Complete Care Homes Limited

Treetops Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 22 May 2016 and was unannounced.

Treetops Nursing Home is registered to provide accommodation for up to 24 older people some of whom are living with dementia or who have needs associated with mental health. There were 24 people living at the service when we inspected. The service has several communal areas which include a conservatory and bright, airy lounge. It has a lift, and is fully accessible to wheelchairs. It has specialist equipment to assist people with mobility problems and is close to local transport links.

The service has a registered manager. 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.

Medicines were safely handled and risks were well assessed to protect people.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the service. The service had sufficient suitable staff to care for people and staff were safely recruited. The environment was safe for people and monitoring checks were regularly carried out. People were protected by the infection control procedures in the service.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date across a range of relevant areas.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and they understood the principles of the MCA and DoLs. People were protected around their mental capacity.

People's nutrition and hydration needs were met. People enjoyed the meals. Specialist advice around people's health care was sought and followed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had knowledge and understanding of people's needs and worked together well as a team. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed and which were in line with their preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were

kept up to date when needs changed, and people were given opportunities to take part in drawing up their care plans, their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. Everyone we spoke with told us that if they had concerns they were always addressed by the registered manager who responded quickly and kindly.

The service had an effective quality assurance system in place. Treetops Nursing Home was well managed and staff were well supported in their role. The registered manager had a clear understanding of their role. They consulted appropriately with people who lived at the service, people who were important to them, staff and health care professionals, in order to identify required improvements and put these in place. Records around good governance were clear and accurate and led to planned improvements.

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 were protected from the risks of acquiring infection because the service had good infection control policies and procedures and staff acted on these.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people.

Staff involved people in decisions.

Staff had respect for people's privacy and dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported staff to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon

Treetops 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 registered 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 25 May 2016 and was carried out by one adult social care inspector. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. 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. We used the information on the completed PIR to support our judgements and also gathered information we required during the inspection visit.

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

During the inspection visit we spoke with four people who lived at the service, six visitors, four members of care staff including one nurse, the registered manager and deputy manager. After the inspection visit we spoke with four health and social care professionals.

We looked at all areas of the service, including people's bedrooms, when they were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for four members of staff. We also observed the lunchtime experience and interactions between staff and people living at the service.

Good

Is the service safe?

Our findings

People told us that they felt safe at Treetops. One person told us, "I am looked after safely here." Another person said, "They are really gentle when they are moving me. I know I am safe." A visitor told us, "I feel [they] are safe and looked after as a person not a number." Another visitor said, "Yes I can go home feeling confident they are safe." A health care professional told us, "There are a lot of staff around which is nice to see. There are plenty of nurses and carers happy to help." Another health care professional said, "When I went in there was a high presence of staff. The staff member stayed with me throughout my consultation." Another professional said, "Risks are being assessed all the time. They are very aware of the risks involved for people who are living with dementia."

We saw there were safeguarding policies and procedures in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the service procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us they calculated this using the numbers and dependency levels of the people living at the service at any time. Staff told us and we observed that there were sufficient staff on duty to care for people safely with a consideration of skill mix and seniority. The service had a clinical lead in place so that nursing staff had a senior person they could go to for support and advice. The registered manager had considered times of the day such as early mornings when people were being supported to get up, washed and dressed, and early evenings when people may become unsettled due to their condition. At these times there were more staff on duty. A member of staff told us, "We have recognised that some people [become] agitated in the evening so an additional member of staff is working on that shift." Another member of staff told us that when people required one to one attention there were sufficient staff on duty to provide this.

Staff told us that they had time for handover between shifts so that important information about people's care could be shared. One member of staff told us, "We have good detailed handover." The service employed three activities workers whose role was to work exclusively with people to provide stimulation and entertainment.

We looked at the recruitment records for four staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff and that two references were obtained before staff began work. DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. This meant that the service had taken steps to reduce the risk of

employing unsuitable staff.

Care plans identified a person's level of risk and records showed that these were regularly updated to reflect people's changing needs. When they were able to do so, people told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. Risk assessments were proportionate and included information for staff on how to reduce identified risks while avoiding undue restriction. Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the service had an open and positive approach towards managing risk and that management supported and encouraged them to challenge any practice they considered unsafe.

