Trilodge Limited

Oakfield Nursing Home

Inspection report

30 Oakfield Road
Ashtead
Surrey
KT21 2RD

Tel: 01372272540

Date of inspection visit:
21 June 2016

Date of publication:
17 August 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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Oakfield Nursing Home is a care home that provides care for 29 people with mental health support needs, these included schizophrenia. At the time of our inspection 29 people were living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home was well decorated and adapted to meet people's needs. Flooring was smooth and uncluttered to aid people's mobility needs. The home had a homely feel and reflected the interests and lives of the people who lived there.

The inspection took place on 21 June 2016 and was unannounced.

People gave positive feedback about the management of the home; however we have made recommendations where two areas for improvement were identified. Quality assurance checks were not consistently effective at identifying areas where the home could improve. Records used around the home were not always effective at giving the management an oversight into how well the home was run.

There was positive feedback about the home and caring nature of staff from people who live here. One person said, "I'm quite happy here." Another person said, "I do think I am well looked after here." The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout the day of our inspection, such as staff talking with people and showing interest in what people were doing. People could have visitors from family and friends whenever they wanted.

People were safe at Oakfield Nursing Home. There were sufficient staff deployed to meet the needs and preferences of the people that lived there. Risks of harm to people had been identified and clear plans and guidelines were in place to minimise these risks, without restricting people's freedom. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police.

The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home. Staff received a comprehensive induction and ongoing training, tailored to the needs of the people they supported.

People received their medicines when they needed them. Staff managed the medicines in a safe way and were trained in the safe administration of medicines.

In the event of an emergency people would be protected because there were clear procedures in place to

evacuate the building. An alternative location for people to stay was also identified in case the home could not be used for a time.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Staff were heard to ask people for their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and specialist diets either through medical requirements, or personal choices were provided. People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them. When people's health deteriorated staff responded quickly to help people and made sure they received appropriate treatment. People's health was seen to improve due to the care and support staff gave.

Care plans gave a good level of detail for staff to reference if they needed to know what support was required. People received the care and support as detailed in their care plans. Details in the care plans matched with what we saw on the day of our inspection, and with what people told us.

People had access to activities that met their leisure and mental health needs. The staff knew the people they cared for as individuals, and had supported them for many years.

People knew how to make a complaint. No complaints had been received since our last inspection. Staff knew how to respond to a complaint should one be received.

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.

People felt safe living at the home. Appropriate checks were completed to ensure staff were safe to work at the home.

Staff understood their responsibilities around protecting people from harm.

There were enough staff to meet the needs of the people.

The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Is the service effective?

Good

The service was effective

Staff said they felt supported by the manager, and had access to training to enable them to support the people that lived there.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where peoples liberty may be being restricted, appropriate applications for DoLS had been completed.

People had enough to eat and drink and had specialist diets where a need, or preference, had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

Staff were caring and friendly. We saw good interactions by staff that showed respect and care.

Staff knew the people they cared for as individuals. Communication was good as staff were able to understand the people they supported.

People could have visits from friends and family, or go out with them, whenever they wanted.

Is the service responsive?

Good

The service was responsive.

Care plans gave detail about the support needs of people. People were involved in their care plans, and their reviews.

Staff offered a range of activities that matched people's interests. People had good access to the local community.

There was a clear complaints procedure in place. Staff understood their responsibilities should a complaint be received.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Quality assurance checks were not always effective at ensuring the home was following best practice. Records management also needed to improve to ensure management oversight of the home was effective.

People and staff were involved in improving the service. Feedback was sought from people via an annual survey.

Staff felt supported and able to discuss any issues with the manager. The provider and registered manager regularly spoke to people and staff to make sure they were happy.

The manager understood their responsibilities with regards to the regulations, such as when to notify CQC of events.

Oakfield Nursing 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 21 June 2016 and was unannounced.

The inspection team consisted of one inspector, an expert by experience who was experienced in care and support for elderly people, and a nurse specialist with experience of care for people with mental health support needs.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had 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. This information was reviewed to see if we would need to focus on any particular areas at the home.

We spoke with seven people who lived at the home and seven staff which included the registered manager and the provider. We also 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. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included six care plans and associated records, three medicine administration records, four staff recruitment files, and the records of quality assurance checks carried out by the staff.

