Mrs Susan Brand & Mr Lloyd Brand

Pembroke Lodge Rest Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 09 and 10 December 2014 and was unannounced.

Pembroke Lodge Rest Home provides personal care and support for up to 19 people. Nursing care is not provided. Care is provided to older people, who may be living with a variety of conditions including diabetes, sensory impairment, risk of falls and long term healthcare needs for long term or respite care. There were 14 people living in the service on the day of our inspection. This was a busy time as another of the provider's services had just been closed and there were a number of new people who had just moved from this service into Pembroke Lodge Rest Home and were settling in. Additionally there were a number of staff who had been redeployed from the other service, and were busy being inducted into working at Pembroke Lodge Rest Home and getting to know all the people living in the service and the new staff team.

The service had a registered manager, who was also one of the owners and who was present for part of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

There were systems in place to assess and manage risks and to provide safe and effective care.People had a range of risk assessments completed. However, we found that in some instances these had not been completed accurately or did not detail actions in place to minimise the risk. We have asked the provider to make improvements.

Staff had received training and guidance in the Mental capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 sets out how to act to support people who do not have capacity to make a specific decision. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 to make sure that people living in a care home are looked after in a way that does not inappropriately restrict their freedom. Current information and guidance had been sought. However, the provider had not ensured staff had adequate policies and procedures in place to inform staff of the procedures they were expected to follow to ensure continuity, with a review process to ensure guidance was updated to detail current legal requirements. We recommend the provider to make improvements to the policies and procedures specific to the service.

People's individual care and support needs had been assessed. Care and support provided was personalised and based on the identified needs of each individual. People's care and support plans were detailed and reviewed regularly.

People had access to healthcare professionals, including their GP and district nursing team, staff from the falls advisory service and the older people's mental health team. All appointments with, or visits by, health care professionals were recorded in individual care plans. People told us they had felt involved and listened to. One person told us, "I think it's an excellent place."

People were treated with respect and dignity by the staff. They were spoken with and supported in a sensitive, respectful and professional manner.

People told us they felt safe. They knew who they could talk with if they had any concerns. They felt it was somewhere where they could raise concerns and they would be listened to. We recommend that the complaints procedure be developed to include information on who can be contacted if people need further guidance and support.

People said the food was good and plentiful. Staff demonstrated an awareness of individual's dietary requirements, and people were regularly consulted about their food preferences.

There were sufficient numbers of suitable staff to keep people safe and meet their care and support needs. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively.

Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They confirmed that they felt valued and supported by the registered manager, who they described as very approachable.

People were asked to complete satisfaction questionnaires, and had the opportunity to attend residents meetings.

A range of internal audits were completed to review the quality of the care provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. However, not all the risks had been identified or correctly recorded to ensure people continued to be safe.

There were sufficient staff numbers to meet people's personal care needs.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

People were protected from abuse and avoidable harm.

Medicines were stored appropriately and there were systems in place to manage medicine safely.

Is the service effective?

Good

The service was effective. Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people in the decision making process if someone lacked capacity to make a decision.

Staff had a good understanding of peoples care and support needs. Communication systems in the service worked well and ensured that staff were made aware of people's current care and support needs.

People were supported by staff that had the necessary skills and knowledge. Staff had up-to-date training and regular supervision and appraisal.

People's nutritional needs were assessed and recorded. People were consulted with about their food preferences throughout the day and were given choices to select from.

Is the service caring?

Good

The service was caring. Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

Staff were mindful of people's privacy and dignity when supporting them with personal care.

Is the service responsive?

Good

The service was responsive. People had been assessed and their care and support needs identified, and these had then been regularly reviewed and

Summary of findings

changing needs were responded to. The views of people were welcomed through residents meetings and the completion of quality assurance questionnaires. Information received informed changes and improvements to service provision.

People's individual care and support needs were regularly assessed. People had access to health care professionals when they needed it.

People had been consulted with as to what activities they would like to be run in the service.

