Abingdon Court Care Limited

Abingdon Court Care Home

Inspection report

Marcham Road
Abingdon
Oxfordshire
OX14 1AD

Tel: 01235535405
Website: www.abingdoncourtcarehome.co.uk

Date of inspection visit:
24 August 2016

Date of publication:
10 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 24 August 2016.

We last inspected this service on 30 June 2015 and we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found some improvements had been made.

Abingdon Court care home is registered to provide accommodation for up to 64 older people some of whom were living with dementia and require personal or nursing care. At the time of the inspection there were 61 people living at the service.

There was a manager in post who was in the process of registering with the Care Quality Commission (CQC). 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 manager worked closely with the deputy manager.

People who were supported by the service felt safe. Staff had a clear understanding on how to safeguard people and protect their health and well-being. 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 required, staff involved a range of other professionals in people's care.

The service had enough suitably qualified and experienced staff to meet people's needs. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

The manager and staff had a good understanding of the Mental Capacity Act 2005. 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. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The 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.

Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff who 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.

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. People were supported with meals in line with their care plans.

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's choices and wishes were respected and recorded in their care records.

People had access to activities and stimulation opportunities, however, these could be improved. People received limited one to one activities. The service structured group activities to people's interests.

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.

Leadership within the service was open and transparent at all levels. The provider had quality assurance systems in place. The provider had systems to enable people to provide feedback on the care they received.

The manager informed us of all notifiable incidents. The 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 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 risk and keep people safe.

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

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

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.

Visitors to the service and visiting professionals spoke highly of the staff and the care delivered.

Is the service responsive?

Requires Improvement

The service was responsive.

People received activities and stimulation which met their needs or preferences. However, these could be improved.

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.

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.

Abingdon Court 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 24 August 2016 and was unannounced. The inspection team consisted of one inspector, a dementia Specialist Advisor 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 two 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 also contacted commissioners of the service to seek their views.

We spoke with 12 people and ten relatives. We looked at eight people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the deputy manager and nine members of staff which included nurses, care staff, housekeeping and catering staff. We reviewed a range of records relating to the management of the home. These included eight staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people who used the service and their relatives.

Good

Is the service safe?

Our findings

At our inspection on 30 June 2015, we found the service did not have sufficient numbers of suitability qualified, competent, skilled and experienced persons deployed in order to meet the requirements and people's needs. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in August 2016, we found improvements had been made.

People were supported by sufficient staff with the skills to meet their individual needs. One person told us, "I have already noticed a big difference from being here the past few days. I get my meal and my medicine on time. I have a clean room and I have people around to talk to me". Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The home used a dependency assessment tool at the beginning of care provision to assess the staffing ratio required. The manager considered sickness and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels.

People told us they felt safe when supported by staff. They said; "I feel safe here. I never have the door closed so I can see people as they pass by" and "I am safer here than when I was at home day and night. There is somebody that checks on me. When I am in my room I have my call bell and although sometimes I have to wait, I know that someone will come". People's relatives were also complimentary of the home and felt their family members were safe at the service. One person's relative told us, "More staff has been recruited and we know they [people] are safe. We have a peace of mind when we go home".

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments were reviewed and updated promptly when people's needs changed. For example, one person who usually mobilised independently fell and sustained an injury. The person was assessed for risk of falls and given equipment to support them when moving around the home. Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. 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, using bed rails and moving and handling. Ways of reducing the risks to people had been documented and staff knew the action they would take to keep people safe. Records showed people had Personal Emergency Evacuation Plans (PEEP) in place and the home conducted regular fire drills. They also had fire wardens and first aiders on duty every day.

Staff were knowledgeable about the procedures to keep people safe from abuse. For example, 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 told us, "In the morning whilst preparing to assist somebody with personal care I noticed bruising on the person. I immediately reported it to the staff nurse who contacted the manager. I recorded this in the notes. This was investigated by the manager and reported to the safeguarding agency".

Safe recruitment procedures were followed before staff were appointed to work at Abingdon Court care home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. Staff files included application forms, records of identification and appropriate references. One member of staff told us they were interviewed for their job and were required to submit two references. They also had to undergo police check. 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.