We also contacted Healthwatch, and commissioners of the service to see if they had any information to share about the home. At our previous inspection in January 2014 we had not identified any concerns at the home.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Oakfield Nursing Home. One person said, "I do feel very safe here." People were cared for in a clean and safe environment, however some parts of the homes decoration looked tired and worn. One person said, It's a very clean place, it's hoovered every morning and they do our rooms as well." There was a calm, friendly and happy atmosphere throughout the Home.

There were sufficient staff deployed to keep people safe and support the health and welfare needs of people living at the home. One person said, "There are enough staff here, they work pretty hard." A staff member said, "We have a lot of staff, so we can take people out if they want to go." The registered manager explained that the staffing levels reflected the needs of the people and also the activities and appointments of that particular day. Staffing rotas recorded that the number of staff on duty matched with the numbers specified by the registered manager. This demonstrated the flexible approach to staffing levels to meet people's needs.

People were protected from the risk of abuse. People knew who they could speak to if they had any concerns, and believed their concerns would be addressed promptly. Staff had a clear understanding of their responsibilities in relation to safeguarding people. Staff were able to describe the signs that abuse may be taking place, such as bruising or a change in a person's behaviour. Staff understood that a referral to an agency, such as the local Adult Services Safeguarding Team or police should be made.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager to look for patterns that may suggest a person's support needs had changed. One staff member said, "We talk to people and explain why their support may need to change after an accident." Appropriate action following incidents had been taken. At the time of our inspection there had been very few accidents at the home, showing people received a good safe level of care.

People were kept safe because the risk of harm from their health and support needs had been assessed. Assessments had been carried out in areas such as smoking, mobility, and behaviour management. Measures had been put in place to reduce these risks, all of which involved the person. One person said, "The staff are very good with the difficult residents." The assessments recorded how each person had discussed the risk with staff, and how they had agreed to control the risk. For example the risk of fire from people smoking had been controlled by use of a designated smoking room. The room was supervised by staff when anyone was in it. Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs.

People were cared for in a clean and safe environment. Assessments had been completed to identify and manage any risks of harm to people around the home. Areas covered included infection control, and fire safety. Staff understood their responsibilities around maintaining a safe environment for people. One staff member talked how they supported one person to mobilise safely around the home, such as looking for trip hazards, and ensuring equipment like walking frames where to hand for people that needed them.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire. One person said, "We have regular fire drills." These were carried out to check that people understood how to respond in the event of a fire. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. There was also a continuity plan in place to ensure people would be cared for if the home could not be used after an emergency. Other safety equipment such as first aid boxes were checked weekly to ensure items were present and safe to use.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People's medicines were managed and given safely, and people were involved in the process. One person said, "I do have medication and I get them at regular times of the day." Another person was able to self-administer their medicines, and said, "I do have medication and they trust me to take them." A staff nurse was available on each shift to ensure that people received their medicines at the times they required them and at the right dose. They had introduced blister packs for medicines six months ago and the qualified staff had training about the use of the system. One nurse said, "This system is much easier and we have encountered no problem so far."

Staff that administered medicines to people received appropriate training, which was regularly updated. Staff who supported people with medicines were able to describe what the medicine was for to ensure people were safe when taking it. For 'as required' medicine, such as pain killers, there were guidelines in place which told staff when and how to administer the pain relief in a safe way. The Registered General Nurse who administered the medicine took time to carefully read the MARS before giving the medicine to people to ensure they were going to the correct person, at the correct time, and at the correct dosage and quality. The MARs recorded that the administration of medication for the control of Type 2 diabetes was safe. People's blood sugar levels had been checked and monitored appropriately to ensure they received the correct amount of insulin. People with diabetes had comprehensive care-plans in place to manage their conditions. Where people had allergies this was recorded on the MARs, and staff who gave medicines knew about them.

The ordering, storage, and disposal of medicines were safe, although some minor improvements had been identified with regards to how medicines were stored, such as non-medicine items stored in the medicine cupboard. Medicines were stored in locked cabinets and within the recommended temperature to keep them safe when not in use. Medicines that required storage in the refrigerator were kept in the fridge. The refrigerator was not locked as indicated by the home's medicine policy. The temperature of the fridge was checked daily and monitored. However, the staff did not know what actions to take in the event of the fridge temperature going below or higher than the recommended temperature for medicines. Temperature records recorded that the refrigerator temperature had been maintained within safe limits, so risk to people was low. When medicines were received at the home staff logged them in. They detailed the date received, name of person they were for, the name of the medicine and the quantity. Used medicine was collected by a specialist contractor for safe disposal and a receipt given for records.

