Cross Keys Homes Limited

Kingfisher Court

Inspection report

Kingfisher Court
Thistle Drive
Peterborough
Cambridgeshire
PE2 8NZ

Tel: 01733396484

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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

Kingfisher Court provides personal care to people living in on-site individual flats. Each person's flat is provided with kitchen, lounge and an en suite shower. Communal bathing and dining facilities are provided. Short and long stays are offered. At the time of our inspection there were 20 people receiving personal care.

This comprehensive inspection took place on 22 November 2016 and was unannounced. It was carried out by one inspector.

The provider is required, as part of their registration, to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a registered service. 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. A registered manager was in post at the time of our visit.

People were kept safe because staff were knowledgeable about reporting any incident of harm. There were enough staff to support people with their individual needs. Pre-employment checks were completed so that only suitable staff looked after people who used the service. People were supported to take their medicines as prescribed.

People were helped to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. At the time of our inspection no person was assessed to lack capacity. Staff members had an understanding of the application of the MCA. The provider was aware of the actions to take if a person required a DoLS application to be made and had clear policy guidance about this legislation.

People benefited from being looked after by staff who were trained and supported to do their job. Staff morale was good due to the level of support that they received.

Staff treated people in a kind and caring way. People's right to choice, privacy, dignity and independence was valued. People and their relatives were involved in the review of their or family members' individual care plans.

People's individual health and social care needs were met. Staff were punctual and they stayed the duration of people's planned care visits. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

There were management arrangements in place which supported care staff to look after people. Staff were

made aware of their roles and responsibilities to provide people with safe and quality care. Staff and people who used the service were able to make suggestions and actions were taken, if these were needed.

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.

Staff were trained and informed about how to recognise any signs of harm and how to respond to any concerns appropriately.

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

Risk assessments were in place to ensure that people were cared for as safely as possible and that any risks were identified and minimised.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

People were able to make informed decisions about how they wanted to be looked after on a day-to-day basis. The provider was acting in accordance with the principles of the MCA legislation.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff.

People's rights to independence, privacy, choice and dignity were valued and respected.

People were involved and included in making decisions about how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual health and social needs were met. Staff were punctual and stayed the duration of time in accordance with people's planned care.

Up-to-date care records were kept under review with the involvement of the person and people who were important to them

There was a procedure in place which listened to people's concerns and complaints which were dealt with to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People and staff were enabled to make suggestions to improve the quality of the service provided.

There was an open and transparent leadership culture within the management of the service.

Quality assurance systems were in place which ensured that people were being looked after in a safe way.

Kingfisher Court

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 agency, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 November 2016 and was unannounced. It was carried out by one inspector.

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

Prior to the inspection we sent out 49 surveys to people who used the service and 19 of these completed surveys were returned. We sent out 49 surveys to people's relatives or friends and one of these was returned.

During the inspection we visited the service office and on-site premises where people lived. We spoke with the registered manager; a care business development manager; one member of senior care staff; four members of care staff and the chef. We also spoke with four people who used the service and two people's relatives. We saw how staff looked after people.

In addition to the above, we looked at four people's care records; audits; minutes of staff meetings and records in relation to the management of staff.

Good

Is the service safe?

Our findings

We checked and found that arrangements were in place to keep people safe. In all of the completed surveys the respondents told us that people were kept safe from harm. During our visit people told us that they felt safe because of how the staff looked after them. Often we heard people describe members of care staff as being "very good." One relative told us, "The staff look after [name of family member] very well." Another relative said, "This is one of the better places [family member] could be in. It does give me a peace of mind."

We found that people were protected from the risk of harm. The provider told us in their PIR that, before staff looked after people, they were trained in safeguarding people at risk. Members of staff told us that they had attended such training. Furthermore they were able to demonstrate the learning that they obtained from the training. They were able to names the types of harm that people might experience and the names of the appropriate authorities to report such untoward incidents to. This included their manager, police and local safeguarding authorities. In addition to this, members of staff were able to identify the physical and psychological signs and symptoms of harm. The member of senior care staff said, "The person could become withdrawn. Or have marks on them that haven't been there before." One member of care staff told us, "When you go in day in day out you get to know them [people who used the service]. You get to know the difference [in changes of a person being harmed.]"

