Care Quality Commission

Tudor Bank Limited

Tudor Bank 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

Overall summary

This unannounced inspection was conducted on 11 August 2015.

Situated in Birkdale and located close to public transport links, leisure and shopping facilities, Tudor Bank Nursing Home is registered to provide accommodation for up to 46 younger and older adults who have mental health needs and require nursing or personal care. The location has a specialist unit for people living with dementia. It is a large three storey property which is fitted with a passenger lift. All the bedrooms are currently in use for single occupancy and have hand-basins. Two of the bedrooms where suitable for shared occupancy.

The location offers two services:

- Services for younger people with mental health conditions.
- Services for older people requiring nursing and personal care including people living with dementia.

At the time of inspection 36 people were using the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the

Summary of findings

requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. All staff spoke positively about the influence of the registered manager.

There were sufficient numbers of staff available to meet the needs of each person living at the home. There was a programme of staff training available, which included general health, social care and specialist topics relevant to the needs of the people using the service. Staff were recruited subject to satisfactory references and appropriate checks being completed.

At the time of the inspection two magnetic door closure devices were not operating. Wedges had been used to keep these doors open. The registered manager took immediate action when alerted to the matter.

Systems were in place for people living in the home, their relatives and staff to raise concerns. Evidence of appropriate and timely responses to issues raised was provided. The provider had received one formal complaint in 2015. The provider shared documents which demonstrated that they had listened to and acted on concerns and complaints. There were systems in place to engage with people using accessible communication.

The service had a system for the ordering, storage, administration and disposal of medication and conducted regular audits and checks. Medication was administered safely in accordance with this system.

Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the Local Authority. Some people had a deprivation of liberty safeguard (DoLS) plan in place. Staff sought people's consent before providing routine support or care.

Individual dietary requirements were met through the production of personalised menus. This was documented in care files.

People had access to a range of primary health care and specialist services, such as GPs, dentists and mental health teams.

People were supported with dignity and respect throughout the inspection. Staff spoke to them before providing care and checked that people understood what this meant. Staff demonstrated awareness of the needs of the people and interacted with them in a professional, caring and courteous manner. Each person had a nominated key-worker.

Each person was supported to be as independent as possible through a process of positive risk taking. Appropriately detailed risk-assessments supported this process. The service had supported people to move-on to alternative provision.

People had private space within the service and staff were respectful of this when engaging with them.

Relatives and friends were free to visit the service without any obvious restriction other than at mealtimes which were protected for the benefit of some people living in the home.

Systems were in place to encourage people to discuss any concerns with staff. Changes to care plans demonstrated that the provider had responded to people's preferences and changing needs. The service had systems in place to monitor and support quality assurance.

The accommodation was decorated and furnished to a high standard. People had chosen to decorate some areas according to their personal preference. Shared areas were bright, clean and uncluttered.

The provider had appointed an activities coordinator who had successfully developed a range of individual and group activities for people to access.

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?
The service was safe.

Assessments and support plans promoted positive risk taking.

The service had systems for checking the safety of recruitment, administration of medicines, equipment and the buildings.

Staffing levels were appropriate to meet the needs of the people living at the home. Staff were trained in adult protection and safeguarding procedures.

Staff had been recruited following the receipt of two references and appropriate checks.

Good

Is the service effective?
The service was effective.

Staff received training that equipped them to meet the needs of people living at the home.

Information was available to staff to inform the provision of care and support and consent was sought.

People's health was supported by access to primary health services.

People were supported to ensure their nutritional needs were met.

Good

Is the service caring?
The service was caring.

Staff demonstrated understanding of the people living in the home and their care needs.

Staff spoke to people in a manner which promoted dignity, respect and autonomy.

Each person living in the home had a person-centred care plan that staff understood and used in the delivery of care and support. A person-centred care plan is one that is adapted to meet the needs and preferences of an individual.

Good

Is the service responsive?
The service was responsive.

People's independence was promoted through person-centred approaches, positive risk-taking and regular reviews.

The provider had recruited an activities coordinator who had developed a range of individual and group activities for people.

The provider had systems in place to deal with feedback and complaints.

The provider consulted and communicated with people who lived in the home over changes.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The provider had systems in place to monitor service quality and individual outcomes.

The provider had systems in place to communicate with service users, relatives and staff.

