Doulton Court Limited

# Doulton Court Care Home

## Inspection report

Alford Road
Sutton-on-Sea
Lincolnshire
LN12 2HF

Tel: 01507441026
Website: www.fshc.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

.We inspected Doulton Court Care Home on 30 August 2016. This was an unannounced inspection. The service provides care and support for up to 41 people. When we undertook our inspection there were 39 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks, with some having loss of memory.

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

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there were six people subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan.  People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home.  The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements.

## 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.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

### Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

### Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

### Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

## Is the service well-led?

Good

The service was well-led.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The views of visitors and other health and social care professionals were sought on a regular basis.

# Doulton Court 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.

This inspection took place on 30 August 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of 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 improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals during the site visit.

During our inspection, we spoke with eight people who lived at the service, eight relatives, four members of the care staff, a trained nurse, a housekeeper, an activities organiser, a cook, the hairdresser, the deputy manager and the registered manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the registered manager had completed about the services provided.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at the home. They were consistent in their opinions of how staff treated them, were caring and how nice the home was to live in. People who required help with their mobility told us they felt safe with the assistance given to them. A relative told us, "My [named relative] is very well looked after here. [Named relative] is safe, kept clean and well fed."

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a daily and monthly basis. We saw details of two people's accident records on the computer data base. The records ensured any investigation action was recorded and lessons learnt from each incident were recorded. For example, ensuring a person's falls analysis was up to date and the care plan reflected any new needs. Any changes were past on to staff through handovers and staff meetings. We saw this in the staff meeting minutes for August 2016.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks, to ensure they were capable of being as independent as possible. For example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely around the building.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would not remember where the exit doors were in the building. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document.

We were invited into eight people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. Staff had taken into consideration when writing the care plans of environmental risks for some people, especially those with loss of vision. This included ensuring rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair. However, we did see some trailing wires in the conservatory area which was part of the call bell system. This had been extended so people who did not wish to sit anywhere else had access to a call bell. We pointed this out to the registered manager who took immediate remedial action.

The entrance to the home was through a door which had a key pad to operate it. People told us they could have the code if they wished and we saw several relatives using this method of entry. Staff told us this ensured people's safety of people not gaining entry that did not have business in the home. However, to exit the building was a push button. This could mean that people could exit the building when it was not safe for them to do. All areas of the garden were safe to walk in and there was no direct entry to the gardens from the main road. All bedroom areas had locks on the doors. These are only enabled at a person's request. No-one had requested keys to lock their bedroom door at the time of our visit. This was discussed with the manager who told us the entrances and exits to the home were on a planned programme of review.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. There were also signs on the doors indicating what each room was used for, for example, a sitting room or toilet. The signs were in words and pictures. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

People told us their needs were being met and there was sufficient staff available each day. One person said, "Always very willing and helpful." Staff told us that the staffing levels were good. One staff member said, "We have enough staff. It doesn't matter what floor we are on we just help each other." Another staff member said, "We help each other out, but management come on the floor to help too." Staff told us that if there were short term staff shortages that the registered manager and deputy manager would assist with the personal care and treatment of people who needed it. One staff member said, "Even the head office team help out, if there is a need when they visit. Everyone is good like that."

The registered manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These were completed on a weekly basis by the registered manager and submitted to head office. These had been discussed with the commissioners of services. Health and social care professionals told us there were always staff available to speak with them and discuss people's needs. Contingency plans were in place for short term staff absences such as sickness and holidays.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were no current staff vacancies.

People told us they received their medicines and understood why they had been prescribed them. One person said, "Yes I get my medicines." This had been explained by GPs' and staff within the home. This was recorded in people's care plans. People told us that if required the staff would contact the person's GP if medicines needed to be changed. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in two locked areas. There was good stock control. Records about people's medicines were accurately completed. Medicines audits we saw were completed by staff at the home and the pharmacy supplier. We saw the last audit from April 2016 which highlighted one action which had now been completed. The local pharmacy had also completed an audit in April 2016 and this was positive.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and

how it affected people's conditions. For people using oxygen via a cylinder there were signs on the storage area cupboards, but not on the door of the bedroom it was being used in. We pointed this out to staff and this was quickly corrected. This ensured that in the case of an emergency areas where oxygen were stored could be easily identified in the event of such as a fire or explosion.

Good

# Is the service effective?

## Our findings

People we spoke with and their relatives told us they thought the staff were trained and able to meet their or their family's needs.

