Four Seasons (Bamford) Limited

Botham Hall Care Home

Inspection report

Botham Hall Road
Milnsbridge
Huddersfield
West Yorkshire
HD3 4RJ

Tel: 01484646327

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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 8 December 2015 and was unannounced. We previously inspected the service on 9 September 2013. The service was not in breach of health and social care regulations at that time.

Botham Hall is registered to provide personal care and accommodation for up to 40 older people and people living with dementia. There were 38 people living at the home at the time of the inspection. Accommodation was split over two floors. Eight of the rooms on each floor provided en-suite accommodation and each floor had communal bathrooms, lounge and dining areas.

The service had a registered manager in place. 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.

People told us they felt safe living at Botham Hall Care Home and their family members also said they felt their relatives were safe. Staff had a thorough understanding of safeguarding procedures and staff knew what to do if they thought anyone was at risk of harm or abuse.

We found staff were recruited safely and trained appropriately. There were enough staff to meet people's needs.

Medicines were managed appropriately and staff who were responsible for administering medicines had been trained to do so.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards. We found that staff had a thorough understanding of these safeguards. Authorisation had been appropriately sought when people's freedom or liberty was being restricted.

People were involved in their care planning and people received personalised care that was regularly reviewed.

A caring environment was evident and people's cultural and religious needs were considered. Staff were caring in their approach and there was a positive atmosphere in the home. People's dignity and privacy were respected.

Regular checks and audits took place to try to continually improve the home. The registered manager held regular meetings with staff and with people who lived at the home, and their relatives, with a view to assessing and improving quality.

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.

Robust recruitment practices were followed to ensure that staff were suitable to work in the home.

The environment and premises were well managed and appropriate safety checks took place to ensure people's safety.

Good infection prevention and control measures and cleaning processes were in place.

Is the service effective?

Good

The service was effective.

Staff knew the people who they were supporting well.

Staff were trained in, and had a thorough understanding of, the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People had access to health care services when they needed them.

Is the service caring?

Good

The service was caring.

We observed positive interactions between staff and people who lived at Botham Hall Care Home.

People's privacy and dignity were respected.

The home had received an award for high quality of care provided for people in final years of life. People's end of life wishes were considered and respected.

Is the service responsive?

Good

The home was responsive.

Care plans were detailed and reflected people's preferences and choices and plans were tailored to each individual. This enabled personalised care to be provided by staff.

Care plans were evaluated monthly and people were involved with this.

People's living spaces were personalised to their tastes.

Is the service well-led?

Good

The service was well led.

Staff felt supported by the registered manager.

Communication and sharing of information was good and effective.

Quality assurance systems worked effectively and actions were taken as and when required.

Botham Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8 December 2015 and was unannounced. The inspection was carried out by two adult social care inspectors. Before the inspection we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider had been asked to complete a Provider Information Return (PIR) and had submitted this to us prior to the inspection. 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 also used to assist with the planning of our inspection and to inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with four people who lived at the home, two relatives, a visiting professional, the registered manager and deputy manager and two care staff.

We looked at four people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, with their permission, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

One person we spoke with said, "I feel safe here. I couldn't look after myself so I needed to come here. I like it."

A relative told us, "I can have a good night's sleep knowing [name]'s here." This relative told us they had also spoken with relatives of other people living at the home before deciding whether to choose this home on a permanent basis. We were told that other relatives also felt their family members were safe and well cared for.

The registered manager was clear about safeguarding reporting procedures and was able to outline different types of abuse and the potential signs to look for, which may indicate if someone was at risk of harm or being abused. The registered manager had received training and also attended regular best practice meetings with the local authority. Staff we spoke with also understood how to identify the signs of possible abuse and the procedures to follow if they had any concerns. There was a safeguarding policy and whistleblowing policy in place and staff were aware of these. We saw that coasters were placed on tables throughout the home with details of safeguarding reporting procedures. This meant that people were protected from abuse and improper treatment because staff had received relevant training and the registered provider had robust procedures and processes in place to protect people.