People living in the home, their relatives and staff spoke positively about the registered manager's management style and leadership of the home.

The registered manager demonstrated a high-level of competence and understood his responsibilities in relation to the home and his registration.

Tudor Bank Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 11 August 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist in supporting people with complex and challenging behaviours and an expert by experience with an understanding of the needs of people with mental health conditions. 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 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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authority who provided information. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the home and their staff. We also spent time looking at records, including four care records, five staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted social care professionals who had involvement with the service to ask for their views.

On the day of our inspection we spoke with six people living at the home. We also spoke to three relatives. We spoke with the registered manager, the regional manager, the activities coordinator and four other staff.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at the home. One person told us, "I feel safe and I like the way staff support me." Another person said that they found the behaviour of another person, "Threatening." Staff had responded to this concern by providing the person whose behaviour caused concern with one-to-one support. Their care plan in relation to this behaviour was detailed and had been regularly reviewed. A reduction in challenging behaviour had been recorded by the registered manager.

We asked people living in the home about staffing levels. The majority of people did not comment on staffing levels, but one person told us that they went out in small groups for walks and to access community facilities. We asked relatives who were visiting the home at the time of our inspection about the staffing levels. A relative said, "I think there is plenty of staff. I have never seen anybody kept waiting." Another relative said, "There appears to be enough staff on duty, they are very kind. I don't go home and worry about [relative's] care." This meant that there were enough staff to meet the care needs of all of the people living at the home and to keep them safe.

There was a nurse on duty and four care staff throughout the day. This reduced to a nurse and three care staff at night. There were two cleaners, a maintenance person, a cook and an activities coordinator on duty each day. Five staff personnel files were reviewed as part of the inspection. Each file was detailed and consistently structured. Staff were recruited following interview and receipt of two references and a Disclosure and Barring Service' (DBS) check. A DBS check is a process for establishing if potential employees have a criminal record or have exhibited behaviours which make them unsuited to working with vulnerable adults. We saw that interview notes had been taken and that qualifications had been checked. Nurse' qualifications were checked through an on-line system to ensure that their registration had been maintained.

The registered manager told us that the service did not use restraint but had a focus on knowing each person and recognising signs of anxiety or distress to reduce the risk of an escalation in behaviour. We saw evidence of individual behaviours detailed in care files with a clear explanation of how staff should intervene in each situation. Staff demonstrated an understanding of the needs of each person through their discussions with the inspection team and in the way we observed them delivering care and support.

Throughout the inspection we observed that staff were available to attend to the needs of those people living with dementia. We observed that people with mental health needs were not always supported or engaged by staff. We saw people sitting without staff in a lounge for prolonged periods watching television. We asked staff about this and they told us that the people in the lounge were encouraged to participate in activities, but generally refused. The registered manager told us that they liaised with commissioners where the needs of people changed and declined admissions where their assessment indicated that current staffing levels would be unsafe.

Each person had a personal emergency evacuation plan (PEEP) in place. These were present in their individual files and in a separate information pack held in the front-office. This pack included floor plans with evacuation points and utilities clearly marked. The registered manager told us that this would be used by staff and shared with the fire service in the event of an emergency. Other risks were recorded in care files with clear instructions recorded for staff. These included risk assessments for the use of bedrails, moving and handling and alcohol consumption. We saw evidence that risk was assessed on an individual basis and that consent was sought where any restrictions had been applied. Risk assessments had been reviewed on a regular basis.

A nurse call system was in place and accessible to people from their beds. Thermometers were present in each room to check room temperatures. Window restrictors were in place on all accessible windows. They were of a modern, robust design and could only be disengaged with a key.

People were protected from bullying, harassment and avoidable harm, because staff were trained in relevant topics. They used this training to monitor behaviours and intervened at an early stage where necessary. Staff were trained in adult safeguarding and demonstrated a good understanding of processes when questioned. Information was readily available to support reporting to the relevant team within the local authority. Information was clearly displayed on a notice board in the front office. Staff accessed the office throughout the inspection.

Good

Is the service safe?

The provider had systems in place to record incidents and identify patterns or themes. There was limited evidence in people's files that this information had been used to review risks to individuals or amend care plans. The number of safeguarding referrals had decreased in recent months. The registered manager assured us that this was because the number of reportable incidents had decreased. This view was supported by the analysis tool provided to the inspection team by the registered manager.