None of the staff we spoke with had been newly recruited. However, they told us that the induction programme at the time of their initial days at the home had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The registered manager told us that all staff were now registered for the new Care Certificate. This would give everyone a new base line of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling, fire and health and safety. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. Staff had also completed training in particular topics such as dementia awareness, pressure area care and nutrition. This ensured the staff had the relevant training to meet people's specific needs at this time. We saw training was recorded on a computer data base. This recorded what topics staff had covered and gave a percentage score for each topic of how many staff had attended. For example, food safety was 100% of staff completed and first aid awareness 93%. Any shortfalls of staff not attending courses were addressed at staff supervisions.

Staff told us the provider was encouraging them to expand their knowledge by setting up courses on specific topics. This included national awards in care and being encouraged to attend local support groups in topics such as infection control and sepsis. The trained nurses were being supported to maintain their registration with the Nursing and Midwifery Council (NMC). The provider had developed a portfolio for staff to record their training for the NMC and set up support systems so trained nurses could seek support if required. Staff told us this was proving helpful.

Staff told us a system was in place for formal supervision sessions. They told us that they could approach the registered manager and deputy manager at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a supervision planner on display showing when the next formal sessions were due. All staff had received at least two formal supervisions since January 2016. The supervision planner also identified who was a probationary member of staff on induction training. The trained nurses were also encouraged to attend quarterly clinical supervision meetings. We saw the minutes of the one for August 2016. This covered topics such as the importance of recording weight loss, a recent infection control audit results and signs and symptoms of sepsis.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. Six applications had been submitted to the local authority and authorised. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held to test their mental capacity and ability.

People told us that they liked the food. One person said, "Always plenty to drink, nothing is too much trouble." A relative told us, "If I stop for tea it must be good." Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and where they liked to have their meals. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. This ensured people received what they liked and what they needed to remain healthy.

Menus were on display in the dining rooms and within the kitchen area. Staff told us a new company had taken over the organising of the kitchen, ordering supplies and preparing meals. They said this was now running smoothly, but they still required picture menus for display purposes.

We observed the lunchtime meal. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate or bowl. Staff did not hurry people. When people did not like part of a meal, for example, their dessert, an alternative was found. A relative told us if people changed their minds about their menu choose this was not a problem and an alternative was found. One person with a particular medical condition told us they sometimes required a snack late evening or through the night and staff could accommodate their wishes. Staff took meals to people who preferred to eat in their rooms. They ensured each person was sitting comfortably and had all the utensils and condiments they required. People were offered hot and cold drinks throughout the day. Each bedroom area had a jug of water and squash in the room.

We observed staff attending to the needs of people throughout the day. For example, one person had a change in their dietary intake so staff asked them how they were coping with the new menu. They later were heard speaking with health professionals on further changes which may have to be made. We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. We heard staff discussing with people the effectiveness of some memory aids which had been purchased to help them remember the day of the week. All events were recorded by staff in the care plans.

People told us staff obtained the advice of other health and social care professionals when required quickly and efficiently. One person said, "When I need a GP they get one." In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as flu vaccinations. Staff had recorded when people had seen the optician and dentist. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance. This was affirmed by the health and social care professionals we spoke with before our visit.

Good

# Is the service caring?

## Our findings

People told us they liked the staff and felt well cared for by them. One person said, "They are very good here, much better than sitting at home alone." Another person told us, "I don't' know where the staff get the patience from." A relative told us, "Staff stop and speak and ask how things are."

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "If I want to go to bed, I go to bed." Another person told us, "It's my choice to stay in my room, which staff respect. I'm not a mixer."

People were given choices throughout the day such as if they wanted to remain in their rooms or bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives, and some with staff.

All the staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone was becoming anxious because their relative was leaving the building. Staff told us the person had no concept of time so therefore they became anxious on each visit. Staff used a distracting technique until the relative had left the building. The person was then calm and watched the television. We also observed people who wanted to mobilise independently, but slowly, being allowed to do so.

Some people either through choice or because they were ill remained in bed. We observed staff attending to people's needs who were in bed They ensured they answered people's call bells promptly, politely asked what they required before fulfilling the person's wishes. Staff told us a lot of people needed them at that time and this had been unavoidable. The registered manager can audit the call bell system if required and occasionally completed spot checks.

Staff told us that if personal care of a person was required they ensured the door and curtains were shut. People confirmed this happened.

Relatives told us how staff had supported them when their family members' lives were drawing to a close. They told us staff had been very comforting to them as well as their family members. They had been kept informed about events and felt included in discussions. Staff were described as empathetic and knowledgeable.