Accidents and incidents were recorded and the registered manager explained that they analysed these for trends so that the risk of further incidents was minimised.

In the Provider Information Record (PIR) the registered manager stated that the service carried out a number of safety checks and audits to the building and grounds. Records confirmed that regular checks took place and that any identified shortfalls were addressed. The environment supported safe movement around the building and there were no obstructions.

The service had a fire risk assessment in place and all firefighting equipment was regularly serviced to ensure it remained safe for use. Each person had a personal emergency evacuation plan (PEEP) which was available on the floor where the person's room was located.

The service handled medicines safely. Solid medicines were dispensed using a monitored dosing system (MDS). MAR charts had a photograph of each person on every individual record. This reduced the risk of medicine administration error. When medicines were administered, the member of staff responsible opened the MDS blister pack only when the person was about to take the medicine. This reduced the risk of cross infection and error. After the medicine was administered the member of staff recorded this immediately. Codes were used appropriately on MAR charts, for example when medicines were refused or destroyed.

Those medicines which were not stored in the MDS and were provided in boxes or bottles were stored in named individual sections of the medicine storage trolleys to reduce the risk of administration errors. All medicines stored in this way were dated on opening and a running stock balance of tablets and fluids was kept so that stocks could be accurately monitored. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their potential for misuse. This meant that people were protected around the management of CDs.

The service had a safe system for returning unused medicines and for the disposal of sharps. Some medicines required refrigeration and these were suitably stored. Records of the fridge temperature and the temperature of the medicines room were kept to ensure the temperature of these was safe for the storage of medicines.

We checked the stocks of some boxed medicines against the MAR charts and these were accurate. We also checked a sample of the MDS blister pack medicines against the MAR charts. These were also accurately recorded with no gaps. We observed part of a medicines round. Medicines were administered safely and signed for immediately following administration. The member of staff we spoke with was knowledgeable about people's medicines and why certain medicines were necessary. Nurses with responsibility for administering medicines had received training. The registered manager carried out regular medicine administration competency observations to ensure nursing staff were following safe medicines practice.

The service had a policy and procedure around medicines which took into account the requirements of the Mental Capacity Act (MCA) (2005).

The medicine handling systems in place meant the service had taken steps to ensure that people were as protected as possible around the way they received their medicines.

We observed that staff wore protective aprons at mealtimes which is good practice and in line with infection prevention and control measures. Staff told us that they had received training in the control of infection during their induction and had received regular updates. They correctly described how to minimise the risk of infection. Staff spoke of the importance of using aprons and gloves and told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. Sanitising gels were available around the service. Bathrooms, toilets and people's individual rooms had wall mounted soap dispensers and paper towels in line with current best practice guidelines. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry was kept separate and laundry was stored in colour coded bags to minimise the risk of cross infection.
The service also employed domestic, laundry and maintenance staff to ensure the building was clean, well maintained and safe.

Good

Is the service effective?

Our findings

People told us that the service supported them with their health care and that they enjoyed the meals. One person told us, "The meals are really good." Another person said, "Snacks and drinks are always available." One visitor said, "The staff are so well trained, they are amazing with people." They added, "Some people can [become distressed] and it is incredible how the staff keep them happy and diffuse situations."

Health care professionals gave positive feedback about how the service met people's health needs. One professional said, "They engage well with us, they refer regularly if they are worried about anyone." Another professional said, "They attend the advice sessions at the hospice," and, "They contact us to discuss the best care for people. They ask for advice and follow it when it is given." Another professional told us, "They are really proactive. They always refer appropriately and I feel we work as a team with the staff here. The communication is very good."

Each member of staff had an induction to the service. Staff confirmed that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the service. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. For example, one member of staff accurately told us about the care a person required including how they should be supported with their medicines, how to support the person to move safely and how other risks should be managed around their care.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they were confident. This was to make sure they understood people's individual needs and how risks were managed.