The provider had a number of systems in place to monitor safety throughout the building. External companies had been commissioned to inspect; fire extinguishers, gas safety, electrical safety, lift safety, moving and handling equipment and conduct water safety testing. All certificates were up-to-date. In addition, the provider employed a maintenance person who checked critical systems and prioritised repairs. The provider had recently installed a new fire-alarm system. On the day of inspection two magnetic closure devices were not operating. Wedges had been used to keep doors open. These were removed immediately after the registered manager was informed and arrangements made to ensure that the two devices were properly linked to the new fire system.

Relatives on the dementia unit told us that people got their medicines on time and that staff stayed with the person to make sure that they had taken them. We did not observe the administration of medicine during this inspection.

We looked at medicines on the dementia unit. The medication for both units was stored in the one clinical room. The room was lockable and specifically allocated for the storage of medication. We looked at the medication administration record (MAR) for two people. They included a picture of each person and any special administration instructions. Allergies to medicines were highlighted in red. Body maps were used to show where topical medicines (creams) should be applied. Medicine that required refrigeration was stored correctly and daily fridge temperatures were recorded and signed for. We were advised that none of the people currently living in the home was prescribed a controlled drug. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Legislation. Medicine audits were completed monthly by a nominated nurse and followed a detailed audit template. We could see that any deficits identified were checked again the next month.

We checked the covert medication administration form for two of the people living in the home. Giving medicine covertly means medicine is disguised in food or drink so the person is not aware they are receiving it. The supporting records were relevant, up-to-date and had involved the family and relevant health professionals. A care plan was in place for how to administer covert medicines.

Some people were prescribed medicines only when they needed it (often referred to as PRN medicine). Staff were able to describe for us how they identified when people needed the medicine, usually for pain relief or when they were distressed. Although people had PRN care plans in place, these did not include enough detail to indicate when the PRN should be administered. For example, a PRN plan said 'for aggression'. It did not say what would indicate aggression or what any threshold might be. We discussed this with the registered manager who agreed that this may present a risk if nurses were unfamiliar with the person. He agreed to add further detail to the relevant administration plans.

A MAR chart was present in bedrooms for people who had topical creams. These were consistently completed. Topical creams were stored safely in bedrooms.

We found copies of the British National Formulary (BNF) and the Monthly Index of Medical Specialities (MIMS) which were out of date by three years. These are nationally recognised medication reference resources. We discussed this with the registered manager who agreed to order up-to-date copies as a priority. Any risk associated with this issue was mitigated by a commitment to access to on-line resources until the new copies were secured.

Good

Is the service effective?

Our findings

Staff were trained in a range of relevant subjects including the mental capacity act, dementia and mental health. In addition to the required training, there was evidence that staff had accessed additional external training in dementia and mental health. The training matrix (monitoring record) provided indicated that staff training was up-to-date and that refresher training was identified at appropriate points. One member of staff told us, "[The registered manager] reminds people if they are due training and checks that they have done it." All staff confirmed that they had received an annual appraisal and regular supervision.

The registered nurses were either qualified in mental health nursing or general nursing. The registered manager told us that additional training in mental health topics was made available for general nurses. One nurse described the induction process as good. They said that they were given one day of supernumerary time to observe practice and familiarise themselves with the service. This was followed by, "A full range of training quickly after starting." The registered manager told us that staff were monitored throughout their induction and that this was linked to a probationary period that could be extended up to six months if necessary.

Staff in all roles demonstrated that they understood the needs of people who lived at the home and delivered care and support accordingly. One person living at the home told us, "The handyman is brilliant and has helped me adapt my room to accommodate my sound system."

Staff meetings were held on a regular basis. The meetings were specific to staff working on the dementia unit, the mental health unit and those in ancillary/domestic roles. Key themes were identified for each meeting. We were shown copies of the minutes of recent meetings. The meeting on the 13 July 2015 featured reference to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 is a piece of legislation which covers England and Wales. It provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. DoLS is part of the MCA and provides legal protection for vulnerable people who are, or may become, deprived of their liberty in a hospital or care home.

