Manor Court Healthcare Limited

Anson Court Residential Home

Inspection report

Harden Road
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Walsall
West Midlands
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Tel: 01922409444

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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

Anson Court is registered to provide accommodation and personal care for up to 33 people, who are mainly older people with Dementia. At the time of our inspection 33 people were using the service. Our inspection was unannounced and took place on 26 October 2016. The service was last inspected on the 20 February 2014 where the provider was found to not be meeting two of the regulations associated with the Health and Social Care Act 2008.

At our inspection of 20 February 2014, we found that the provider was not meeting Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because they were not involving people in decisions and choices about their care. We found that people were woken very early by staff and there was no evidence to state that this was their choice. We asked the provider to send us an action plan of how they were going to meet this regulation which they did. Since our previous inspection the law has changed and the regulation is now Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection that the provider was now meeting the requirements of the law.

We also found during our last inspection the provider was not meeting the requirements of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010. This was because records did not always reflect people's choices and preferences. We found on this inspection they had met the requirements of the law. The law which replaces this regulation is now Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was registered with us as is required by law. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The administration and recording of medicines given to people was not always done safely. Medicines were not always stored at the correct temperature required to keep the medicine at its best. Although criminal records checks were undertaken before staff were able to begin their role, where disclosures had been raised on these checks, risk assessments were not in place to ensure that people were not at risk. A full work history for staff had also not always been obtained. Staff supported people in a way that made them feel safe. Staff understood the procedures they should follow if they witnessed or suspected that a person was being abused or harmed.

Where medicines were given without people's knowledge, there was no evidence that discussions had been made to reach a best interests decision where people did not have the capacity to make decisions for themselves. Staff had the skills and knowledge required to support people effectively. Staff received an induction prior to them working for the service and they felt prepared to do their job. Staff could access on-going training to assist them in their role. Staff could access supervision and felt able to ask for assistance from the registered manager and senior staff, if they should need it. Staff knew how to support people in line

with the Mental Capacity Act and gained their consent before assisting or supporting them. Staff assisted people to access food and drink and encouraged people to eat healthily. Staff supported people's healthcare needs.

Quality assurance audits were not always comprehensive enough to allow patterns and trends to be observed accurately. People were happy with the service they received and felt the service was led in an appropriate way. Staff were supported in their roles. Staff felt that their views or opinions were listened to.

People were involved in making their own decisions about their care and their own specific needs. People felt listened to, had the information they needed and were consulted about their care. Staff treated people with dignity and respect. People were encouraged to retain an appropriate level of independence with staff there ready to support them if they needed help.

People's preferences for how they wished to receive support were known and considered by the staff. Staff understood people's needs and provided specific care that met their preferences. People knew how to raise complaints or concerns and felt that they would be listened to and the appropriate action would be taken.

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.

Medicines were not always given, stored or recorded appropriately.

Staff recruitment was not always carried out safely.

Risk assessments were in place and staff understood safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people were given medicines covertly there was no evidence that this was being carried out in accordance with the Mental Capacity Act 2005.

Staff were provided with an induction before working for the service, on-going supervision and support.

Staff assisted people to access food and drink.

Is the service caring?

Good

The service was caring.

People felt that staff were kind and caring towards them.

People were involved in making decisions about their care and how it was to be delivered.

Staff maintained people's dignity and provided respectful care.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs.

Staff considered people's preferences when carrying out care.

People knew how to raise complaints or concerns and felt that they would be listened to and the appropriate action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance audits were not always comprehensive and detailed.

People were happy with the service they received and felt the service was well led.

Staff spoke of the openness and visibility of the registered manager and senior staff team.

Anson Court Residential 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 unannounced inspection took place on 26 October 2016 and took place out of hours. This was to enable us to view what time people were being woken up by staff following some previous concerns. The inspection was carried out by two inspectors.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The form was completed and returned so we were able to take the information into account when we planned our inspection. We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We liaised with the local authority commissioning team to identify areas we may wish to focus upon in the planning of this inspection. The team are responsible for monitoring services that provide care to people.