Staff received a range of training relevant to their role including specially sourced training in areas of care that were specific to the needs of people at the service. The registered manager told us about the training they considered mandatory in the PIR. Staff told us about other additional clinical training such as diabetes care, dementia care, pressure ulcer prevention, tissue viability and palliative care. Training was delivered in a variety of ways according to what was most appropriate. This included e- learning and externally provided face to face training.

Staff told us that they received regular supervision and appraisal. We saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions.

People's need for advocacy involvement was assessed and recorded. The service had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity, and they should support people to make their own decisions.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and waited for a response. Care records also showed that people's consent to care and treatment was sought. Care plans contained instructions on how to look for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. People's choices about their care were recorded for staff to follow.

Decisions which needed to be made in a person's best interests were recorded and evidence was provided that this was carried out with a multidisciplinary team approach as the MCA advises. We spoke with a DoLS assessor who told us that the staff were knowledgeable about each individual they came to assess. All people who lived at the service had been referred to DoLS for an assessment and this was in line with the DoLS assessor's expectation.

We also spoke with an advocate who told us they often worked with people to support them in their decision making and choices. They told us, "I am involved in the decision making process on behalf of a number of people who live at Treetops Nursing Home. A document is placed in the files of people who use me as an advocate, so that they are reminded to involve me when it comes to the care plan review. I find this works well."

The living environment had been organised so that people were supported with their needs for stimulation and activity. One area was decorated with a woodland theme, there were signs to support people to find their way around and there was a board with information for people about which staff were on duty, details about the weather and date.

The service had links with specialists, for example the diabetic care nurse, tissue viability nurse and the speech and language therapy team (SALT). Advice from these specialists was written into care plans and daily notes confirmed that the advice was being followed. This advice helped staff to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person or someone they wished to be involved. One visitor commented that they had been concerned about their relative's weight loss and were reassured by the way the service dealt with this. "The manager knew about it as they had been weighing [my relative] monthly. [My relative] was referred to the right person and then was prescribed fortified meals and quickly improved."

Care plans contained details of how to meet people's clinical care needs. Examples included pressure care, nutrition and fluids, and how to support people to move safely. Risk assessments were in place around clinical care. The service used the malnutrition universal screening tool (MUST) which is a recognised risk assessment tool to determine whether people are at risk of malnutrition. They had scales which could be

used for people who were not in a position to bear their own weight. When these were not suitable, a nurse told us that they used the MUST guidance to measure upper arm circumference.

Food, fluid and turning/ monitoring charts were in place to protect people where necessary. Those we checked were accurately completed with no gaps and reflected the guidance set down in the care plan and risk assessments. This ensured that the registered manager could monitor whether people were receiving appropriate food and drink for their needs.

The service had been awarded a level 5 food hygiene rating by the local council which meant that the level of food hygiene had been assessed as very good.

The service user guide for the service stated that the service provided planned and structured menus which took into account people's preferences, that meals were nutritious, balanced and enriched where required, and menus allowed people to eat in whichever way was easiest or most appropriate for them. Staff confirmed that people were provided with a choice of meals and that meals were adapted to people's needs. For example, some people managed finger foods more easily than meals which required to be eaten with a knife and fork. These were provided so that the person could be as independent as possible. We observed that people were provided with adapted cutlery and crockery where needed and that people were supported to eat however and wherever they were most comfortable.

Snack and drinks were available throughout the day and food such as biscuits, crisps and fruit was available and in sight for people to help themselves at any time.

We observed a lunch time meal where a hot meal was served and appeared of a good quality and quantity. Three care workers were supporting people at this time. This meant that staff were nearby at all times to assist people. The food appeared nutritious, well presented and people were given choices of drinks to have with their meal. Care workers were attentive to people's needs, and sat with them at eye level when they were supporting them with eating. This meant that staff responded to people's needs regarding support whilst eating and drinking.

Care plans contained information about people's food likes and dislikes. Those people we spoke with told us their preferences around food were respected. Allergies in relation to food or drink were also recorded. Specific diets to take account of medical conditions such as diabetes were recorded, and any fortified or prescribed supplements in use. This meant that people's needs in relation to food and drink were assessed and provided for.