The registered manager told us that risk was managed by assessing risks and putting measures in place to reduce risks, whilst also trying to ensure people maintained their independence. People had access to call bells in their bedrooms and in bathrooms. We saw individual risk assessments were in place, for example in relation to the risk of choking or falling and in relation to moving and handling. A member of staff also told us that risks to people were discussed regularly in 'flash' meetings, which were held two or three times a week with staff and the registered manager. This helped to ensure staff were aware of who was at risk and what actions to take to reduce risks.

We viewed the fire safety records and these showed that regular checks had been completed, for example, in relation to emergency lights, smoke and heat detectors and fire blankets. The fire systems were checked weekly. Fire exits were clearly marked as well as notices showing what action to take on discovering a fire. Fire risk assessments were displayed in the reception area. This helped to ensure people's safety in the home, in the event of an emergency evacuation.

Health and Safety Executive guidance states that if hot water, used for showering or bathing, is above 44°C there is increased risk of serious injury or fatality. Hot water temperature checks were regularly undertaken and these showed that outlets were within safe parameters.

Regular maintenance checks took place, for example in relation to hot surfaces, the nurse call bell system and window restrictors for example. We saw that equipment such as bath hoists had been recently tested and other safety checks such as lift servicing and gas appliance inspections were up to date. This meant that steps had been taken to ensure the premises, and any equipment, were safe.

We saw that, following any accidents or incidents, action was taken. For example, we saw one person had sustained three falls within two weeks. We saw evidence the person had been observed for 24 hours following each fall, preventative measures had been put into place and a referral was made to a falls clinic.

The staff we spoke with told us they felt there were enough staff employed at the home to meet people's needs. The registered manager told us that a dependency tool was used in order to determine the number of staff required. This tool took into account people's needs such as how many staff were required to support each person. We saw the number of staff identified as being required were deployed and we observed people's needs being met.

The registered manager told us they had felt that an additional staff member was required on the night duty rota. The registered manager had raised this in their supervision and this was approved. This additional staff member was being inducted at the time of the inspection. Furthermore, the registered manager told us the skills mix of staff were also considered when staff were deployed. For example, the registered manager ensured newer staff members were working alongside more experienced members of staff. As well as employing a housekeeper and domestic staff, the home employed four activities coordinators. Having dedicated activities coordinators meant that staff at the home were able to continue to deliver care whilst people participated in activities.

We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed and Disclosure and Barring Service (DBS) checks had been carried out. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at whether medicines were managed, stored and administered appropriately and safely. Staff had received specific training in the safe administration of medicines. We saw medicines were stored securely and appropriately. Temperature checks were undertaken twice daily to ensure medicines were being stored at the correct temperature. Medicines were dispensed from packs which clearly indicated dates and times for medicines to be administered and people were assisted to take their medicine safely. We saw the staff member ensured they did not touch the medicines as they dispensed them from the packs. This showed they followed good practice in relation to the storage of medicines and infection prevention and control.

We saw the staff member who was responsible for administering medicines was well organised and had prepared a jug with water and cups in advance. Medicines were placed in separate pots for people to take. The medication administration records (MAR) contained a photograph of each person. This helped to reduce the risk of errors being made.

Some people were prescribed PRN medicine. This is medicine that is taken 'as and when required'. We saw the staff member ask people if they were in pain and whether they needed this medicine at the time. Although the staff member recorded this medicine had been given, they did not record the time it was given. This could increase the risk of people receiving incorrect doses of medicines. We raised this with the registered manager, who advised they would address this.

Some people were prescribed medicine in the form of a cream, which was applied to their skin. This was kept in people's bedrooms and was clearly labelled with the date of opening. Additionally, body maps were used so that it was clear where the cream should be applied. This was good practice and reduced the risk of creams being applied inappropriately.

Staff who administered medicines had their competency checked regularly. We saw this was well organised and the registered manager had devised a list showing when competency assessments were next due. This helped to ensure staff had the skills and knowledge to administer medicines safely.

We saw notices were displayed in bathrooms and adjacent to sinks to highlight effective hand washing procedures. Cleaning schedules were displayed and were completed and up to date. Staff had completed infection prevention and control training and a member of staff was the designated Infection Prevention and Control Champion. This staff member received additional training and attended best practice meetings so they could share their knowledge and maintain good infection control practice. This helped to ensure people were protected from harm by the prevention and control of infection.