A complaints procedure was in place. People were comfortable talking with the staff, and visitors told us they knew how to make a complaint if necessary. No complaints had been raised in 2014.

Is the service well-led?

Good

Systems were in place to audit and quality assure the care provided.

There was a registered manager in post, who was supported by a team of senior staff. The leadership and management promoted a caring and inclusive culture.

Staff told us the management and leadership of the service was approachable and very supportive. There was a clear vision and values for the service, which staff promoted.

People were able to give their feedback or make suggestions on how to improve the service, and this was acted upon.

Pembroke Lodge Rest 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 checked 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 09 and 10 December 2014 and was unannounced. The inspection team consisted of an inspector, a specialist advisor and an expert-by-experience, who had experience of older people's care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications and complaints we have received. (A notification is information about important events which the service is required to send us by law.) 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. This enabled us to ensure we were addressing potential areas of concern. We telephoned the local authority commissioning team, and three health care professionals from the district nursing service, the older people's mental health team and the falls advisory service to ask them about their experiences of the service provided.

During the inspection, we spoke with eight people and three visitors who were friends or relatives. We spoke with the registered manager, the operations manager, the care manager/deputy manager, four care workers, the domestic assistant and the chef. We observed care and support provided in the communal areas, the mealtime experience over lunchtime, we sat in on one of the social activities and a staff handover between staff shifts. We observed a medicines being given to people and looked around the service in general including the communal areas, a sample of people's bedrooms, and the main kitchen. As part of our inspection we looked in detail at four people's care and support, and we reviewed their care and support plans. We looked at menus and records of meals provided, medication administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and two staff recruitment records. We also looked at the provider's quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt happy and were well treated in Pembroke Lodge Rest Home. During our inspection we spent time in the communal areas with people and staff. We saw people were comfortable with staff and frequently engaged in friendly conversation. Although people told us they felt safe, we found areas of practice which did not fully protect people.

People were supported to live autonomous independent lives. People had individual assessments of potential risks to their health and welfare and these were reviewed regularly. Where risks were identified, staff were given guidance about how these should be managed. However, although staff could tell us what was in place to protect people who went out of the service on their own, the actions for care staff to follow to minimise any risk had not been recorded in their care and support plans. As new staff started work in the service there was a risk of a lack of consistency in the support provided to ensure people's safety when going out of the service. People had a risk assessment completed in relation to their skin integrity. Not all the risk assessments we looked at had been correctly completed. This meant the outcome at the end of the assessment was not correct and could put people at a lower risk of skin damage than they should have been. Therefore staff did not have all the information they needed and were not fully aware of the appropriate care to provide.

People identified at risk of developing pressure ulcers had air mattresses to minimise the risk. These had been regularly checked and settings recorded to ensure they were maintained to meet people's individual assessed needs. Staff also told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed.

Radiators were in the process of having a guard fitted. Where the last radiators had not yet been guarded a risk assessment had not been carried out and recorded to ensure any potential risks had been identified and minimised. However risk assessments were subsequently undertaken and copies provided to the CQC after the inspection. The environment was clean and allowed people to move around freely without risk of harm. Staff told us about the regular checks and audits which had been completed in relation to fire, health and safety and infection control. Records confirmed these checks had been completed. Contingency plans were in place to respond to any emergencies, flood or fire. Staff told us they had completed health and safety training and so were aware of what to do in an emergency. There was an emergency on call rota of senior staff available for staff to contact for help and support.

Senior staff told us how staffing was managed to make sure people were kept safe. A formal dependency scoring tool, which had a formula for staff to follow to match the staffing levels to people's assessed care needs was used. The care manager demonstrated she knew the people well. She told us she monitored people's dependency and people's care needs were regularly reviewed. We looked at the staff duty rota, which detailed people's role and when they would be working in the service.