Good

Is the service effective?

Our findings

People were supported by trained staff that had sufficient knowledge and skills to enable them to care for people. One person said, "I think they are very well trained."

Staff had effective training to undertake their roles and responsibilities to care and support people. The induction process for new staff was robust to ensure they would have the skills to support people effectively. Induction included shadowing more experienced staff to find out about the people that they cared for and safe working practices. Ongoing training and refresher training was well managed, and the registered manager ensured staff kept up to date with current best practice.

Staff were effectively supported. Staff told us that they felt supported in their work. One staff member said, "I have supervision every month." This is a regular one to one meeting with the manager. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people. Staff told us they could approach management anytime with concerns, and that they would be listened to and the management would take action.

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. Some people all had capacity to make decisions for themselves, and were able to go out on their own if they wished. One person said, "The staff do involve me in decisions about my care." Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met.

Staff had a good understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They were able to demonstrate how it had been used to ensure a person's human rights were not ignored. Staff were seen to ask for people's consent before giving care and support throughout the inspection. They also took time to explain decisions and possible consequences to help people make decisions for themselves.

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 are called the Deprivation of Liberty Safeguards (DoLS). One person told us, "I am free to walk out if I want." Staff understood that people's capacity could change, and if they had to restrict someone's freedom to keep them safe, they knew they would have to do an MCA assessment, have a best interest's decision, and apply for a DoLS. Where people's liberty was restricted to keep them safe, appropriate applications had been made to the DoLS Board. People were supported in accordance with these DoLS.

People had enough to eat and drink to keep them healthy and had good quality, quantity and choice of food and drinks available to them. A person said, ""I'd say the food is excellent. Portions are big enough and

we are asked if we want more." Another said, "If I don't fancy the menu, they give me something else." People's special dietary needs were met, such as soft diets for people who had difficulty swallowing, or vegetarian diets for those that choose not to eat meat. Menu plans, and food stored in the kitchen matched with people's preferences and dietary needs. People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy.

People received support to keep them physically and mentally healthy. Many of the people in the home suffered from schizophrenia. They could succumb to risks of negative symptoms like spending long hours in bed, isolating themselves from others, neglecting their personal care, or cutting off contacts with their relatives and the community. Lack of stimulation and not accepting help from staff can often lead to low self-esteem, depression, and deterioration of their mental state and admission to hospital. During our inspection everyone was downstairs in the main area interacting with each other and staff. People looked clean and tidy which showed they had attended to their personal care. Their rooms were clean and tidy with personal mementoes like photographs, family photographs and TV, radio, magazines. The files we reviewed recorded that people had not required hospital admission due to any deterioration of mental health in the last 12 months. There was also no incident of challenging behaviours which is often common with poor compliance, lack of stimulation, undue stress placed on people by the environment, or poor understanding of peoples mental health needs. Effective care and support had been given.

People who had nursing support needs were effectively cared for by staff. People's health was seen to improve due to the care and support of staff. One person said, "I had a rash on my back and they treated it". To ensure a good standard of care staff sought support from other health professionals including the GP, psychiatrist, physiotherapist, diabetic nurse, and incontinence specialist. One person said, "If I'm not feeling well the doctor will come to see me." Care plans were constructed with the input from the relevant professional and recorded the advice, guidelines and training required to meet people's needs. Staff were seen to work within the guidelines during our inspection. The care of a person with leg ulcers had an up to date and detailed care-plan. Pictures were taken at regular intervals which showed progress with healing. The daily notes recorded that the wounds were regularly cleansed and dressed. The entries showed the involvement of the tissue viability nurse (TVN), so the person had received appropriate care and support.

Good

Is the service caring?

Our findings

We had positive feedback about the caring nature of the staff. One person said, "They (staff) are very good and nice, they listen and I can approach them." Another person said, "The staff are very pleasant, kind and attentive." A staff member said, "The most important thing is how we look after people, it's the best part of the job."

The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. People looked well cared for, with clean clothes, tidy hair and appropriately dressed for the activities they were doing.