We spoke with six people who used the service and four relatives, three care staff and the registered manager. We reviewed a range of records about people's care and how the service was managed. This included looking closely at the care provided to seven people by reviewing their care records, we reviewed three staff recruitment records and five medication records. We also looked at records that related to the management and quality assurance of the service, such as staff training, rotas and audits.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care, to help us

understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Staff told us that prior to commencing in their role they had been requested to provide references, identification and to undertake a Disclosure and Barring Service (DBS) check. The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults. One staff member told us that they hadn't been allowed to begin their employment until their DBS certificate was received and that it was updated every three years. We found that where staff members had a disclosure on their DBS, a risk assessment was not in place to ensure that people were protected from any possible risk. The registered manager told us they were sure that these had been completed, but could not show us any evidence to reinforce this. The registered manager informed us that risk assessments would be completely immediately where a concern was raised as part of a DBS check. Records showed that staff members had not been asked for or provided a full work history as part of their application and instead the provider requested a 10 year work history. This meant that if the applicant had worked with vulnerable people prior to ten years previously, the provider would not be aware of this and any issues that may have arisen during the employment. Of the files we looked at, two had a full work history and one had no work history at all. The registered manager told us that the details would be obtained retrospectively and that in future it would be recommended to the provider that a full work history was obtained. Where staff had been subject to disciplinary matters this had been done professionally and the correct procedures were followed. We found that an audit trail demonstrated the steps taken to reach a conclusion were appropriate.

We observed the senior staff member administering medicine leave open the medicine trolley within the dining room and leave it unattended whilst giving out medicines in the room. At one point blister packs of medicines were left on the table where a person was sitting alone and the senior member of staff walked away with her back to the person, unable to monitor them around the medicine. We saw that no other staff were in the proximity to ensure that the person did not access the medicine. We witnessed this occur multiple times and asked the registered manager to accompany us to the dining room to witness the scene. Following discussions with the registered manager and senior member of staff about this being an unsafe practice they agreed to resolve the issues.

We observed staff members stay with people whilst they took their medicine, but on one occasion a dissolved tablet that hadn't been taken was found in a glass left on a table. We spoke with the senior staff member administering the medicine and they told us that they had watched the person put the tablet into their mouth, but felt that they must have taken some back out and that was what was placed into the glass. The senior staff member logged this on the Medicine Administration Record (MAR) sheet and said that it had never happened before, but in future they would be more aware.

We found that medicine records did not always tally with the amount of medicine available, with no explanation for this. We saw that one person was missing a medicine record for a painkiller and a new box of a controlled drug had not been signed in by staff. Some medicines are controlled under the Misuse of Drugs legislation and this means stricter controls apply to prevent them being misused, being obtained illegally or causing harm. The balance left in stock was not always recorded regarding controlled medicines. Medicine taken 'as and when' was recorded on a separate record, but staff were not able to show us specific protocols

for how to give these medicines.

We found that temperatures for storing medicines were only taken for controlled medicines. Fridge temperatures were not being recorded on a regular basis for these controlled medicines. Some recordings showed too high temperatures and this meant that medicines could lose their effectiveness and not work in the way they were required to. Staff told us that they were aware of this issue and had brought a fan into the room, but this was not switched on.

One person said, "I always get my medicine on time". We were told by a senior staff member that where a person refused medicine continuously a referral would be put into the mental health team to address the situation and we were shown paperwork that would be utilised to carry this out.

People told us that they felt safe, one person said, "I feel safe, we are being looked after and are all ok". A relative told us, "I know [relative] is safe here". A staff member told us, "I don't feel rushed to do my job. I help people manage risk by observing them and supporting them such as, giving them their walking frame to keep them safe". We saw examples of how people were kept safe, for instance when a person was transferred from their wheelchair to a chair this was done safely by staff and re-assurance was given to the person throughout the process. Additionally where a person was at a high risk of falls we saw a staff member remain within close proximity of the person and the risk assessment reflected this.