Detailed on the staff rota on a Saturday there was effectively a decrease in the number of care staff on duty as the care manager was on duty with only one care worker, and was also covering the cooking duties on that day. We discussed this with care staff to ascertain how this worked in practice, and found people were at risk of not receiving all the care they needed particularly with the recent increase in the number of people living in the service. We also discussed this with the registered manager who reviewed the staff duty rota and deployment of staff during the inspection. A new staff rota was written to commence that weekend, and a further member of care staff was put on the rota to be on duty on Saturday. At the time of the inspection there was adequate staff on duty to meet people's care needs. The care manager was on duty and there were two care staff working during the day, with a waking night care worker on duty at night. Detailed duties to be completed at night had been written for care staff to follow, which included two hourly checks of people and the building was recorded for staff to follow. They were supported by ancillary staff who covered domestic, administrative and catering duties in the service. Staff told us there was adequate staff on duty to meet people's care needs, and minimum staffing levels were maintained. Staff absences were usually covered by existing staff who knew people well and not by agency staff. They also spoke of good team spirit and that the team worked well together. Redeployed staff were being inducted into working in the service and had not been fully integrated into the rota.

Requires Improvement

Is the service safe?

A call bell facility was available throughout the service. People told us they had a prompt response when they used the call bells for assistance. One person told us, “They come quickly.” Another person told us, “They are quick.” Visitors told us their experience was there were always enough staff on duty to meet people’s needs. On the day of our inspection there were sufficient staff on duty to meet the needs of the people living in the service. Staff had time to spend talking with people and support them in an unrushed manner. Staff had time to spend talking with people and support them in an unrushed manner. Accidents and incidents records had been audited. This was so senior staff could see if there were trends or repeated accidents which could be used to inform the staffing levels provided.

Medicines were stored correctly and there were systems to manage medicine safely. Audits were completed to ensure people received their medicines as prescribed. People who wished to were supported to manage their own medicines and keep their independence, using a risk management assessment. Care staff told us they had received medication training, and they were aware of the procedures to follow in the service. The dispensing pharmacist was also available for guidance and support and had also undertaken an audit in 2014. The recommendation made following the audit of regularly checking the temperature of the fridge where medication was kept had been actioned.

Senior staff told us they followed the local multi-agency policies and procedures for the protection of adults. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. They had received safeguarding training which had been recently updated. It was clear staff understood their own responsibilities to keep people safe from harm or abuse. They had a good understanding of the types of abuse and who they would report any suspicions or concerns to. We talked with staff about how they would raise concerns of any risks to people and poor practice in the service. Staff were clear about their role and responsibilities and how to identify, prevent and report abuse. Staff told us they were aware of the whistleblowing procedure and they would use this to report any concerns they had about care practices. People had also been made aware of the policies followed. Safeguarding had been a topic discussed at a recent residents meeting, where it was explained how staff were trained to keep people safe and the whistleblowing procedures that could be followed.

People were cared for by staff who had been recruited through safe procedures and to ensure their suitability to work with older people. Each member of staff had completed an application form, been interviewed, had two written references requested and undergone a criminal records check before starting work. Two new care staff were able to confirm the process was followed. The provider ensured as far possible that they only employed staff who were suitable to work and safeguard adults.

Good

Is the service effective?

Our findings

People told us they felt the care was good, and staff were knowledgeable and understood their care needs. They told us their preferences and choices for care and support were met. Where possible they were involved in decisions about their care and were kept informed of any changes to their care and support plans or medication. One person commented, “Staff are lovely they must be handpicked. I am very lucky to be in the home.”

Staff monitored people’s health and wellbeing on a daily basis. The service had a communications book which recorded any input, advice or guidance from a visiting healthcare professional, if the person looked unwell or if urgent medical care was required. People were supported to access healthcare services if they had an appointment or they had become unwell during their stay. Care staff worked effectively and were pro-active in referring people for diagnosis and treatment. One person told us, “If you are not well they call your own doctor in.” Appointments with, or visits by health care professionals and guidance to be followed were recorded. People received necessary medical treatment, care or advice promptly. The three healthcare professionals confirmed this. They felt staff had called them for support and guidance in an appropriate and timely manner and any guidance they gave had been followed.