Staff were very caring and attentive with people. They knew the people they looked after and involved them in making decisions about their life. Throughout our inspection staff had positive, warm and professional interactions with people. When a person appeared upset a member of staff got down on their knees and put their arms around them to comfort them. All the care staff were seen to talk to people, asking their opinions and involving them in what was happening around the home.

Staff were knowledgeable about people and their past histories. Throughout the inspection it was evident the staff knew the people they supported well. Staff were able to tell us a lot about the people they supported without access to the care notes, including their hobbies and interests, as well as medical support needs. One staff member said, "You get to know a lot about them and what makes them happy." Care records recorded personal histories, likes and dislikes, and matched with what staff had told us.

Staff communicated effectively with people. When providing support staff checked with the person to see what they wanted. Staff spoke to people in a manner and pace which was appropriate to their levels of understanding and communication needs. People were given information about their care and support in a manner they could understand. Information was available to people around the home. It covered areas such as local events that people may be interested in.

Staff treated people with dignity and respect. One person said, "They do respect our privacy, they talk in our rooms on private matters." Another person said, "Staff are discreet when giving me personal care." When giving personal care staff ensured doors and curtains were closed to protect the people's dignity and privacy. Staff were very caring and attentive throughout the inspection, and involved people in their support. An example was given where a person liked to carry around coins in their pockets. The weight of the coins caused the person's trousers to lower. A solution was found by giving the person a bag to carry their coins, which protected the person's dignity by stopping their trousers lowering. People's independence was also promoted by staff. One staff member said, "We encourage people to do things for themselves, X likes to dress himself, but sometimes he doesn't take care. So we just remind him, and don't do it for him."

People's rooms were personalised which made it individual to the person that lived there. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs, and how the person's care may be affected due to those beliefs. Staff also respected people's faith and supported them

by reading religious texts with people when asked, even though the staff member may not have the same faith. People had access to services in the community and in the home so they could practice their faith. People told us they could have relatives visit when they wanted, or go out on their own or with their relatives if they wished.

Good

Is the service responsive?

Our findings

People told us that they felt their care was responsive to their needs. People's needs had been assessed before they moved into the service to ensure that their needs could be met. People were involved in this process. One person said, "When I came here, they asked me about myself." Another told us, "They did ask me about my past." Assessments contained detailed information about people's care and support needs. Areas covered included eating and drinking, sight, hearing, speech, communication, and their mobility, as well as personal preferences and histories.

People were involved in their care and support planning. Care plans were based on what people wanted from their care and support. One person said, "I have a care plan and we have reviews".
They were written with the person by the nurses or registered manager. Reviews of the care plans were completed regularly with people so they reflected the person's current support needs.

People's choices and preferences were documented and were seen to be met. One person said, "I do have a care plan and I had something changed because I did not agree with the comment." There was detailed information concerning people's likes and dislikes and the delivery of care. The files gave a clear and detailed overview of the person, their life, preferences and support needs for example their activities of daily living such as, health and physical well-being, medication, diet and nutrition, personal care, life choices, spiritual and religious belief, and house hold and domestic tasks they could take part in. However, they were not totally person-centred, as people did not have individual goals or aspirations recorded.

Care plans addressed areas such as how people communicated, and what staff needed to know to communicate with them. Other areas covered included keeping safe in the environment, personal care, mobility support needs, behaviour and emotional needs. The information matched with that recorded in the initial assessments, giving staff the information to be able to care for people. Staff were seen to give care as detailed in the care plans on the day of the inspection.

People had access to a range of activities, some of them based in the community. One person said, "There's a lot to do here". Another person said, "We have activities, a variety of things, there's plenty to suit all." There was an occupational therapist employed to provide activities for people. Most of the activities were group based activities. The home also employed a driver specifically to take people to the local community, or on day trips out. The trips were planned by the staff but showed little choice and participation by the people in where they went.

People had individual activity programs to meet their mental health support needs. One person said, "I do feel my stay here has helped my general improvement." The plans worked by ensuring that people engaged in all the activities of daily living for example having a balance diet, having a good balance between rest/sleep and play, engaging in community activities to keep in touch with the outside world, and reality orientation to keep them in touch with the real world. The plans also encouraged visits with the relatives to keep people in touch with their loved ones. One person confirmed this when they said, "I do get visitors and they can come when they want."