Medicines were stored and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescription. One person commented, "I receive my medication on time and I see the doctor regularly about my medication". Where people had limited capacity to make decisions about their own treatment, the provider had a detailed covert medicines policy which they followed. The policy stated how the covert medicines were to be given and that this was the least restrictive way. 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's bedrooms and communal areas were clean. One person commented, "The cleaners are very good and keep my room and the home spotless. It never smells". Equipment used to support people's care, for example, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. Maintenance staff conducted checks on bedrails which were used to reduce the risk of falling out of bed, ensuing they were safe for people to use". We observed staff using moving and handling equipment correctly to keep people safe. Staff were aware of the providers infection control polices and adhered to them.

Good

Is the service effective?

Our findings

At our inspection on 30 June 2015, we found staff employed by the service provider did not always receive appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in August 2016, we found improvements had been made.

Staff were knowledgeable and skilled to carry out their roles and responsibilities. People commented, "The carers know what they are doing and I trust them" and "They get training and seem to know how to help me". A healthcare told us, "Staff are knowledgeable about their residents who can often be quite challenging".

Staff completed the provider's initial and refresher mandatory training in areas such as, safeguarding, manual handling, infection control and fire safety. Staff were supported to attend other training courses to ensure they were skilled in caring for people. For example, staff had received training in dementia care and management and prevention of pressure ulcers from the tissue viability nurses. Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and could identify any need for extra training. One member of staff said, "I could not have done my job without the training and input I had. They have taught me everything I know now".

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. Staff told us they shadowed until they were confident enough to carry out their tasks. One member of staff commented, "I had a period of induction and had to complete some training. I have just passed my probation".

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervision meetings. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans also formed part of the annual appraisal process. Staff told us they had supervision four times a year and records confirmed these had been completed. Staff told us, "I had my supervision last month and the next one has already been arranged" and "I have my supervisions every three months and whenever necessary".

People had access to healthcare services and on-going healthcare support. One person told us, "I see my G.P regularly and when I need to". Another person said, "I see the chiropodist for my foot and the doctor at least twice a month. Since I have been here I have been to the dentist several times. I am very well looked after". People were supported to stay healthy and their care records described the support they needed.

Health and social care professionals were complimentary about the service and told us, "They [staff] refer

residents regularly and appropriately and I am always confident my recommendations will be well received and implemented". People's care records showed details of professional visits with information on changes to treatment if required.

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. The kitchen staff knew all the residents and had flexible menus. Some people had special dietary needs, and preferences. For example, people having pureed food or thickened fluids where choking was a risk and having diabetic diet. 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. One person told us, "I have seen the dietician about my food". Records showed people's weight was maintained. Snacks were available for people throughout the day. Where staff were concerned about a person's nutrition or hydration, they monitored and recorded the person's food and fluid intake. Staff were aware of the amount of food and fluid needed for the person to remain healthy.

People told us they enjoyed their food. Comments included; "I have my meals in my room out of choice as I can't sit for long. If there's something I don't like an alternative is always available and the choices are quite good. Yesterday there were two lots of curry on the menu, I don't like curry so I had an omelette" and "Here it is nice to be provided with hot meals. I don't have to worry about cooking. On my birthday I get a cake".

People enjoyed the lunch time meal experience. There was chattering throughout all three dining rooms. People chose where they wanted to sit and did not wait long for food to be served. People were given choices and staff presented them two plates for each course of meal. Staff sat with people and engaged with them whilst supporting them to have their meals at a relaxed pace. People supported with meals in their rooms had the same pleasant dining experience as those in dining rooms. Staff asked people if they wanted more and this was provided as needed.

People's consent was sought before any care or support was given. 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 washing and dressing. Records showed people, or family members who had legal power of attorney on their behalf, gave consent for care people received. For example, all files reviewed showed consent for taking and using photographs.

The provider followed the Mental Capacity Act 2005(MCA) code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. 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 manager and staff were knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected. Where people were thought to lack the capacity to consent or make some decisions, staff had followed the MCA code of practice by carrying out capacity assessments. Where people did not have capacity, 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.

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 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 followed the requirements in the Deprivation of Liberty Safeguards (DoLS). Applications under the DoLS had been authorised and the provider complied with the conditions applied to the authorisation. 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 told us they enjoyed living at Abingdon Court Care home and were complimentary of the staff. They said; "The carers are very good. I don't always have to press the bell, they ask when they are passing if I need anything" and "Staff are very kind, caring, helpful, and hard-working". One person's relative said, "The home seems to run efficiently, and the caring is very good".

Staff told us they enjoyed working at the service. One member of staff said, "I like working here. The atmosphere is good". One healthcare professional told us, "They [staff] go the extra mile to think of ways to give them [people] good, individualised care".