There were recruitment systems in place to ensure that only suitable staff looked after people. The provider told us in their PIR that staff were subject to recruitment checks before they were considered suitable to work. This included, "DBS [Disclosure and Barring Service police check] checked, reference checks and eligibility to work in the UK, before delivering any care." Members of care staff confirmed that they had these required checks carried out and this was before they started their new employment. The provider had a staff disciplinary procedure in place. The registered manager told us that this had been carried out when members of staff had failed to meet the provider's expected standards of work.

We found that people were provided with care by sufficient numbers of staff to meet their needs although not necessarily in a consistent way. One person's survey read, "...some weeks I have between 9 and 12 different carers in a week." Another person's survey read, "Due to high staff turnover the quality of care is not always consistent. Agency [care] staff are not conversant with their duties, this can cause distress due to the limited time allotted to each care visit and tasks do not always get completed as they should be. Dealing with elderly or disabled people cannot be effective if rushed." Because of these comments we explored this further during our visit.

Staff told us that there was enough staff on duty and that, more often than not, they looked after the same people. One member of care staff said that people's care had "...got better in a lot of ways. I have the same people [to look after]. I like that and they like that." People told us that this was the case although sometimes they were looked after by different staff. One person said, "I see about three or four different staff." However, they said that this was not a problem for them. They told us that all of the staff were able to meet their needs and were satisfied with the quality of their care. One relative said, "We don't mind who comes in." The registered manager and care business development manager explained that this was an

area that had improved. They told us that this improvement was due to a decrease turnover of staff and better scheduling of how staff were rostered to work.

One person said that there was always enough staff on duty to help them. They told us that they had help with their moving and handling needs and this was always with two members of care staff. We saw one member of care staff respond to their call for assistance without delay. We saw another member of care staff walk patiently with another person to the dining room, which told us that they had time to do this. To cover unplanned absences there was a bank of staff or permanent staff worked extra shifts. The senior member of care staff said, "We have good staff here who are willing to pick up extra calls [work]."

In their surveys most, but not all, of the people told us that staff arrived on time and stayed the duration of the call visit. The provider told us in their PIR what remedial action was being taken to improve how people were being looked after. The PIR read, "Since May [2016] the management team has been reviewing all task rota's to improve the continuity of care delivery for both the customer [person who uses the service] and staff member. A recent internal audit has shown that customers [people who used the service] appear happier with service delivery, since the changes." Because of this variance of people's experiences, we looked into this in more depth. People told us that care staff arrived on time and stayed the duration of the call visit. One person said, "The staff ask me that, when they have done, if they then can go." People's completed daily records showed that staff arrived on time and stayed the duration of the scheduled visit.

To keep people safe, risks were assessed and measures were in place to manage the assessed risks. The records of these showed that risks included those associated with people's physical conditions and conditions of where they lived. Members of care staff were aware of such risks and how these were managed. One member of care staff described how they helped a person, who was at risk of choking, to eat their food. They said, "The food is 'mashed' up and they are to take small quantities at a time. And a carer sits with them all of the time to make sure [person] is eating a mouthful before having the next. Because [person] could choke otherwise." They also told us how people's premises were risk assessed and any trip hazards were known. These included, for instance, ensuring that trailing electrical cables were made safer and were not a trip or electrical hazard.

The provider told us in their PIR that staff were trained in "Medication Management". However, they also told us that there had been eight errors occurring in the management of people's medicines. The provider had arrangements in place to reduce such risk. In their PIR they said, "In order to improve medication delivery and eliminate medication errors, we are in the process of piloting an electronic medication administration record (EMAR). The system flags missed medication and more importantly flags instances where medication is slightly late so that remedial action can be taken prior to 'it' becoming an issues (sic)." The registered manager told us about previous action they had taken in response to medication errors. This included, for example, the re-assessment of the responsible member of staff's competency in managing people's prescribed medicines.

Members of care staff told us that they had attended training regarding medicines and were "frequently" assessed to be competent in the handling of people's medicines. Records of observations of staff at work demonstrated that the safety of the management of people's medicines was monitored. People told us that they were satisfied with how staff helped them to take their prescribed medicine. One person told us that staff "popped it [prescribed] out of a blister pack" on to a saucer for them to take from. They said that this was done only after the member of care staff had checked the medicines administration records [MARs]. Another person said that they were comfortable because they were having their medicines for pain relief as prescribed. Theirs and other people's MARs were completed to show that people had their medicines as prescribed. Some of the people were independent, or had help from their relatives, with managing their

medicines and had been assessed to be safe with this. This included ordering, storing, administration and disposal of their prescribed medicines.