Good

Is the service effective?

Our findings

A relative we spoke with told us staff knew their family member well and they were confident that staff were skilled and well trained.

New staff received an induction and we saw evidence that an induction checklist was completed. In addition to this, new staff were allocated an induction mentor and had the opportunity to shadow more experienced staff, whilst being supernumerary to the team, until they felt confident in their role. This helped to ensure new staff developed the necessary skills and were given the support they required. New staff were subject to a probationary period and the registered manager kept this under review.

We saw staff had received up to date training in areas such as basic life support, equality and diversity, fire safety, first aid awareness, food hygiene, moving and handling, The Mental Capacity Act (2005), safeguarding adults and infection prevention and control. Staff also received specific dementia care training and some staff had received training in palliative care and the principles of pain management and depression. Staff demonstrated a good understanding and were able to share their knowledge of dementia care with us. Additionally, the registered manager and some staff had completed 'resident experience' training. This provided staff with a better understanding of the needs of people they supported because staff had experienced what it was like to be supported. This meant the registered manager had taken steps to ensure staff had up to date skills to enable them to provide effective care and support to people.

One member of staff said that, although they had completed their mandatory training, they had not learned as much as they may otherwise have done, because much of the training was completed on-line.

We looked at the training matrix and saw training was well organised and the registered manager had a clear understanding of which staff had undertaken which training and when this was due for renewal. This showed measures were in place to enable staff to receive appropriate training at regular intervals.

The registered manager told us staff had supervision bi-monthly as well as an annual appraisal of their performance. Supervisions and appraisals were well organised and the registered manager had a clear plan of when they would take place. We saw minutes of supervision and items discussed included caring skills and competence, communication, attitude, professionalism and general conduct. This showed that staff were receiving regular management supervision to monitor their performance and development needs.

The registered manager had sought best practice guidance in relation to care and the environment at Botham Hall Care Home. The service had achieved recognition for, 'Passion and commitment shown by the staff team. Person-centred care is clearly embedded within the home.' This had been awarded from the Positively Enriching And enhancing Residents' Lives (Pearl) programme for their dementia care. The PEARL programme is an accreditation programme specifically designed by the provider, Four Seasons Health Care, to ensure up to date training, communication and interventions for people with dementia are provided. The PEARL programme had resulted in the service making changes to the environment, for example, in relation to signage, colours, different coloured crockery and acquiring rummage boxes; all of which enhanced the

lives of people living with dementia.

People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. We saw there were some orientation boards on display. Additionally, pictorial signage was used to help people to find bathrooms and shower rooms for example. People's bedroom doors were also personalised, including pictures.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

The registered manager and staff had received training in relation to MCA and DoLS and they demonstrated a good understanding of the associated principles. Applications had been submitted and approved by the local authority to ensure the rights of people who were being deprived of their liberty were protected. The registered manager had ensured staff were aware of which people had their DoLS application approved and the staff we spoke with confirmed this.

Consent was sought, for example in relation to people's care plans and whether they agreed to have photographs taken. In the care records we sampled this was clearly documented and signed by the person, or their representative. Where people lacked capacity, mental capacity assessments indicated this, following the principles of the Mental Capacity Act 2005 (MCA). Where people did not lack capacity, this was also clearly documented. In a care plan we looked at, we saw it stated, '[name] has capacity to make complex and non-complex decisions.' This helped to ensure that people's rights were protected, in accordance with the principles of the MCA.

We observed a lunchtime dining experience. We saw tables were set with condiments, flower displays, cutlery, glasses and tablecloths. Food was served from a hot trolley that was in the corridor outside of the dining room. Food was served onto plates in the corridor and taken to people at the table. People were offered a choice of drinks and asked what they would like to eat. However, we did not hear anyone being asked what vegetables they would like with their meat or whether they would like gravy. This was poured onto every plate and this meant people could not choose whether or how much gravy to have. We shared this with the registered manager who was responsive and agreed to give this consideration.

There was a pleasant atmosphere and people chatted and some people sang in between courses. We could hear appropriate banter and laughing between staff and people. We heard people being respectfully encouraged to eat more.