Staff had received or were due to attend training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood the importance of gaining consent from people before delivering care and respecting people’s decisions if they refused, declined any care or treatment. Senior staff were aware of who to contact if people lacked capacity to make decisions for guidance and support. Current information and guidance had been sought. A policy specific to the service for staff to follow in relation to MCA and DoLs had been written. However, this was limited in content.**We recommend the provider develops the policy and procedure, to ensure that all staff were fully aware of the provider's expectations of the procedures to be followed.**

Staff told us that the team worked well together and that communication was good. People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. People were encouraged to have their weight monitored regularly and there were clear procedures in place regarding the actions to be taken if there were concerns about a person’s weight. Staff told us they checked the care and support plans regularly to update themselves with any changes to each person’s care. They used shift handovers, and the communications book to share and update themselves of any changes in people’s care. One member of staff told us the handovers were, “The most important and useful part of the day.“ Care staff were reading and updating people’s care and support plans during the day. We sat in on a staff handover in which care staff demonstrated a good knowledge of people and their individual care needs and likes and dislikes.

We found people were supported by staff that had the knowledge and skills necessary to carry out their roles effectively. Staff were aware of their roles and responsibilities. The provider had an on-going schedule of essential training for staff to ensure they had the skills to prove care to older people. Staff told us that all new staff initially “shadowed” more experienced colleagues, when supporting people. Two new care workers confirmed that when they started they had an induction and worked closely alongside more experienced colleagues. They told us this had provided the support and information they needed to provide care to older people and meet the care needs of people living in the service. Records we looked at confirmed this. They said they had been introduced to people and their individual care needs and routines had been explained, as part of their induction programme. One senior care worker told us of how they ‘buddied’ new care workers as part of their induction. Staff told us they received training and refresher training, and had supervision and an appraisal completed where staff had worked longer in the service. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff commented they felt sufficiently trained and spoke positively of the training opportunities essential in meeting the needs of older people. Staff had received a range of training which included moving and handling, safeguarding, infection control, fire training, first aid health and safety and food hygiene. They had also completed training in dementia awareness so they would have the information and skills should people’s care needs change.

People told us the food was good and they had plenty to eat and drink. One person commented, “I like the food

Good

Is the service effective?

here." Another person told us, "So far the food has been good." Another person told us, "The food is excellent." People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions process. The records were maintained to detail what people ate. There was a weekly seasonally changed menu, and further alternatives were available if people did not want the main meal provided. Minutes of the residents meetings confirmed people had been asked for feedback on the meals provided and for suggestions for new dishes to go on the menu. Quality assurance audits had also been completed for further feedback on the catering arrangements in the service. People had a copy of the menu, and the menu was displayed in lounge area and showed people the options available that day. Some people had specific dietary requirements either related to their health needs or their preference and these were detailed in their care plans. These were followed by the chef who also had lists of people's dietary needs, allergies and preferences to ensure that appropriate meals were provided. We spoke with people and looked in detail at the care plan and observed the care provided where people were diabetic, and found their care needs had been met.

People were invited to go down to the communal area prior to lunch to socialise and have sherry or a soft drink. The atmosphere was relaxed during lunchtime in the dining room and people were chatting throughout the meal. Staff assisted people in a respectful way encouraging when needed, but promoting independence whenever possible. Some people had chosen to eat their meal in their own room. Staff monitored people's nutritional intake and recorded if people refused, declined or did not eat any meals. Drinks and snacks were available for people to have throughout the day and night. Care staff were regularly checking with people if they would like a drink or a snack, and discussing their choices with them. The dining area had tea and coffee making facilities for people and there were cold drinks available in the communal area.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their visitors stated they were satisfied with the care and support people had received. People told us they were happy and they liked the staff. One person commented, “Nice crowd we have here.” During our inspection we spent time in the communal areas with people and staff. People were comfortable with staff and were frequently engaged in friendly conversation.