Good

Is the service effective?

Our findings

We checked to see how people's rights were being protected. The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services 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. At the time of our inspection all of the people had the mental capacity to make decisions about their care.

Information contained within the PIR told us that staff had attended training in the application of the MCA. Members of staff told us that they had attended training in the application of the MCA and DoLS. They were aware of the need for people to be assessed to determine if they had mental capacity. To refresh their memory all staff carried an 'aide memoire'. This was to remind care staff about the key principles of the MCA. Staff told us that they found this to be helpful. One member of care staff said, "I often look at it to remind me." The senior member of care staff was also aware of the process to follow for the administering of prescribed medicines hidden in food and drink. They told us that this would only be carried out with the agreement of the prescribing GP.

We found that staff were supported to do their job. The PIR told us how the provider aimed to support staff by "regular supervision sessions where they [staff] are encouraged to contribute to their own development plan, identifying areas of learning." In addition to this staff were also supervised as part of being 'spot checked' when at work. The PIR read, "Regular observations of staff working is undertaken to monitor the quality of service being delivered this includes dignity and respect, communication, health and safety and food preparation." Staff confirmed that they had this range of supervised practice and that they had attended one-to-one meetings with the registered manager. One member of care staff said that, during their one-to-one, they were able to discuss any work-related issues and training needs. They said that they felt listened to and supported. Another member of care staff added, "If we need help or advice someone is here and they [managers] always help us. We are never actually on our own."

We found out how staff were effectively trained to do their job. In all of the returned surveys the respondents told us that they considered that members of staff had the skills and knowledge to do their job. Staff told us that they attended an induction during which they 'shadowed' to watch more experienced staff members at work before being competent and confident to work on their own. The senior member of care staff said, "Induction training was reading about policies and procedures. Medication and moving and handling training. And 'shadow' training. I went out with another carer on care calls. After so many days they observed me [at work]. Observations were on personal care and medication and moving and handling. To ensure I

was competent to do that work." Records showed that staff had attended induction training and were signed off when they were assessed to be competent with the described areas of learning.

Information in the PIR told us that staff had attended training in a range of topics which included: basic life support; moving and handling; privacy and dignity and nutrition. People told us that they had confidence in the ability of members of staff. Staff members said that they had attended a range of training. One member of care staff said, "I think we are all up-to-date with our training. They [the provider] are very good with that." Certificates of training showed that members of care staff had attended a range of training, as described by the provider in their PIR. In addition to the listed training staff had also attended training in dementia awareness. Members of care staff demonstrated their learning gained from such training. For instance, one member of care staff said, "You've got to speak to people slowly and see what they are saying from their point of view." Another member of care staff said, "If a person tells me that they are looking for their suit to go to work, I ask them about their work." Staff said they engaged with people to gain an understanding of their [the person's] reality. This told us that staff were trained to ensure that people's needs were safely and individually met.

We checked to see how people's choices about what they wanted to eat and drink were being met. On-site dining facilities were available for people to eat a choice of menu options. People were offered a choice of menu options in written form or by members of staff telling people about this. We heard one person choosing soup and quiche for their lunch. The chef told us that, "If there is nothing on the menu they [person] likes I will give them an alternative. For example, one person had eggs, bacon and sausage for their lunch [as an alternative.]" People said that the food was "good". One relative told us that they helped cook their family member's meals which they often chose to eat together in the quiet of their flat.

We found that people's individual nutritional needs were being met. People told us that they had enough to eat and drink. One person said, at 11:45, "I had a drink of tea about 11:00." The majority of people who we spoke with said that they could eat and drink independently. However, people were supported with this, if needed. One member of care staff said, "If [person] wants to feed them self they will. And [person] will let us know if they want us to help." One person also told us that they recently had a snack brought up to their flat from the kitchen. They said, "I was feeling a bit peckish the other day and they [staff] went to the [communal] kitchen and got me a sandwich to eat." They also told us that they ate a 'healthy' diet to manage their health condition. The chef manager told us how they shared information with the team of care staff in relation to people's nutritional needs. They said, "You get to know them [people] and their dietary needs and eating habits. If they [person] is not eating as much we pass it [information] on to the care staff. If someone doesn't come down [to the communal dining room] we tell the care staff and plate a meal up for carers [care staff] to take to them."