Good

Is the service caring?

Our findings

People told us that the staff were kind and considerate. One person said, "The girls are good and I am looked after well. I am glad to be here." One visitor told us, "They are marvellous, they know just how to cope when [my relative] has off days." Another visitor said, "It's like one big family here. Smashing care." Another visitor told us, "The staff are always helpful with getting [my relative] ready when we come to take [them] out," and "The staff are grand and have responded if I need some assistance." A visitor told us, "The way the staff handle my relative is wonderful. I see them treating other people with respect and dignity too."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and listened to their responses. Those people who were in discomfort were attended to with kindness. Staff reassured people where this was appropriate and showed that they were aware of people's likes and dislikes, those people who were important to them and details of their personal history. Examples of positive interactions were staff chatting and laughing with people, sitting quietly with people offering reassuring support, looking through newspapers and magazines with people, and talking with people about activities and plans for the future.

We observed that staff approached people with respect and concern for their dignity. Staff told us that they respected people's right to privacy and dignity and spoke using a kind tone of voice, listened to people and were sure to support people discreetly and in a way which made them feel comfortable. Care plans contained instructions for staff on each person's needs in relation to emotional support.

People were assessed when required, around their need for advocates or Independent Mental Capacity Advocates (IMCAs) so that their voices and wishes could be heard and acted on. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.

The registered manager had organised for people who needed them to have communication aids so that they could make an informed decision about options open to them. This included support to attend sight and hearing tests, and to have dental check-ups. Staff told us they visited people in their own rooms and chatted to them so that they did not feel isolated. We observed that staff did visit people who were being nursed in their rooms in this way.

People were involved in their care plans, and supported to make choices and decisions about their care. Evidence for this was provided in care plan documents and daily notes.

Some people had Advance Plans in place which were well documented. (Advance Plans record people's preferences when they near the end of their lives). Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, and where we saw these they were correctly completed and regularly reviewed.

Staff told us about the way people were cared for in their final days. They emphasised the need for close

liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the service and each other at that difficult time. Care plans included details of who should be involved when a person reached the end of their life and who had lasting power of attorney. Care plans also contained an information pack to support people to make plans and for their families to access the appropriate support when a person reached the end of their life. A palliative care professional told us that the service worked well alongside them to ensure people were supported with their care at the end of their lives and that the service liaised well with them around pain relief and monitoring people's condition.

Good

Is the service responsive?

Our findings

People told us that the service was responsive to their needs. A visitor told us," The staff are very attentive and always address [my relative] by name. They always explain what they are doing [when giving personal care] and are very patient." Another visitor said, "They are focused on [my relative's] care and treat [them] as in individual." Another visitor told us that they liked the way staff had encouraged them to personalise their relative's room with objects and photographs they liked. A health care professional told us, "They know a lot about the residents and know about their life histories."

When people had the capacity to do so, they gave us an account of the care they had agreed to. They told us that staff consulted with them while completing their care plans. Some people or those they wished to act on their behalf had signed their care plans. We saw that care plans were regularly reviewed. It was clear from the records that people had been involved either through signing their care plans, or by staff writing records of what the person had told them. Reviews focused on wellbeing and any improvements which could be made to people's care. Relevant specialists were consulted for advice at these reviews. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care.

People had identified areas of interest, likes, dislikes and preferences within their care plans. People's life histories were recorded with their permission. Plans contained information such as previous occupations, hobbies, family and friendships, spiritual needs, preferred clothing and ways to spend time. Where people did not have the mental capacity to give a view, efforts had been made to consult with others who were important to them, advocates or IMCAs.

Specific staff were employed to engage people in one to one or group activities according to their preference. The service employed three activities workers whose role was to work exclusively with people to provide stimulation and entertainment. People's preferences around daily activities had been recorded and staff told us that they supported people who chose this to go out on outings to places such as the local garden centre, the supermarket, or to a local park. People had the opportunity to attend a 'Singing for the Brain' activity which was specifically designed for people living with dementia and was held in a local church.