We questioned staff about MCA and DoLS and they demonstrated a good level of understanding in relation to the people that lived at the home. A member of staff told us, "It's about protecting people's civil liberties. They need protection if things are being done for them that they don't really want, but they need." We found evidence of good quality, decision-specific mental capacity assessments in place. These assessments were signed by the relevant people. Six people using the service where subject to DoLS.

We saw records of regular staff supervision and annual appraisal. The frequency of supervisions varied and some had not taken place in accordance with the schedule. The registered manager told us that this was because of annual leave. They acknowledged that alternative dates for supervisions should have been scheduled.

The cook kept a record of dietary requirements in the kitchen and prepared meals on an individual basis where required. One person who lived at the home had diabetes and the cook told us how their meals included slow-release carbohydrates to help maintain consistent blood-sugar levels. Mealtimes were protected and visitors were discouraged at these times. One relative that we spoke with said that they understood because, "[relative] can be easily distracted from eating." People could choose where they ate within the building and there were accessible kitchen facilities for people to use outside of mealtimes. These facilities were monitored at all times to ensure that they were used safely. Cold drinks were readily available throughout the building. One relative told us, "My mother gets lots of drinks."

We observed the lunchtime experience and one of the team was offered a meal. The lunch was basic, but alternatives were available. These included a hot meal, soup, sandwiches and a dessert. It was in line with the menu which was available in written and pictorial form. The menu was repeated every four weeks. Portion sizes were small, but people were asked if they wanted more. A relative told us, "I've seen the food. It looks very nice." Some people needed assistance to eat their food. We observed that staff did this is a friendly and unrushed manner. Records of fluid and food intake were completed for those who needed them. We saw evidence that these records were completed daily.

One person who lived at the home became visibly distressed at lunchtime. She was supported on a

Good

Is the service effective?

one-to-one basis and reassured until she calmed. She told us, "[the activities coordinator] is a very kind person. I feel a lot better. This is a wonderful place and the staff are marvellous. The food's very good as well."

People were supported to access a range of healthcare services. Relatives said that communication was good regarding any change in healthcare needs. One relative told us, "They [staff] communicate very well. They are on the phone instantly if something happens. They ring the doctor promptly when it's needed."

Care files contained detailed admission assessments and clear evidence of liaison with health and social care professionals. One person who lived in the home had been recorded as losing small amounts of weight. They were referred to a dietician and their care plan adjusted accordingly. Other assessments in place included; falls, pressure ulcers, continence and pain. Temperatures and blood pressures were regularly checked. We saw evidence of regular blood-sugar level checks for a person with diabetes. One person living in the home said, "Every Thursday they weigh you and check your BP (blood pressure)."

The views of people living in the home and staff had been taken into account when developing the service. We saw that the décor, equipment and activities had all been changed recently and that further plans were being developed. Some of these changes had been introduced to make the environment more dementia-friendly. A dementia-friendly environment uses specific colours, lighting and equipment to reduce people's confusion and maintain their independence as their condition develops. The registered manager told us about their plan to build a small 'dementia village' in the rear garden to support the specialist needs of some of the people living in the home. He explained what was going to be built, what the potential benefits would be and how it would be funded. There was evidence of similar activity throughout the service.

Good

Is the service caring?

Our findings

We asked visiting relatives how caring they found the home. A relative told us, "I can't fault the staff. They are lovely and my [family member] likes it here." Another relative told us, "The staff are marvellous with my [family member]. They love [them]."

We asked the registered manager and the regional manager about the philosophy of care in the home. The regional manager said, "This is their home. We are invited guests."

We observed that staff knocked on people's doors before entering. They spoke to people in a gentle tone and supported their communication by smiling and using other facial expressions at appropriate moments. There was gentle physical contact between staff and the people living in the home, for example, hand-holding which aided communication. We observed that people responded with warmth towards staff and that staff demonstrated compassion and care for the people living in the home.

Staff demonstrated a good knowledge of people's backgrounds, likes and interests and used this information to engage, re-assure and calm people. We saw a member of staff support a person with their personal care in a manner that was respectful and discrete. We also saw a staff member responding to a person who was cold by going to get a blanket and placing it over them as they sat in their her chair. This was done without delay. Staff delivered care and support with respect and explained what they were doing when supporting each person. When people refused care or failed to respond to staff, they were treated with respect. Where necessary staff repeated or re-phrased a question and offered gentle encouragement.