We found that people's individual health needs were being met. Information in the PIR told us how this was area of people's care was managed. The PIR read, "The staff work closely with other professionals to ensure that health needs are met. These include district nurses, chemists, occupational therapists, Macmillan nurses, physiotherapists." People told us that they were independent with making their own health appointments. One person said that they had the district nurse visit them every "Monday and Thursday" to review and treat their health condition. They added that their eyes were checked by the GP. One relative told us that their family member was due for their two-yearly eye check and would be taking their family member to this appointment.

The service offered short stays for people to be rehabilitated following a change in their condition. This could be, for example, after being discharged from hospital and before returning home. Members of care staff told us that people had access to physiotherapists [PT] and occupational therapists [OT], as part of the

rehabilitation programme. One member of care staff said, "We get them [people] to do the majority of it [care] and by following the OT's advice." They also told us that a PT came to review the person's change of needs.

There were arrangements in place to enable people, if practicable, to be looked after during the end stage of their life. People's palliative care needs, to control symptoms such as pain and discomfort, were met by nurses, which included those supplied by a charitable organisation, and GPs. People's health records complemented the service's care records to enable all agencies to provide people with a continuity of health care. In addition to these services, the district nurses also helped people have access to pressure-relieving aids. They supported care staff in the monitoring and reviewing of people's skin, particularly if they were assessed to be at risk of developing pressure ulcers. One person who was at risk of developing pressure ulcers told us that when they were starting to feel sore, the staff applied cream to the affected areas.

Good

Is the service caring?

Our findings

We found that people were being well-cared for. We received positive comments in people's surveys. One of these read, "[I am] Very happy with [the] service and carers." Another person's survey read, "[I am] Well and truly satisfied, they are wonderful carers here." In their surveys people told us that the care they received enabled them to remain as independent as possible. The completed relative's survey also shared this view. In addition, all of the surveys told us that people were respected and that their dignity was valued by kind and caring members of staff. The provider told us in their PIR that, "Each customer [person who uses the agency] is treated as an individual, their support plan is written to ensure that staff are aware how to meet their individual choices & needs."

During our visit we often heard people telling us about the kindness of the staff. One person said, "The girls [care staff] are nice. They are good carers. If I want anything they do it for me. They also will sit and chat." One member of care staff said, "I enjoy listening to people's stories about their lives." One relative said, "[Family member] gets on very well with them [staff.]" We saw examples of good care provided by patient staff. This included when a person was choosing what they wanted to eat for their lunch and when people were being helped to go to the dining room.

People were looked after by staff who treated them as individuals. The improvement in making sure that people were looked after by the same team of care staff fostered positive relationships. One member of care staff said, "You get to know people on a personal level and they trust you as you see them every day." Another member of care staff said, "They [people] trust us when you get to know them and they get to know you."

We saw that staff respected people's privacy. All flats were provided with lockable doors and door bells, which staff used and waited for a response before entering. Care staff were aware of those people who were able to fully respond, or not. One member of care staff said, "We ring the doorbell and wait for them [people] to shout to come in. And then you go in. It is their home." On occasion we saw some of the people were unable to give their permission for staff to enter their flat. To overcome this we saw how this was managed. After opening the person's door [with the use of a security system] staff, including the registered manager, announced their arrival, and gained the person's permission, before entering further into the privacy of the person's home. We also found that people's privacy regarding their mail, was valued. People had their own letter box to receive their mail in private.

People's right to making choices about how they wanted to live were respected. People told us that they had a choice of when they wanted help with personal care; what to eat and drink and if they wanted to be alone or with other people. In one person's daily records we saw that they were helped with their personal care and when they chose not to have this level of support. The person also told us that their morning care had been provided at an earlier time than what they preferred. However, they told us that, after speaking with the registered manager, changes were made and this took into account when the person chose to have their morning care at a later time.

There were no restrictions imposed on when people could receive their guests. One person told us that they had visits from their relatives or friends "every day." Another person also told us that they had made friends with other people living in the same building. We saw that social and recreational activities enabled people to meet one another in the communal areas of the building.