We observed many caring interactions between staff and the people they were supporting during our inspection. For example, we saw staff get close to people in order to be able to communicate with them. Some of them got on their knees to be at the same level in order to maintain eye contact. 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. One visitor commented that whenever they came to the home there was always a good feeling in the home and a real sense of kindness between staff and residents. Another person's visitor said, "The girls are really good with the residents".

Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted by staff in a patient way, offering choices and involving people in the decisions about their care. One member of staff said, "We always ask people what they want and how they want things done. It makes the tasks much easier".

People were given options and the time to consider and choose. When people were unable to verbalise their choices easily, staff gave them time to express their preferences through non-verbal cues, such as nodding and smiling. People received support from staff who knew them well. One member of staff said, "When you have been here as long as I have been you know the people very well and know what they like and when and how they like things done. They would tell you if they did not like it".

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other limitations to their communication. Staff knew how to comfort people who were in distress and unable to communicate their needs verbally. People's care plans specified the facial expressions and body language of people and the sounds they would make to express their discomfort if they were unable to explain it verbally. Additionally, the actions required to comfort people were described clearly. Records guided staff to respond appropriately, for example by speaking calmly, offering reassurance and identifying the source of a person's distress. We observed staff followed the guidance. For example, one person's care plan stated 'If agitated, you can calm me down by talking to me about my family'. We saw staff talking to this person about their family when they got agitated during activities.

People were treated with dignity and respect by staff and they were supported in a caring way. Staff ensured

people received their care in private and respected their dignity. For example, staff told us how they treated people with dignity and respect. One member of staff told us, "Respecting people's dignity is to respect their choice and to always ask them 'what they want, where and how'. And if they refuse care, explain and come back later". People's comments included; "I am always treated with dignity and respect" and "Staff treat us with dignity and respect. It's lovely to see the way they [staff] try to meet everybody's needs".

Staff understood and respected confidentiality. One member of staff said, "We discuss residents in privacy and only on a need to know basis". Records were kept in cabinets in nurses' stations. However, the nurse's station doors were not locked. We discussed this with the registered manager and deputy manager who immediately locked the offices.

People and relatives were involved in decisions about their 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 would be able to make 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. One member of staff told us, "We make sure residents are comfortable during end of life. We involve the GP and palliative care team".

Requires Improvement

Is the service responsive?

Our findings

At our inspection on 30 June 2015, we found the service did not have sufficient numbers of suitability qualified, competent, skilled and experienced persons deployed in order to meet the requirements and people's needs. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in August 2016, we found some improvements had been made.

The provider employed an activity coordinator. The activity coordinator told us they facilitated group activities during the week. Records showed people received group activities as planned, however, one to one activities were limited. The activities coordinator was also responsible for escorting people to day clubs and appointments to doctors, opticians and podiatry. This meant the time they had to spend on coordinating activities was very limited. Staff told us they did not have enough time to interact with people except during tasks. One member of staff commented, "Most of my job is physical care and I don't have time to sit and talk to the people or play games and activities. There is an activity coordinator for that. I help whenever I can". Another member of staff told us, "I enjoy working here but there is more responsibility and less time". One person said, "Staff work very hard. You see them on the go all the time, but they have little time for a chat. I suppose this is not part of their job". Group activities were linked to people's hobbies and interests. People were also supported to attend church services. We spoke with the manager about these findings and they said they were going to review provision of one to one activities and ensure people were prevented from social isolation. The manager had recruited a number of new staff some of whom were still going through their probation period.

The manager assessed people's needs before they came to live at Abingdon Court care home to ensure they could be met. Staff used these assessments were used to create a person centred plans of care which included people's preferences, choices and interests.

Care planning was focussed on a person's whole life, including their skills and abilities. The provider used a 'Getting to know me' document which captured people's life histories including past work and social life enabling staff to provide person centred care and respect people's preferences and interests. People's care records contained detailed information about their health and social care needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up. People and their relatives told us they were involved in planning their care.

The provider had a key worker system in place. A keyworker is a staff member responsible for overseeing the care a person receives and liaise with families and professionals involved in a person's life. This allowed staff to be the point of contact and build relationships with people and their relatives through consistency. The key workers reviewed care plans monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, a person fell and sustained a skin tear. The person's risk assessment was reviewed and the person was to use a sensor mat. The person was involved in reviewing this risk and through best interest decision supported to using the sensor mat. Their care plan updated to reflect the changes.