People were given a choice of two meals from the menu and the registered manager told us people were able to make an alternative choice if they wished. One person told us, "The food's okay." We heard good communication between care staff and catering staff, to ensure people's dietary needs were met, for example, if people wanted their food saving for later. We saw the minutes from a residents' meeting stated, '[Name] said the food was excellent.' A feedback form that one person had completed stated, 'Am a fussy

eater but there is always something they can do for me, asking me what I would like and I am happy at mealtimes.' We observed a person being served two eggs and beans, which was not on the menu, at their request. We saw people being encouraged to drink throughout the day and there was a bowl containing fresh fruit available for people. This helped to ensure people's nutritional and hydration needs were met.

People had access to health care and we saw that referrals were made to other agencies or professionals. For example, we saw referrals to an optician, general practitioner, chiropodist and falls clinic. This showed people using the service received additional support when required for meeting their care and treatment needs.

We found the environment to be clean, airy and odour free. There were two lounges and each was divided into two distinct areas; one with a television and another, quieter area. This helped to facilitate social interaction. There were pictures and displays and quotes on walls which gave Botham Hall Care Home a real homely feel. Corridors had 'rest areas' with benches and items of interests. There were items relating to bygone years, particularly in relation to the vicinity of the home such as books, pictures and sports teams of the area. We saw some minutes from a relatives' meeting which stated, in relation to the rest areas, 'Everybody commented on how they have noticed how more sociable the residents are since they were introduced.'

Good

Is the service caring?

Our findings

A person we spoke with said, "Staff are kind. They have a tough job you know, but they do it well."

We saw there were posters displayed around the home, highlighting advocacy services available. An advocate is a person who is able to speak on other people's behalf, when they may not be able to do so for themselves.

We observed a person being assisted to move and transfer with the use of a hoist. Staff spoke with the person and reassured them throughout, using phrases such as, "Up we go. You're alright. Going down now [name]." Staff protected the person's dignity by discreetly pulling their jumper down, as it began to ride up slightly. We saw staff stroked the person's arm in a natural, caring and reassuring manner.

Throughout the home and many times during the day, we observed carers interact with people whilst offering care and support. Singing, laughing and chatting could be heard and we observed staff use appropriate touch to reassure people. This demonstrated a caring service that was not task-led.

We observed a person who was seated in a position that may have made them uncomfortable after a period of time. A carer discreetly asked the person to sit up and they patiently assisted the person to do so. The carer advised the person they would, "get a stiff neck," if they stayed in their current position. This showed that carers had an awareness of people's needs and were able to offer support to make people comfortable.

We asked the registered manager how they knew whether staff were caring. We were told the registered manager worked, 'on the floor,' with staff. Staff confirmed this was the case.

People had their religious needs met and they received support to enable them to practise their faith. Regular faith services were held at the home. Consideration was given to people's spiritual and cultural needs in their care planning. We saw one care plan stated, 'Ask me if I want to see the priest when he comes.'

People were able to keep their possessions secure and they had a key to their room, if they wished to have one. Where people lacked capacity, an assessment had been undertaken and a decision made in their best interest regarding whether it would be appropriate to have a key to their room. This showed that people's privacy and security had been considered.

Staff had a good understanding of privacy and dignity and staff told us they protected people's privacy and dignity by ensuring that doors and curtains were closed when people were being assisted with personal care. Staff also told us they would always be discreet with people when they were asking if people would like assistance with personal care. We observed this in practice.

The registered manager told us their aim was for the home to be homely, friendly, caring and safe with a variety of activities. We observed this to be the case during our inspection.

The home had achieved a Recognition Of Care and Kindness (ROCK) award during 2015, which was awarded to all staff at the home, from the Chief Executive Officer of the provider company. Additionally the home had achieved a Commend Quality Hallmark Award for, 'High quality of care provided for people in final years of life.'

The registered manager told us end of life wishes were discussed with people and their wishes were documented in their care plan. We saw that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were also recorded and kept in care plans. This showed that people's wishes, in relation to the end of their life, were considered.

Good

Is the service responsive?

Our findings

We looked at some feedback responses from people who lived at the home. The feedback from one person, when they were asked whether staff treated them as an individual, was, 'Treated like a queen.'

