don't need to complain. If I did, I would talk to the manager as she is very approachable" and "I have not needed to complain, but I would talk to the manager". One person's relative said, "I have raised a concern about cooked food which was a bit cold with the manager and owner and they say they are looking into it". People and relatives spoke about an open culture and felt that the home was responsive to any concerns raised. There were many compliments and positive feedback received about the staff and the care people had received. Staff told us they used complaints and compliments as learning points. One member of staff said, "We make improvements from the complaints we receive".

Good

Is the service well-led?

Our findings

Churchfields was led by a registered manager who was supported by the provider and deputy manager. At the time of our inspection, the registered manager had only been in post for a year. We saw significant changes had been made since the registered manager's appointment. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

There had been significant changes within the last year since the provider took over. Staff were appreciative of the provider and the positive changes they had implemented. Staff told us, "Providers are very much hands on. They ensure staff and residents are well looked after", "The providers have built amazing staff support. With all the improvements, this home is going to be fabulous" and "Everything we ask for is provided by the providers". One healthcare professional said, "Previously there had been a difficulty in retaining staff at the home, which is no longer the case". The provider told us, "Key priority is building a great team and making the home more homely so as to improve our quality of care".

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff spoke positively about their work and we observed open communication between staff and members of the management team. Staff felt that they could approach the registered manager or other senior staff with any concerns and told us that management were supportive and made themselves available. Staff told us, "We have an open door policy and can talk to the manager anytime" and "I can go to the manager about anything. I know she will listen and deal with it professionally". One healthcare professional echoed, "There is a clear management structure and I have seen the weight of the burden on the lead nurse disappear over time, through delegation of tasks".

The registered manager led by example. Throughout the inspection the registered manager was visible around the home and available to people, visitors and staff. It was clear the management team created an open, caring culture that put people at the centre of all they did. The registered manager and deputy knew people, staff and visitors well. They took time to stop and speak with everyone, showing empathy and support for all. We saw staff mirrored this approach and maintained this positive culture that was embedded into the caring ethos of the home. One healthcare professional commented, "There is a nice philosophy in the home where the resident is at the centre". One member of staff told us, "I love working here. All staff are compassionate and we put residents first".

Staff were complimentary of the registered manager, the support they received and the way the home was managed. They told us, "Manager is open, honest and knowledgeable", "Manager is approachable and supportive" and "I cannot fault the management team. Everyone is so approachable and friendly".

People and their relatives clearly knew the registered manager who was visible around the home throughout our inspection. People told us the service was well managed. Comments included, "The manager is very approachable" and "I can chat to the manager. She is doing a good job". One person's relative said, "I have found them [management] approachable. I think it is well managed".

We received complimentary feedback from health and social care professionals. They spoke highly about their relationship with the registered manager and staff. They commented on how well staff communicated with them in a timely manner. One healthcare professional told us, "The manager and owner are both clearly leading the team in a professional manner". Another healthcare professional said, "They refer to me appropriately and I am always confident that my recommendations will be carried out. It is a real pleasure to visit this home".

Staff commented positively on communication within the team. We observed a staff handover session which was comprehensive and detailed enough to allow continuity of care. Team meetings were regularly held where staff could raise concerns and discuss issues. The meetings were recorded and meeting minute made available to all staff. We saw a record of staff meeting minutes. During one meeting staff discussed about ways to improve communication and respect within the team. Staff told us, "We have great communication" and "We don't think less of each other despite our different roles.

Staff told us they felt supported in their roles without any exception. They also informed us that there were different arrangements in place to provide them with the support needed to do their work. Debriefing meetings were also arranged following stressful events to allow staff time to reflect. The provider facilitated team building meetings and staff appreciated them. One member of staff said, "We have had two team building meetings and we now work better as a team".

The provider had effective quality assurance systems in place to assess and monitor the quality of service provision. For example, in-house quality audits including falls, medicine safety and care plans. Quality assurance systems were operated effectively and used to drive improvement in the service. For example, one care plan audit identified incomplete records and action had been taken to ensure that record keeping in this area had improved. The provider undertook quality monitoring visits as well as facilitating external audits to monitor the quality of care.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. The registered manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents. One member of staff told us, "We complete an accident and incident form and record in the care plan".

The provider had a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and provider would support them if they used the whistleblowing policy. They told us, "I can report bad care to CQC, safeguarding or social services" and "We have a whistleblowing policy that we follow".

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.