People told us that they were aware of advocacy services available to them. They told us that, as part of a social agenda, representatives of charitable organisation for older people, visited and gave a talk. One person said that the talk enabled people to raise any concerns they may have with this agency. Information about advocacy services was publicly available for people, staff and visitors to access if needed. Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

We found that people's needs were assessed and met. The PIR provided information in how people's individual needs were assessed. This document read, "Following a meeting to discuss the individual's needs, preferences, interests, religious beliefs and family and friend network a support plan is written. This will be discussed and agreed with the customer [person who used the service] so they are personalised to reflect their needs." People and their relatives told us that they had been actively involved in the assessment process before they or their family member started to receive the care. People told us that they were very satisfied with how the care met their needs. One person said that they stayed in bed and how staff made them comfortable. They said that two members of care staff had helped them with their personal care and helped to change their position. Another person said that the staff were able to understand their complex communication needs. A third person told us that they were able to be more independent with their mobility due to the aids and adaptations provided in their flat.

On-site community facilities provided an area for people to take part in social activities to reduce the risk of social isolation. Information in the PIR read, "… a [name of religious denomination] service takes place on a weekly basis which enables some customer's [people who use the service] spiritual needs to be met. Armchair aerobics takes places weekly to help with fitness, fortnightly chat groups attend the scheme." People told us that they were given the opportunity to take part in the arranged activities. We heard information being announced about the afternoon's communal board game. The announcement advised people if they needed help to attend, they were to call the care staff for assistance. This was to enable people to go to the communal lounge where the activities were being held.

The nature of the care and provision of on-site activities helped meet people's social needs in other ways. The registered manager told us that improvements had been made in relation to the range of on-site social and recreational activities to create a "community" feel.

Some, but not all, of the respondents told us in their surveys that they had been involved in making important decisions about their care. We explored this further during our visit and found people were involved in such decisions. These included, for example, the level and type of care that they needed. This included, for instance, end-of-life care and treatment and day-to-day care in how they wished to spend their time. One person said, "I like it here because you are free and there are no restrictions in what you want or need." We found that people were also included in the reviews of their planned care. People and their relatives told us that the reviews had been carried out and signatures were entered on the reviewed records to confirm people's involvement. One person said that their review had shown that the care was meeting their needs. They added that a minor change was made so that their morning call was to take place 30 minutes later than before. One relative said that their family member's care plan was reviewed and no changes were required.

To ensure that people received the care to meet their needs in a consistent and safe way, members of staff had access to up-to-date care plans. These contained details of people's individual needs, their life histories and risk assessments. Members of care staff said that the care records were easy to follow. People told us

that members of care staff read their care plans and kept their daily records up-to-date. One member of care staff told us that people's care plans were, "Pretty good. They are up-to-date and easy to follow." They explained how they ensured that people's care was kept safe by means of maintaining records. They said, "Every time we go in [to give a person their care] we fill in the daily logs [records] with the time and our signature and before we leave." The daily records showed that people's needs were met and detailed the person's demeanour. In addition the daily records showed that staff had arrived and stayed the duration of the planned call visit.

We checked to see how the provider operated their complaints procedure and listened to and acted on what people said. The provider wrote in their PIR, "We use complaints as a learning tool. All complaints are investigated and responded to in accordance with our corporate policy, each one details the response/action and the learning outcomes. 'How to make a complaint' is detailed in our customer's [people who used the service] guide that is given to all customers on start on their care delivery." However, in their surveys some but not all of the respondents said that they knew what to do if they wanted to raise a concern or complaint. Because of this we explored this further. During our inspection people had information about how to complain and this was held in their individual care files. People were also able to name key managers who they would speak with if they were unhappy about something. Members of care staff were aware of what to do if a concern or complaint was initially brought to their attention. One member of care staff said, "I would listen and record it and tell my manager about it."

The provider told us that in the previous 12 months they had received, and resolved to the person's satisfaction, three complaints. However, there was no emerging trend that required any improvement action for the provider to take. Of those survey respondents who knew how to raise a concern or complaint 12 out of 19 people said that they were satisfied with how the provider had responded to these. Due to the discrepancy of information in relation to the numbers between our surveys and that reported in the PIR we looked into this in more detail. The registered manager explained that only formal written complaints had been recorded. However, improvements were being made to record all complaints and concerns. They said, "If I don't know about it [concern or complaint] I can't put it right and improve [the quality of the service]."

Good

Is the service well-led?