Staff ensured they asked people if they were happy to have any care or support provided. Staff provided care in a kind, compassionate and sensitive way. Staff responded to people politely, giving them time to respond and asking what they wanted to do and giving choices. We heard staff explaining options to people and were attentive and listening to them. One member of staff told us, “It’s up to us to be friendly and engaging and give them options.” There was a close and supportive relationship between them. People looked comfortable and well cared for.

Maintaining independence was promoted within the service and staff understood the principles of supporting people to be as independent as possible. Care provided met peoples individual needs. Staff spoke about the people they supported fondly and with interest. Further information on people’s personal life histories were starting to be gathered and recorded in their care files; there was information about their likes, dislikes and the type of activities they enjoyed. Staff were able to tell us how they could meet people’s different cultural and religious needs if this was needed. For example, how specific dietary needs could and had been arranged to meet individual preferences.

Staff spoke positively about the standard of care provided and the approach of the staff working in the service. Care staff talked about a stable, caring and committed staff group. One member of staff told us, “I feel it is a truly loving home.” Another told us, “I love it here.” People were supported to be as independent as possible. They decided where they wanted to be in the service, what they wanted to do, and decided when to spend time alone and when they wanted to chat with other people or staff. People were involved in making day to day decisions about their lives. For example we saw people deciding what they wanted to eat for their meal. One person told us, she was a free agent to move around and do as she pleased. She went out in the garden daily for air and enjoyed sitting out when the weather was fine. All the people had family or representatives to support them. The care manager was aware how to access advocacy services should this be required.

People told us they were respected and their privacy and dignity considered when care was provided. One person told us, “Yes certainly. Another told us staff were, “They are very polite.” People were addressed according to their preference and this was mostly their first name. People had their own bedroom and ensuite facility with a television for comfort and privacy. They had been able to bring in items from home to make their stay more comfortable. People had the opportunity to take advantage of the communal areas for social interaction. People had their care provided in a professional and discreet way. Care staff told us how they were mindful of people’s privacy and dignity when supporting them with personal care. They were able to tell us of examples of ways they ensured people’s privacy and dignity. One care staff told us, “I knock on the door and wait for a response, then discreetly go in to ensure they are decent. The door is not open when personal care is provided. It’s their home and personal space.” The care manager asked people who had come downstairs for a religious ceremony that was held in the communal area where they would like to take their medicines. Would they prefer to stay downstairs or go back to the privacy of their room.

Good

Is the service responsive?

Our findings

People were involved in making decisions about their care wherever possible. People told us they received care, support and treatment when they required it. People and visiting relatives said staff listened to them and were responsive to their needs. People were listened to and enabled to make choices about their care and treatment. One person told us, "They are very good." Another person told us that the staff were good and caring and pleasant. What he asked them to do, they do it.

A new more detailed pre-admission assessment had been drawn up and used for any potential new people wanting to move into the service. This identified the care and support people required to ensure their safety. All the new people who had recently moved into the service had an assessment completed. This information was then be used to inform then care and support plans. Care staff told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning and in the regular review of people's care needs. The care and support plans were detailed and contained clear instructions about the care and support needs of the individual. Individual risk assessments including falls, nutrition, pressure area care and manual handling had been completed. There were instructions for staff on how to provide support tailored and specific to the needs of each person. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the falls advisory team. During our discussions with staff we found that they knew people and their individual needs and it was evident that they knew them well. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans.

Records of residents meetings and quality assurance questionnaires completed confirmed that people had been asked for their views and ideas on the care provided. People were comfortable in the service. People were supported to maintain relationships with friends and families, and visitors were welcomed. Visitors told us they could visit at any time and they were always made to feel welcome.