Each person had their own bedroom that had been decorated and furnished to reflect their preferences and personality. Each bedroom displayed a one page document titled; 'All About Me.' It included detail of the person's personal history, preferences and routines. The activities coordinator had developed these documents. Newer staff told us that they were very helpful. Another member of staff said, "[the registered manager] has encouraged us to personalise rooms. We are asking families to bring in things."

Each person had a person-centred plan. A person-centred plan identifies what is important to the person and tells staff how their care and support should be provided. We saw evidence which indicated that people had been involved in the development and review of their care plans. They had been reviewed on a regular basis. Plans included reference to the promotion of choice and control. People were encouraged and supported to be as independent as possible. People with mental health conditions were assessed with a view to moving on to alternative accommodation. The regional manager told us, "Residents have made progress and moved on to independent living." They offered two examples where this had happened and said that the people had kept in touch with the home following their moves.

Shared spaces were bright, comfortable and welcoming. Visitors were welcome to visit at any time, although mealtimes were protected for the benefit of some people living in the home. Lounges and bedrooms provided adequate visiting facilities which offered privacy when required. Some people went out with their visitors to access local facilities.

When questioned and observed staff demonstrated a clear understanding of people's rights regarding privacy and dignity. An audit of privacy and dignity was conducted by the provider in February 2015. No recommendations were made as a result of the audit.

Good

Is the service responsive?

Our findings

People living in the home were involved in the planning and review of their care. Care records provided evidence of regular review and personalised approaches. This was particularly evident in the planning of activities. The provider employed an activities coordinator to develop individual and group activities. One person told us that they were supported to go swimming each week because this was an activity that they had enjoyed previously. Another person told us, "Staff help me make salmon sandwiches and cake." One of the people living in the home said that they wanted to feel sand on their feet. Sandpits had been purchased specifically for this person and were used on a regular basis.

We observed that people received care and support in their rooms, in lounges and in dedicated activities areas. People received care and support as they needed it in a non-intrusive and respectful manner. Staff were observant and responsive to people's changing needs throughout the inspection. Care records showed clear evidence of family involvement in the pre-admission assessment and subsequent reviews. Person-centred plans were all signed by family members. The registered manager acknowledged that the service could not always accommodate people's preference for gender-specific care because of the ratio of female to male staff.

The décor, furniture and equipment in rooms was personalised. One person had the sounds of a fish-tank playing in their room and was provided with talking newspapers from the area where they used to live. The activity areas and some of the lounges were well-equipped to provide stimulation for people with dementia. The activities coordinator told us that the activities programme was fluid and flexible, because people's presentation could vary. They said, "It [the activities programme] cannot be treated as a regime as it needs to be open-ended." A copy of the programme was clearly displayed and people were also told about the alternatives for the day. The activities coordinator also told us, "We bought a piano and someone comes in to play for the residents. They love music." She told us that an art teacher came in to the home specifically for the younger people living there. We saw that the walls were filled with art work produced by people living in the home. One design had been chosen as the new logo for the home and was in use on current literature. We saw evidence of activities that took place in the local community and that members of the community came into the home to deliver additional activities. These included art lessons and entertainers. Community-based activity was included in the activities time-table for individuals and groups. These activities included trips into Southport to access shops and pubs and excursions to other locations.

People living in the home were invited to attend weekly meetings where they could discuss matters of concern or interest. Minutes of these meetings were made available to the inspection team. The minutes included reference to; food, activities, décor and the allocation of rooms. The last meeting was recorded on 10 August 2015. Each person had an allocated key-worker who represented their interests at staff meetings. People were given a questionnaire in an easy to read format so that they could share their views on the service. Each completed questionnaire was read and signed by the registered manager. The last questionnaire was issued in July 2015. There was evidence that some of the comments made regarding the menu had been shared with the cook.

People were consulted about changes to their care and were able to influence other aspects of the service. For example, the hallways and corridors were decorated with paintings produced by people living at the home and images that were relevant to them. One person living at the home said, "I am consulted about making improvements and I know who the manager is." Another person told us that their keyworker sits down with them nearly every month to discuss their plan. A keyworker is a member of staff that specific responsibility for gathering and sharing information about a person living at the home with other staff and managers. He said, "If you want something you have to prompt them and they will respond, but you might have to wait five or ten minutes." They also said, "Every meeting you can have your say, but if they act on it it's up to them."