We saw people were involved in their care planning and one relative told us they had been involved in the care planning for their family member and had been asked for their views.

We looked at four people's care files. The files were person centred and contained a photograph of the person and detailed information such as the person's preferences, things that were important to the person, significant events that the person liked to talk about, how best to support the person, important memories, relationships and cultural needs.

The level of detail included in care plans meant people received care and support that was person centred. For example, information included, 'I like to go to bed between 9pm and 10.30pm,' and, 'I like both baths and showers. I like to choose each time,' and 'If I am stressed or tired, having my hair brushed helps me to relax.' Another care plan stated '[Name] is likely to respond to bodily sensation and will enjoy tactile activities.' Another stated, 'Talk to me if I talk to you,' and, 'I like to sit on the benches and watch what is going on.' We also looked at a care plan for a person who had been admitted to the home only four days prior to our inspection. We saw this care plan was also fully completed, consent having been sought from the person and their family and the plan contained comprehensive information regarding the support the person required. Staff we spoke with told us they had the opportunity to read people's care plans. This helped to ensure people received care and treatment that was personalised and specifically for them.

Each file we sampled contained a detailed plan of support the person required. The plans included information regarding consent and capacity, medication, mobility, nutrition, continence needs and personal hygiene, psychological needs and communication. Care plans included daily notes and these were completed twice a day. Information such as activities, mood, and personal care assistance was included. This meant staff could share important information and this could be used when evaluating care planning.

The registered manager told us care plans were evaluated every month, or sooner if people's needs changed and we saw evidence this was the case. Care plans were written with the involvement of the person, and their family if appropriate, and reviews also took place with their involvement. For example, in one of the care plans we looked at we saw the person had been asked what level of support they wished for in relation to medicines. We also saw people were asked whether they would like a key to their room and whether they would prefer their doors to be locked or unlocked. This showed that people were involved in their care planning and changes to people's needs were evaluated regularly.

With permission we looked in some people's bedrooms and could see they were personalised to the individual, reflecting their own interests. We saw one person's room had religious symbols on display, relevant to the person's faith. People had their own personal and sentimental items on display. Bedroom doors had names displayed on them.

Each person's bedroom on the first floor, where people were predominantly living with dementia, had a short life history of the person displayed on their wall. This would enable staff to better engage with the person and offer personalised support.

The first floor of the home provided accommodation for people who were living with dementia. One relative told us they were particularly happy because the registered manager had given consideration to which part of the home would best suit their family member. This showed that the home was flexible in meeting people's care needs.

There was an activities plan and this was flexible according to what people wanted to do. People's likes and dislikes were documented in their care plans. Daily newspapers were delivered for people who wanted this. Activities included pet therapy, arts and crafts, chair exercises, ball games and bingo. We saw minutes from a resident meeting and these stated, 'Everyone said they were happy with the activities in the home.' As well as the structured activities we saw people chatting, singing, looking at books and newspapers and watching television. A member of staff had accompanied a person outside for, 'A stroll,' and we saw a carer assisting a person with the jewellery they had chosen to wear. A Christmas Fayre was being held the day after the inspection involving people, staff, relatives and visitors.

The registered manager told us friends and relatives were able to visit the home whenever they wished. They were welcome to stay and eat meals and the registered manager told us some people chose to stay all day.

The complaints procedure was displayed and there was an electronic feedback station in the reception area. The information from this feedback was sent electronically to the registered manager so that any necessary actions could be taken.

Good

Is the service well-led?

Our findings

The home had a registered manager in post, who was registered with the Care Quality Commission and had been managing the home since 2000.

The registered manager had due regard for the duty of candour, which meant they acted in an open and transparent way. The most recent inspection ratings, infection control report and food hygiene ratings were displayed and shared on the noticeboard for anyone who wished to see them. We saw a notice displayed on the entrance to the home, stating, '[name of registered manager] is available at all times.'

Service user guides were on display, which included information in relation to administration, fees, how to complain, staffing, safety and the care philosophy of the home. This demonstrated the registered provider was open and transparent about the service it provided and what could be expected.