Staff were able to describe to us the possible signs or symptoms that may indicate someone was experiencing abuse and cited both physical and emotional responses from people that may indicate abuse was occurring. A staff member told us, "If I had a safeguarding concern I would report it to the manager or whoever was available higher than me". A relative told us that where a safeguarding concern had previously been raised in respect of their loved one, this had been notified to the relevant external agencies and action had been taken. Records showed that safeguarding issues were dealt with appropriately.

We reviewed the records the provider kept in relation to incidents and accidents that occurred within the service and found that they were appropriately recorded. We saw details of where emergency action had been taken to support a person who had been taken ill and an ambulance had been called. We found that details were recorded accurately and a skin map was completed. Where required the relevant external agencies had been notified.

Staff were able to share with us what action they would take in the event of an emergency. One staff member told us, "In a medical emergency I would call the emergency buzzer for a senior to attend and they would assess whether an ambulance should be called". All staff understood the process to ring 999 if they required the emergency services and said that they would do so. There was a specific fire evacuation plan for each person giving details for staff of how to evacuate safely and staff were familiar with this.

We found that risk assessments were in place that provided staff with the information required to keep people safe. Risk assessments identified and considered the risk and what support could be offered by staff to minimise it. Staff we spoke with were knowledgeable on risk posed to people and how to minimise the risk. Risk assessments in place included those around mobility, people attempting to leave the building, nutrition and hydration, health and behaviour. Where people had encountered three or more falls the registered manager told us that they would be referred to the falls team within the local authority and we saw the process that staff followed in these circumstances shown the process that this took.

People told us that there were enough staff to care for them and that they knew staff well. One person told us, "We always see staff about the place". A relative told us, "They [staff] always come quickly if [person's

name] needs them, there are enough staff". A staff member told us, "We are not short staffed". We saw that one agency worker was on duty, but that people were familiar with them. The registered manager told us that where possible staff absence was covered by permanent members of staff, but where staff were not available, specific agencies were used and the same staff were requested. The registered manager showed us a profile of agency workers they utilised and we saw that details of their experience, qualifications and skills were noted.

Requires Improvement

Is the service effective?

Our findings

Covert medication is the administration of any medical treatment in a disguised form. This usually involves disguising medication by administering it in food and drink. People who live in care homes and have been assessed as lacking capacity should only be administered medicine covertly if a management plan has been agreed after a best interests meeting. The Mental Capacity Act 2005 (MCA) states that covert medicines should only be used in exceptional circumstances and when such means of administration is judged to be necessary and in accordance with the Act. We found that where a person had undergone a mental capacity assessment and was deemed to lack capacity medicines had been given to them covertly, with no best interests agreement in place to show that the arrangement had been agreed by all interested parties. This meant that people who could communicate the views and interests of the person, such as external healthcare professionals or family members had not been given the opportunity to discuss their wishes and feelings on covert medication and have them recorded in accordance with the Act. Instead, a directive from the person's GP was given, which stated that all the medicines listed in the GP's letter could be given covertly.

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that applications had been submitted appropriately and at the time of our inspection 19 applications had been approved by the relevant external agency. Records showed that prior to the DoLS application being made a mental capacity assessment had been carried out to ensure that the person lacked capacity and that restricting their liberty was appropriate. Staff were able to share their understanding of MCA and DoLS with us and one staff member said, "I understand mental capacity and DoLS to be if a person has capacity to make a sound decision and how decisions can be made by others in that person's best interest". Staff were able to direct us to where the information on DoLS was kept and told us that they used it for reference.

People told us that staff asked for consent prior to carrying out tasks. One person told us, "Yes, they [staff] ask my consent and wait for a reply". A staff member told us, "I ask permission by asking people, if they say no I give them that choice. I use facial expressions to know what people are saying". We saw examples of staff asking people for their consent, this included when giving medicines and at mealtimes

People told us that staff had the skills and knowledge required to support them effectively. One person told us, "Staff are on the ball with things". A relative told us, "Staff knowledge is excellent, they are always able to answer my questions". Staff that we spoke with were knowledgeable regarding people's needs and were able to tell us who experienced communication difficulties, who was at risk of falls and who had specific

dietary needs. We saw an example of where one person had a sore leg and that staff had noticed the risk that it posed. The person told us that the visiting nurse had been notified and was due to check it and we saw that this was done and the person's leg was attended to.