The registered manager showed us a complaints file. Each complainant had received a written response and been invited to comment on the content. There was one complaint recorded in 2015. The registered manager made use of an external website for people to raise issues or pass on positive feedback. Instructions on how to access this facility were available in the reception area.

We saw evidence of regular communication with relatives and structured relatives' meetings. The last relatives'

Good

Is the service responsive?

meeting took place on the 31 July 2015. The registered manager told us that attendance at the meetings wasn't always good because they maintained open communication with families and they didn't feel the need to attend the meetings. One relative said, "I got invited to the family forum, but I did not go as I did not think there was anything I could add to improve the place."

Good

Is the service well-led?

Our findings

People living in the home, relatives and staff spoke positively about the registered manager and his management of the home. One person living in the home said, "They [the registered manager] are alright. They listen to your views and if they can help they will." A relative told us, "Problems get dealt with and sorted straight away."

Throughout the inspection the registered manager demonstrated knowledge of the people living in the home and his staff team. They spoke with compassion and insight and were professional in their use of language and their approaches to staff. One member of staff said, "[the registered manager] is a wonderful leader. They allow you to blossom, but will rein you in if you are not doing your job properly. They are open to new ideas." Another member of staff said, "[the registered manager] is a very good nurse, that's why they are good as a manager." All of the staff that we spoke with referred positively to the registered manager's leadership and managerial skills. We saw evidence of these views in practice.

The registered manager had completed a wide range of quality and safety audits in 2015. They included; death and dying, social content and activities, autonomy and choice and meals and mealtimes. They had communicated extensively with people living in the home, their relatives and staff. The registered manager understood their responsibilities with regards to the home and their registration with the Commission.

Systems were in place for staff to raise concerns. These included weekly staff meetings where specific issues relating to care were discussed. Minutes of these meetings were made available to the inspection team. One record from 31 July 2015 stated, 'Resident' well-being must always come first.'

There was evidence of regular communication with staff throughout the inspection. This was in the form of daily handovers, informal conversations, updates to care files, team meetings and supervisions. Staff told us that the registered manager provided feedback on the outcomes of complaints and incidents. They were also clear what action they should take if they felt that they needed to register a concern through whistle-blowing. A member of staff told us, "If I felt uncomfortable with something I would bring it to someone's attention. I would go to [the registered manager] in the first instance or social services." Another member of staff said, "I have queried things before and I would have no hesitation in doing it again."

We saw that following the completion of a risk assessment, one person living in the home had been given permission to bring their dog to live with them. This had proven of benefit to the person and other people living in the home. Most people that we spoke with were pleased about the presence of the dog, but one person said that they were concerned about the dog fouling the garden. We saw evidence of dog fouling in the rear garden. The registered manager made arrangements for this to be cleared as soon as they were informed. One relative told us, "I was not asked about [the introduction of] the dog, but I think it's a great idea. [family member] responds to the dog. It is nice that they allow people to have pets here."

We saw copies of questionnaires that had been issued to people living in the home, relatives and staff. The questionnaires had all been issued recently and contained comments and ratings which were predominantly positive. The registered manager had signed the majority of the forms to indicate that they had read them.

We saw that the staff on duty during the inspection were motivated to provide a high-quality, responsive service to the people living in the home. Our observations of their practice and their responses to our questions were positive throughout the inspection. Staff were supported to develop their skills and competencies. The registered manager showed us a staff training and development plan for 2015/ 2016. The plan included specialist training in addition to mandatory courses. One member of staff had joined the provider as a kitchen assistant and had been supported to develop their skills in supporting people with mental health conditions. They had recently been accepted onto a formal nurse training programme and continued to work part-time at the home.

The registered manager provided evidence of a comprehensive system for quality assurance. The systems required regular checks of; care plans, incidents, maintenance and equipment. Checks were completed by the registered manager and the regional manager. The majority of audits and checks had been completed in 2015. We saw evidence of action undertaken as a result of these audits and checks. Staff audits included reference to exit

Good

Is the service well-led?

interviews and qualifications. Some of the audits were incomplete or not dated. We shared this information with the registered manager who assured us that documents would be checked and omissions rectified as a priority.