We observed a group activity during an afternoon. People were laughing and chatting and clearly enjoying this. Visitors were involved in this activity and staff had created a positive, encouraging atmosphere. The service kept an activities log which gave details of what each person had been doing, whether they enjoyed it and plans for further pastimes. The log included such activities as music, quizzes, reminiscence and hand and eye coordination games such as skittles.

The living environment had been organised so that people were supported with their needs for stimulation and activity. There was a selection of tactile objects for people to use such as mittens with different buttons and textures, hats and jewellery for people to try on, handbags and purses for people to take and use. There was a table containing switches and door handles for people to turn and use as they wished. Staff told us that people enjoyed coming across these objects as they explored the service and that they sometimes

acted as a point of familiar reference for people. In one of the lounges we saw jigsaws, dolls, soft toys and objects to stimulate reminiscence such as posters, newspapers and magazines out on display. People were freely using and engaging with these objects and they were used as points of discussion by staff.

We observed staff encouraged people to chat with them and each other, and they listened to what people had to say, responding to their needs. We observed staff supporting people with looking through magazines. Staff told us that they learned about people through talking with them, reading their history which was kept on the care file, talking to other staff and the nurses and speaking with families.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs. Staff could tell us about people's care needs and how these had changed. Records confirmed this.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw that the service had a complaints procedure and staff told us this was followed. The people we spoke with told us that they were confident that their concerns would be listened to and dealt with courteously. We saw a record of complaints and the outcomes with timescales to monitor how these were managed. When people made a formal complaint the registered manager told us they informed the person of the results of their investigation and consulted the person to check that they were happy with the outcome.

The service had a 'what we could do better' form which some people had completed. The registered manager told us they were planning to log these and provide clearer evidence that concerns raised in this way had been dealt with.

Good

Is the service well-led?

Our findings

People were positive about the registered manager. One person said, "Yes I like [them]." A visitor told us, "I would go to [the registered manager] and would never be afraid to talk with them about anything." Another visitor said, "The staff all mix in and help, that filters down from the management," and, "The manager and deputy are both very approachable."

The service had a registered manager in place. They were supported in their role by deputy staff, a regional manager and by the registered provider of the service. The registered manager told us that the company's senior management offered good support and encouraged them to discuss issues in a positive way.

The registered manager held regular resident and visitors meetings. We saw some sample minutes of these meetings which showed that they were used as opportunities to listen to people's views and to pass on information.

The registered manager carried out a range of audits to ensure that the service provided people with safe and good quality care. These included risk areas such as pressure care, infection control, falls, medicines, accidents, fire, kitchen safety and training. Where shortfalls were identified, an analysis was carried out with actions in place to minimise future risks. Lessons learned and reflections for future learning were recorded for staff discussion in meetings. The registered manager also carried out a daily walk around the building where they identified any issues, and spoke with people and staff. The registered manager told us that this supported them to be more visible around the service and to pick up on things which needed attention.

People and those who were important to them had been surveyed for their views about their care and the registered manager told us that the surveys were analysed and any points for improvement were placed into an action plan.

Staff told us that the manager was open and positive with them, and that they felt supported in their role. They had regular staff meetings which gave them information and guidance to care for the people who lived at the service. Minutes were kept and identified actions were recorded.

People we spoke with told us that the registered manager often stopped for a chat and that they were easy to get along with and helpful.

The registered manager had involved ENRICH in the service. This is the Enabling Research in Care Services initiative which has been set up to improve the lives and health of older people living in care services. Representatives from the initiative visited the service every three months to gather information which was to inform research into improving the quality of care in care settings. The registered manager explained how this benefitted staff as the researchers brought new and thought provoking ideas into the service and encouraged discussion in staff meetings.

The service had an up to date service user guide and statement of purpose which gave useful information to

people who were planning a move into care. Policies and procedures were regularly updated to reflect any changes in legislation and the care given.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the service to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the service, which placed the people at the heart of care.

Notifications had been sent to the Care Quality Commission by the service as required and they also sent notifications to other bodies such as the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous occurrences Regulations (2013) (RIDDOR). This meant that the service provided for external scrutiny of incidents and accidents so that people's wellbeing was protected.