People were aware of the compliments and complaints system which detailed how staff would deal with any complaints and the timescales for a response. This information was contained within the service user's guide which was available in the service for people to read. However, the complaints procedure did not fully detail who people could contact in the event of their not being happy with the resolution of their complaint and how they could be contacted. **We recommend that the provider seeks further advice and guidance as to who people can contact with their contact details to be included in the complaints procedure for people to read.**

People and their visitors told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. No one had needed to raise any concerns during their stay. One person told us, "If I had a complaint I would go straight to the manager, but I haven't yet." Another person told us, "The staff are very forth coming and easy to talk with." People had also been made aware of the procedures individually and in their last residents meeting minutes. In addition to the compliments and complaints procedure, the care manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

People were actively encouraged and supported with their hobbies and interests. Records of residents meetings and quality assurance questionnaires completed confirmed that people had been asked for their views and ideas on activities provided. People were then provided with information about social activities that were being run, which they could join in if they wished to. The notice boards also had information about activities people could attend. This was a mixture of individual and group activities run by the care staff and from external entertainers. Staff told us of people who were on respite care of examples of support so people could continue to attend activities outside during their stay.

Good

Is the service well-led?

Our findings

People told us they were asked for their views about the service. They said they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support.

Senior staff carried out a range of internal audits, including care planning, medication, infection control, falls, incidents and accidents, health and safety and staff training. The audit of the care plans had not identified all the omissions in the paperwork in the service. For example, not all the care and support documentation had been fully dated, which then did not clearly identify when a review would be due. We discussed this with the care manager and operations manager who acknowledged that some recording had fallen behind due to the recent increase in people in the service and new staff inductions being completed. But they were already working to address this.

There was a clear management structure with identified leadership roles. The registered manager was supported by an operations manager and a care manager. Staff told us they felt the service was well led and that they were well supported at work. Staff told us that the registered manager was accessible. One member of staff told us, "The registered manager is here at least four times a week. She goes around and says good morning and enables people to be able to talk to her. The care manager and operations manager get on very well and are doing a good job. Their office door is always open." Another told us, "The registered manager is mainly here in the mornings. She is approachable and visible in the home. We can always talk to the care manager. "Staff told us the care manager worked in the service six days a week. The care manager was very hands-on, approachable, knew the service and people well.

The vision and values for the service was recorded for people to read. The aim was to provide people with a 'Home from Home,' experience with a staff team trained to maintain people's dignity, individuality and privacy. Staff demonstrated an understanding of the purpose of the service, the importance of people's rights, respect, diversity and an understood the importance of respecting people's privacy and dignity. We were told by staff and people that there was on open culture at the service with clear lines of communication. All the feedback from people and staff was that they felt comfortable raising issues and providing comments on the care provided in the service. The three health professionals told us the communication between the staff team was good, with guidance and changes to people's care and support needs being followed through.

Periodic staff meetings were held throughout the year. A staff survey had been completed in 2014. Staff told us they felt although they had not done so they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service. The care manager told us they were supported by the registered manager, and regularly met as part of a management group. This had been a busy year with new paperwork and systems having been implemented in the service, particularly around care plans and support documentation and risk assessments, and staff receiving further guidance and training.

The operations manager had just started a monthly quality assurance audit of the service. This role had been developed with a view to ensure the monitoring and continuous development and updating of the service in line with latest guidance. We looked at their last report following their visit. This detailed where it had been found the service was working well and where it was felt further improvements could be made in relation to the required standards with a timescale for this to be implemented. This had then been discussed in the management meeting.

Systems were in place to gather the views of people and their relatives on the quality of care provided. This was through reviews of the care provided, regular residents meetings and with the completion of quality assurance questionnaires. The registered manager was able to provide us of examples of when changes had been made following feedback received. For example, people said they tended to forget what activities were being run on each day. A copy of the activities sheet has now been printed on the back of the weekly menu sheet that people receive. The activities in winter had been reviewed and more 'pamper days' and indoor activities had been provided whilst the weather was not so good.