Our findings

We found that people benefited from a well-led service. In their surveys some but not all of the people knew who to contact at management level. During our visit we asked people more about this. We found that people were able to name key staff, which included senior members of care staff and the registered manager. We saw the registered manager speak to people; people were aware of who they were and people asked to speak with the registered manager.

We received positive comments from staff members about the management and leadership style of the registered manager. We heard staff describe the registered manager to be "lovely" and "approachable." One member of care staff said, "[The registered manager is very good. They make sure things are in place. The carers respect [the registered manager]. Who is very approachable if you have a problem."

Comparing information that we hold with that of the provider's information held at the service, we found during the inspection there was no requirement for the provider to submit notifications to us. The registered manager was fully aware of their responsibilities in relation to when required notifications were to be submitted to the CQC.

The registered manager told us that, through recruitment, supervision, staff meetings and reassurance, the level of staff morale had improved. The registered manager told us that they operated a learning culture so that lessons could be learnt, rather than operating that of a 'blame' culture. This in turn had changed the way staff provided people with quality of care that they needed. All of the staff who we spoke with told us that they enjoyed their job and worked well as a team. The registered manager told us that, because there was an increased level of job satisfaction, there had been a decrease in the turnover of staff. This in turn enabled people to be looked after by a stable team of motivated staff to provide them with a continuity of care to meet their individual needs. The care business development manager said, "Continuity of care is way, way better than it has been. We now have a stable workforce which is very positive. And a more settled management team." The senior member of care staff said, "We have a stable team of staff."

In their surveys some but not all of the people said that the provider asked for their views about their care. However, the provider had identified this as an area for improvement. In their PIR they told us, "We currently undertake two internal audits by an independent quality assurance officer. This involves customers [people who use the service] completing quality assurance surveys or telephone surveys. We intend to make this process more interactive by the quality assurance officer visiting all customers [people using the service] at the next inspection [to be carried out by the independent quality assurance officer]." During 2016 the provider had carried out surveys asking people for their views about the quality of their care. The results of these formed part of the quality assurance and auditing of the agency. Feedback from the survey's respondents was positive.

Staff were enabled to share their views and make suggestions in improving the way people were looked after. Information in the PIR read, "Regular staff meetings ensures (sic) that staff are briefed of changes and best practice shared." Staff members told us that the meetings were informative and kept them up-to-date

with people's care needs and policies and procedures. People were also empowered to hold their own meetings. People said that they attended these and where they listened to external speakers about advocacy services and police community services.

Quality assurance systems were in place to monitor and review the safety and quality of people's care. The provider told us in the PIR, "The introduction of the compliance tracker has enabled improved monitoring of staff through, regular supervision, spot checks, work place observations and medication comps [competencies]." Information in the PIR also showed how the provider had identified areas to improve the service provided at Kingfisher Court. Such improvements included, for example, providing career development opportunities for senior members of care staff. Another example was to provide end-of-life care for people who wished to remain at home during the final stage of their lives.

Other quality assurance systems included 'spot' checks and direct observations of staff at work. These methods of observing staff at work covered health and safety areas, such as following infection prevention procedures and management of people's medicines. Other observed areas included how people's rights to choice, privacy, dignity and independence were valued by the observed member of care staff. Members of care staff said that they received feedback following their observed practice. One member of care staff said that they had gained insight in how they communicated with people and were aware to speak more slowly when talking to people who they looked after. Another member of care staff said that the feedback had been positive about the standard and quality of their work. The senior member of care staff, who carried out 'spot' checks and direct observations, said, "Feedback is if we've highlighted something staff need to improve. Or highlighted good practice as it gives staff, especially new staff, extra confidence."

The management of the agency operated an open culture to keep people safe by means of a whistle blowing policy. Members of care staff were aware of this policy and the purpose of it. The senior member of care staff said, "Whistle blowing is if you think a team member has done something [wrong] and you need to report it. It's confidential." Other members of care staff were also aware of the whistle blowing policy and when to use this. All of the members of staff said that they would have no reservations in blowing the whistle to keep people from the risk of harm.

There were links with the local community so that people felt part of this and that the provider operated and open culture. The registered manager told us that people attended talks given by an advocacy service in relation to the history of the local neighbourhood. Arrangements were in place for community police officers to give a talk about their roles and responsibilities in keeping people safe.