Records showed that staff had received a detailed induction period prior to them starting work. One staff member told us, "On my induction I did some mandatory training and came into the home and got to know people. I also shadowed staff on shifts. The manager went through everything with me, so I understood, it was good". A second staff member said, "I had the chance to ask a lot of questions on my induction and that really helped me".

One person told us, "I know they [staff] do lots of training courses, they tell me about them". Records showed that staff completed regular training and staff members were able to tell us about courses that they had attended. One staff member said, "I have recently done training to assist in giving medicines. I asked specifically for it and it was provided". A second staff member told us, "There is always training going on it is very useful in our role". Staff told us that they received supervision, but that they were also able to go to the registered manager at any time, should they wish to discuss any matter.

We saw that staff communicated effectively both with people using the service and with their colleagues. We saw staff attending hand-overs and one staff member told us, "Handovers are very good. We get told by staff on the earlier shift how people have been, and what we need to do on shift. This gives me all the info I need to help people".

People said that they enjoyed the food given to them and one person told us, "We are looked after when it comes to the food it is very nice, we have a cooked dinner every day and I choose porridge each morning". Relatives told us, "[Person's name] loves his food and the staff will always give him extra if he wants" and "The food always smells really good and [person's name] has put weight on, which is good". We saw that people had a choice of food at breakfast and lunchtime and that they could sit where they wanted to, choosing to sit with friends to chat with. We saw that staff explained to people what food was on offer and listed the options to them. Alternatives were available where someone had a different preference. Where the person's care plan indicated that prompts to eat were required, we saw staff do so. People who did not eat in the dining room received their meals in a timely manner and those who required assistance to eat received it sensitively and appropriately. Staff were able to discuss people's dietary requirements with us and told us what was reflected within the care plan. Records showed that where people experienced weight loss, where appropriate this was referred to a dietician for investigation. We found that there were plenty of fluids on offer to meet people's needs and that instructions given by healthcare professionals regarding food supplements were followed.

People told us that their on-going health needs were maintained with one person saying, "If I needed the doctor I would get one. It's a good place". A second person told us, "If I need to go the staff take me to appointments". The PIR stated that, 'Any person who needs to go to hospital or be admitted is escorted by a member of staff any time day or night'. Records showed people had attended appointments such as hospital visits, opticians including diabetic eye screening or dentists. Visits by professionals such as the district nurse and nurses who work with people with dementia were recorded and we saw that where concerns were raised staff called these professionals into the home to see people quickly and efficiently. We saw that skin maps were completed where needed, including on discharge from hospital. Where people had skin issues these were monitored and staff worked with medical professionals to alleviate issues.

Good

Is the service caring?

Our findings

People told us that they felt that staff were kind and caring. One person said, "I have been here a long time, I love it. The staff are kind and friendly, both the boys and the girls". Relative's comments were, "The staff are brilliant and so kind and caring. The people here always look lovely and are kept tidy", "The staff are kind they will have a laugh and a joke and are friendly and "The staff know [relative] well and what he likes, they care about him". We saw good interactions between people and staff. People looked comfortable and relaxed in the company of staff members.

We saw an example of staff being aware of people's needs and acting upon them when a staff member noticed that a person didn't seem well at breakfast. The staff member was concerned that the person, "didn't seem herself". The member of staff chatted with the person and they disclosed they were in some discomfort. They were offered painkillers, which they accepted and appeared much brighter throughout the day. We saw many cards of thanks to staff on the noticeboard, the theme of them was similar, with one in particular stating, "Words are not enough to express our gratitude for the love and attention you have shown".

People told us that they made their own decisions, they told us, "I chose what I am wearing today". "There are no restrictions to when we get up or go to bed, it is just like being at home" and, "I go to bed about 9.30pm but if there is something good on the television I will stay up to see it". Relatives told us that they were happy with how people were enabled to make their own decisions. We saw that people chose which lounge to sit in, if they wanted to go to their room to watch television and who they wanted to sit with. A staff member told us, "I always ask people questions like how they want their hair, what they want to eat. People's choices change from day to day, so I never assume".