Abingdon Court care home was suitable for people who lived with dementia. For example, there were people's pictures and names on their bedroom doors. Corridors were decorated differently to aide easy identification of different areas. People could move freely in the communal areas of the building and large gardens. However, on the day of our inspection, despite it being a beautiful sunny day, we did not see any people in the garden siting area or being offered the choice of going out. There were several sitting areas which offered a choice of where people spent their time. People's bedrooms were personalised and contained photographs, pictures and the personal belongings each person wanted in their bedroom.

Feedback was sought from people through regular family meetings and suggestion boxes. Records showed that some of the discussions were around what changes people wanted. Minutes of resident and relatives meetings confirmed people's opinions were sought and action was taken to respond to issues raised. For example, in one meeting people and their relatives questioned the staffing levels on floors. This resulted in the provider reviewing staff deployment on each floor and increasing staffing levels. One person's relative told us, "There is a relatives meeting every two to three months and we have been told of plans and asked for our comments and input".

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 commented; "I will tell the manager if I'm not happy about anything" and "I have never had the need to but I know how to complain". People's relatives told us the manager was always available to address most issues.

We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. In the last year the provider had received a couple of minor complaints and two formal complaints. Records showed complaints raised had been responded to appropriately and that actions were completed and any lessons learnt recorded. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Good

Is the service well-led?

Our findings

At our inspection on 30 June 2015, we found there were no effective systems in place to assess, monitor and improve the quality and safety of the services provided to people. This was a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in August 2016, we found improvements had been made.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. The provider had good quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, health and safety, care plans as well as kitchen and dining experience. The provider had a quality manager in post who performed care home report which audited all the audits monthly. The provider also facilitated monthly quality assurance monitoring to identify shortfalls and allow service improvement. For example, the last service report had identified lack of monthly dependency levels reviews. This meant staffing levels might not be appropriate for people's needs and have a negative impact on the care they received. The provider arranged training for the manager on how to ensure accurate staffing levels were maintained.

Abingdon Court care home had a manager who was in the process of registering with CQC. The manager was supported by a deputy manager. The manager had been in post for six months. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

Staff told us they had confidence in the service and felt it was well managed. Comments included, "Manager is approachable and supportive", "Manager is knowledgeable and available when we need support", "We are like a family here and the manager is very nice. I can talk to my manager about anything I want" and "The deputy manager used to work on this unit and knows us well. She comes on the ward and helps the staff and is not afraid to get her hands dirty. I know she is going to make a difference. I hope she stays".

People and their relatives we spoke with knew the manager. They told us, "The manager is very approachable and he helped with the arrangements outside of the home to enable [person's] arrival to be expedited" and "Yes the home seems to be run efficiently. I often see the manager".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the manager and staff spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was transparent and honest. The manager told us their biggest challenge had been staff recruitment. Records showed the service had a number of newly employed staff and was continuously recruiting. One member of staff commented, "We are going through a good patch now because we have a lot of staff that have started and this gives us hope. However, I don't know how long it will last. Staff seem to come and go at the drop of a hat. I wish we could hang on to the staff we have now".

Feedback received from health and social care professionals was complimentary. They spoke highly about the service offered to people, their relationship with the manager and how well the management and staff

team communicated with them. One healthcare professional told us, "[Manager] has grown in confidence and capability and understands the pressures of being a carer and nurse on the floor as this was where he started. He is still very involved clinically and floor walks every day".

Staff told us the manager and deputy manager had an open door policy, were always visible around the home and regularly worked alongside staff. The management team often encouraged staff to speak freely and report bad care. People, their relatives and other visitors were encouraged to provide feedback about the quality of the service.

Staff commented positively on communication within the team. Staff had handovers at the end of every shift and provided an end of shift report to the manager. Team meetings were regularly held where staff could raise concerns and discuss issues. The meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff discussed the importance of recording conversations with families to ensure all staff are kept up to date with any changes.

The provider had a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the chance of further incidents occurring. The manager discussed accidents and incidents with staff and made sure they learnt from them. All accidents and incidents were audited and analysed every month by the manager. The manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

There was 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. One member of staff told us, "I can raise concerns outside the organisation to the safeguarding team, CQC and Nursing and Midwifery Council (NMC) if a nurse is involved". Staff were confident the management team and organisation would support them if they used the whistleblowing policy.

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