The staff we spoke with told us they felt supported by the registered manager and the deputy manager. Staff felt the registered manager was very approachable and good at sharing information. One member of staff told us, "anything [the registered manager] knows, we know." Another staff member said they felt confident they were learning how to do things properly from the deputy manager. They told us they felt they were part of a supportive team. Staff also said they would feel confident to raise any issues with the registered manager, for example if they had any concerns about their colleagues. The registered manager explained there was an 'employee of the month,' award. An employee was nominated by the registered manager each month. The employee received recognition for their good practice or for going 'above and beyond,' their duties. A token gift was offered to the employee. This contributed towards staff feeling valued and supported.

The registered manager told us they also felt supported in their role by the senior leadership team and said, "I have more support now than I have ever had." Additionally the registered manager had peer support from other home managers.

We were told by the registered manager they were, 'hands on,' and they assisted with caring duties, cooking or domestic duties if required. Staff we spoke with also confirmed this to be the case. We were told the registered manager had a clear understanding of people's care needs. A member of staff told us, "I've never met a manager so hands on."

Staff meetings were held every two months. In addition to this, the registered manager held, 'flash meetings,' with staff if the need arose. We looked at the minutes from staff meetings and saw that issues such as laundry arrangements, staff cover, ideas for improvements and care files were discussed. We saw relevant staff were reminded of the procedures in relation to medicines management. The minutes stated, 'Asked if anyone had any concerns about the home or just anything in general. No-one had.' Staff meetings are an important part of the registered manager's responsibility in monitoring the service and coming to an informed view regarding the standard of care and treatment for people living at the home.

We also saw resident and relatives' meetings were held monthly. Discussion took place regarding activities, food and laundry for example. We saw many positive comments in the minutes from these meetings. For example, '[Name] has never been as happy as [name] is at Botham Hall,' and, 'All residents were happy with the standard of cleaning and all said the home smells lovely.' We saw that action had resulted from suggestions from residents. For example we saw in one meeting there was a request for more seasonal new potatoes to be included on the menu. Minutes from a subsequent meeting stated, 'It was nice that we have new potatoes rather than mash.' This showed the views of people living at the home were sought and acted upon.

The home had shared with us, prior to the inspection through their provider information return (PIR), that they had a Quality of Life programme, which enabled the registered manager and registered provider to respond to feedback from residents, relatives and visiting professionals in a timely manner. We saw this during our inspection. The registered manager completed a daily walk around the home. Checks were made in areas such as cleanliness for example. The registered manager used this opportunity to proactively seek feedback from people who lived at the home. People were asked questions such as, 'do you feel safe,' and, 'are you involved in decisions,' and, 'Do you feel respected?' All 21 respondents who were asked these questions during the month prior to the inspection stated, 'Yes.'

The feedback received was linked into an electronic system that the registered manager would then action, if required. Any actions that were outstanding would be highlighted to the senior leadership team so they could take action if necessary. This demonstrated the registered provider had been proactive in obtaining people's views and that systems were in place to monitor and assess the quality of service. It is important to obtain feedback from people because this can be used to drive improvements.

Monthly quality and clinical governance meetings were held. This provided a forum for the registered manager to discuss issues such as safeguarding, infection prevention and control, care policies and procedures. Additionally, regular audits took place, for example in relation to medication, care plans and fire safety. The frequency of checks and audits were clearly identifiable and the dates were pre-printed in the record sheets so it was clear if there were any missed checks. We saw that, where actions were identified, these were resolved. For example, the checks for October noted the fire doors were not closing properly. This was actioned and it was recorded that the work had been completed. This further demonstrated that systems and processes were in place, such as regular audits, to assess, monitor and improve the quality of service.

We looked at different policies and procedures and found these were in place in relation to management of feedback (complaints, concerns and compliments), infection control, mental capacity, management of medicines, whistleblowing and safeguarding adults for example. We saw policies were regularly reviewed and were up to date. This helped to ensure staff were following the most up to date guidance and procedures to help support people and keep them safe.

We saw the home had formed links with the local community. For example, the home held a bi-monthly coffee morning and faith leaders came regularly to the home to hold services. Carol singers from the local school had recently visited the home, prior to our inspection.