One person told us, "I like having my independence I like doing things for myself." A relative told us, "[Person's name] likes to be independent, but the staff are aware of people's limits". A staff member shared with us, "I always ask if people want to do things for themselves before doing it for them, but they get help whenever they need it". We saw that people were able to move throughout the home independently and where they were able they could choose books from the quiet lounge or go to the kitchen to get a drink from staff.

People told us that staff respected them and promoted their dignity. One person told us, "They [staff] keep my dignity and respect me. Keep me covered up and only have girls helping me, which is what I asked for". A second person told us, "The staff always knock on doors before entering my room". A relative shared with us, "The staff cared for the dignity of my relative so well, when [person's name] was very poorly staff never forgot to keep their dignity". Staff we spoke with were able to discuss ways in which they maintained people's dignity and one staff member said, "We ensure people's dignity by keeping doors and curtains closed when doing personal care". We saw that everyone living in the home was dressed appropriately and within reason for the season.

People told us that their family members and friends visited regularly and that they were welcomed.

Relatives confirmed this and one told us, "They always get me a cup of tea and make me welcome". A staff member told us, "We know relatives well and communicate well with them".

Good

Is the service responsive?

Our findings

People told us that they had been involved in discussions to develop their care plans. One person told us, "When I arrived I was asked about what care I needed and we made a plan (with staff). A relative told us, "When we first came we told the staff all about [person's name] and it became part of the plan. We get invited to all of the reviews of the plan". A staff member told us, "We get people involved in their care plans, we listen to what they tell us". The PIR states, 'On admission of the person we complete an overview information sheet regarding the person's history, family, pets, hobbies etc. This provides the person with the feeling of involvement in deciding on the care they require'. We saw that where possible people and their relatives had been involved in the development of the care plan. We found that care plans looked at the support that people required and the best way that staff could support them, this included medicines and health, maintaining hygiene and people's leisure interests. We found that pre-admission information regarding people's needs including personal care, mobility, health needs, mental health needs were included in the care plan. Care plans were reviewed and updated in a timely manner. Staff were able to discuss with us people's care needs and they were able to relate the care that they provided to the content of the care plan.

People's care plans contained their preferences and how needs such as preferring a shower, requiring prompting at mealtimes and choice of gender of staff members were noted. Other likes and dislikes were noted too, such as enjoying a morning newspaper or not liking certain foods. We saw that expressing sexuality and cultural/religious needs were discussed within the care plan, but people we spoke with said that they had not raised this as something they needed to highlight within their care plan. We saw that a smoker's room was provided for people who liked to smoke.

One person told us, "I have lots of friends and get on with everybody". People shared with us that they had many friends within the home and we saw that staff sought to promote positive relationships between people. Staff knew who got along well and they were encouraged to spend time together whenever they wanted.

We did not see any activities taking place, as the registered manager informed us that the activities co-ordinator was on sick leave, however people told us about the activities that they usually participated in. People told us that they joined in with singing, crafts and keep fit and we saw an activity timetable on the noticeboard which reflected this. Relatives made comments such as; "There are activities and staff encourage [relative] to join in, but they never push him to" and "We have been part of fundraising for the home and they are going to use what was raised on activities. A staff member told us, "Twice a week the activity person comes in, last time everybody made Halloween decorations. The staff put music on and talk to people if there are no activities on". We saw staff members sitting with people and chatting with them.

One person told us, "I like to go out into the garden and my family come and take me out". A second person told us, "I am looking forward to Christmas, we do lots here like singing carols. We do some really good things at Christmas". A third person shared, "We don't need the television on, we all get on and like to chat we like to entertain ourselves".