People were supported by staff that listened to and would respond to complaints or comments. All the people we spoke with said they had never had to make a formal complaint. One person said, "I've never needed to make a complaint." People that had asked for something to improve told us this had been done to their satisfaction. There was a complaints policy in place. The policy included clear guidelines, in an easy to read format, on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission. There had been no complaints received at the home since our last visit.

Requires Improvement

Is the service well-led?

Our findings

There was a positive culture within the home between the people that lived here, the staff and the manager. One person said, "The management are good with all the residents." Another person said, "The management runs this place very well." A staff member said, "I love working with these people, that's why I've been here for twenty years," and "The employer is very good and helpful." The registered manager and provider had a good rapport with the people that lived here and knew them as individuals.

Regular monthly and weekly checks on the quality of service provision took place by the registered manager and senior staff. However these had not always been effective at identifying areas for improvement around the home, or that the home was keeping up to date with current best practice. A medicines check had failed to identify that a tablet was missing at the end of a medicine round. When asked, the registered manager was unable to explain the process they would go through to investigate the missing tablet. They were also unable to provide records on how this had been managed in the past. There was a risk to people as no one knew where the medicine had gone. Other areas where the medicine audits had not identified issues was where none medicine items, such as batteries had been stored in medicine cupboards. The home has a medicine policy but this did not have any robust system in place to record, monitor, investigate, share and learn from such incidences.

The environmental audits by the management had not identified that there were no locks on the communal bathrooms doors. This could affect people's privacy and dignity if they chose to use one of these rooms instead of their en-suite toilet. The registered manager explained that there were no locks on the doors due to the possibility of people self-harming, and staff not being able to get to them quickly. The registered manager had not kept up to date with current internal door lock technology that could enable them to be quickly opened in an emergency. They had also not reviewed the practice of not having locks in accordance with people's needs. At the time of our inspection the registered manager had not identified anyone that was at risk of self-harm, so there was no reason why doors could not have locks on them for people's privacy and dignity.

It is recommended that the provider reviews the quality audit systems in use to ensure that they are effective at identifying improvements that may be required to the service people receive.

Records management around the home needed to improve. Although records such as staff training, supervision and daily care notes were in place these were not stored in a way that made it simple to review to ensure appropriate support and care had been given. Staff records were stored individually with no overview document to enable the registered manager to quickly see what training staff had completed, or that supervisions were up to date. Similarly with care records, although the files had all the relevant documents, they were bulky and the documents were not arranged in an orderly manner. There were loose documents that fell out when the files were opened, giving a risk that information would be lost or misplaced. One example care plan recorded that an air mattress was in place for a person who had a pressure sore. When we checked the person's bed had no air-mattress. The registered manager told us, "The person has got better and is mobilizing." In this case the care-plan had not been updated to reflect the

change in the SU's condition.

It is recommended that the provider review the use and storage of records to ensure that they have a good overview of the home with regards to staff training and that care records reflect people's current needs.

Senior managers ensured a good standard of care was given. They were involved in the home because it was a small business with only two care homes. Both the registered manager and the provider had a hands on approach to care and support, and were in the home on a daily basis. They were both in constant contact with the people and the staff, so could see that a good quality of care was being provided in a safe environment. This made him accessible to people and staff, and enabled him to observe care and practice to ensure it met the home's standards.

People were included in how the service was managed. One person said, "We have residents' meetings every six weeks". Another person said, "They (management) are a listening one and they would sort a problem out." People had access to regular house meetings where they could discuss items they would like to buy, any issues they wanted to raise, and what activities they would like to take part in. Minutes of the meetings showed that people had the opportunity to raise any concerns, and were encouraged to tell the staff what needed to be done around the house, or in relation to their care and support needs.

The registered manager also ensured that various groups of people were consulted for feedback to see if the service had met people's needs. This was done annually by the use of a questionnaire. All the responses from the last survey were positive about the home and staff. People who lived here and their families were involved in these questionnaires, which covered all aspects of care and support provided at the home.

Staff felt supported and able to raise any concerns with the manager, or senior management within the provider. One staff member said, "I do like the manager" and "If I had a problem, I'd go to him straight away." Staff understood what whistle blowing was and that this needed to be reported. They knew how to raise concerns they may have about their colleague's practices. Staff told us they had not needed to do this, but felt confident to do so.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know what to do if they had any concerns. They had also completed the Provider Information Return when it was requested, and the information they gave us matched with what we found when we carried out this inspection.