People told us they knew what action to take if they wanted to raise a concern or a complaint. One person told us, "I haven't had any complaints but they [staff] would answer any questions and deal with problems I'm sure". A relative told us, "We always see the manager around the place, I could talk to her about anything, she would deal with any complaints". A staff member told us, "If a person complained directly to me I would take them into the office to speak with the manager or senior staff and get it dealt with properly". Records showed that complaints were fully investigated with the complainants being updated and responded to appropriately. Complaints were kept within a 'grumbles book'; we saw only one recorded complaint this year for a minor incident, which had reached a satisfactory conclusion.

One person told us, "I don't know if I get any questionnaires, but the staff are always asking me if I am happy". A relative told us, "We get a questionnaire around every six months, they [staff] also let us know the feedback when I come in to see [relative]. Records showed that surveys given to people asked about the effectiveness of staff, activities, cleanliness, and asked for any suggestions for improvement. We saw that the most recently returned questionnaires had provided mainly positive comments, but a small amount highlighted some minor issues. We asked the registered manager if they had completed an analysis on the most recent survey, but this had not yet been actioned. The registered manager also told us that they had acted on the feedback where issues had been raised, but we were not shown evidence of this.

Requires Improvement

Is the service well-led?

Our findings

Some of the records we reviewed during our inspection varied in the level of detail and analysis and/or lacked an update. This meant that the effectiveness of the quality assurance of the service was inconsistent. Examples we found were; the registered manager told us that medicine record audits were carried out and the back of the sheet was signed when it was completed, however this was inconsistent and had failed to identify and take action on a number of gaps within the recording on the sheets. The registered manager told us that staff files were audited, but we saw no evidence of this and any audits which may have occurred had failed to flag up lack of work histories and risk assessments where there were concerns on DBS checks. Random spot checks were also carried on staff members practice during night shifts, but these had not been completed as part of an audit for day time staff. We discussed these issues with the registered manager who acknowledged our concerns and said that they would act upon them. At the time of our inspection an independent auditor was carrying out an audit of health and safety related to the well-being of staff members.

People told us they were happy with the service they received. One person told us, "The staff are lovely, I don't want to go home, my people are here". A second person said, "I would recommend this place to others". A relative told us, "It's like a home from home for [relative]". Staff members commented, "We look after the residents well, I can't think of anything we could improve on" and "I love working in this place".

People and staff spoke about how the service was well led and managed. One person told us, "The manager is about a lot". A relative shared with us, "The manager is very visible, very hands-on". A staff member told us, "[Registered manager's name] likes to be out helping". The registered manager told us that they favoured being out on the floor supporting staff and people in the home, however the paperwork that was required within the role, took up a lot of time. The registered manager told us of how they had spoken with the provider regarding employing a deputy manager and that there was a strong possibility that it would happen.

We saw that the registered manager had been pro-active in forging links with outside agencies that may be beneficial to people living within the home. Advertisements for dementia awareness drop in sessions run by the local authority were displayed within the home. People told us that although they hadn't yet attended, it was something they may like to do in the future. Staff members said that they felt part of the service. Records showed that regular team meetings occurred and staff told us that they were able to give their opinions and felt listened to. Issues discussed in meetings related to the care of people and staff satisfaction. We saw that staff had signed to say that they had attended the meeting or read the minutes. We found that additional night staff meetings took place, with a similar agenda.

The registered manager told us they were developing staff's knowledge and skills by giving them additional roles within the team. These included a nutrition champion, a dignity champion and a dementia champion. The latter had resulted in some staff now trained as 'dementia friends.' Staff members were able to discuss with us the roles they had taken on and how they would impact upon the people they cared for.

Staff members commented, "I would report any concerns through whistle-blowing and it would be supported. I have read the whistle-blowing policy and know who I can go to" and, "The manager has told me how to whistle-blow". A whistle-blower is a person who tells someone in authority about wrong-doing they witness. Staff told us that they had received information on how to whistle-blow from senior managers and understood the process.

The registered manager told us that they felt supported by the provider and that any requests they had were considered, the proposed employment of a deputy being given as an example. Staff told us that they saw senior management at provider level visit the home.

We found that notifications of incidents were sent to us as required, which enabled us to see how staff responded to incidents or concerns, however we had not been made aware of all of the DoLS approvals. The registered manager told us that this would be completed in the future.