Throughout our visit we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

We observed staff helping someone whose behaviour was challenging to others. They ensured the staff

member who used the call bell system was not on their own and gave reassurance to the person concerned. Other people in the area were politely asked to move away until the situation was calmer. People did this readily and one person said, "Don't these staff cope well when this happens." A relative said, "One word, brilliant", when they saw the actions of staff. One person told us how when they had a "bad" day, staff were caring and patient.

People told us they could have visitors whenever they wished and this was confirmed by relatives. We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. Relatives told us they were offered refreshment when visiting. This was recorded in the care plans. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them. There was also a payphone in a quiet area for people to use.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. All members of staff were involved in conversations with people and relatives. Each staff member always acknowledged people when walking around the building. Staff greeted people with their first names if this was their wish and smiled at people. Staff engaged with people about the person's day, asking a person's well-being or engaging in lengthier conversations.

People told us staff treated them with dignity and respect at all times. One person said, "When I go to the bathroom they ensure no-one is around in the corridor. I don't like people to see me in my dressing gown." A relative said, "One word, brilliant."

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the moment.

Good

# Is the service responsive?

## Our findings

The people we spoke with gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. One relative said, "There are always staff about." One person told us, "You only have to ask". People told us staff responded quickly when they used their call bell, day and night.

People told us staff had talked with them about their specific needs. This was in reviews about their care. They told us they were aware staff kept notes about them, but most people preferred to have what was described as "a chat with staff". People told us they were involved in the care plan process, but if they could not read their notes staff would do this for them.

Staff received a verbal handover of each person's needs at each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use. Staff told us this were used as a reminder of what had been said and useful if they had been on holiday. We observed the lunchtime handover. This was unhurried and staff were given time to ask questions. Details included the well-being of each person, what medicines required to be ordered, any wound dressings still to be refreshed and which relatives had requested an update to their family member's care.

People told us staff had the skills and understanding to look after them and knew about their values and beliefs and that staff knew them well. Staff knew how to meet people's preferences with suggestions for additional ideas and support; such as ensuring they had talking books if their vision was affected by illness. This meant people had a sense of wellbeing and quality of life. Information leaflets were on display about a variety of topics such as; local health care services and some leaflets on specific illnesses, as well as information on how the provider had experts on hand to address specific issues.

People told us that staff took time each day to discuss their care and treatment. As well as the opportunity to speak with other health professionals. This was recorded in each care plan. For example being able to see a dentist when they required one. Professionals' visits to the service said it was focused on providing person-centred care. On-going improvement was seen as essential and lessons learnt were past to all staff. Social care professionals we had contact with before the inspection told us staff informed them quickly of any issues. They were confident staff had the knowledge to follow instructions and did so.

We were informed that an activities co-ordinator was employed and they had two assistants. This ensured that social activities could take place seven days a week. We saw them facilitating a number of activities throughout the day. They kept separate records from the care plans called an activity journal. The activities records stated people's general interests, past employment and preferred social activities. For example different entertainment they enjoyed such as singers. They also recorded events which had taken place such as board games, themed events and visits out. One of those consisted of a visit to the local seaside resort a short distance away. There was a small shop where people could purchase a selection of sweets and biscuits. People told us they were encouraged by staff to invite family and friends to the home to take part in

social activities and we saw this during our visit.

Each floor had an activities board listing the events of the week and photographs of past events. There was a home newsletter available on each floor. This gave details of planned events such as those for dementia awareness week and events coming up. Staff told us they were exploring other methods of producing this as those with little sight or who could not read written English had the newsletter read to them.

People were actively encouraged to give their views and raise compliments, concerns or complaints. People's feedback was valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. For example, one person wanted a certain fruit with their breakfast and a relative told us this was actioned immediately. We saw the complaints procedure on display. The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the cases had been passed to staff at their meetings in 2015, as no formal complaints had been made since January 2015.

The compliments book was very full and give many positive comments about the care which had been delivered to individuals. Some thank you cards for care recently delivered were on display.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post. People told us they could express their views to the registered manager and deputy manager and felt their opinions were valued in the running of the home. One person said, "Manager is very good at sorting out problems."

Questionnaires had been sent to people on topics such as making decisions for themselves and the involvement people had in their care plans. People told us they had completed questionnaires. The results were displayed on a notice board entitled "you said, we did". The results were displayed for the August 2016 survey. Results showed nothing less than a 97% satisfaction rate. Residents and relatives told us they had the opportunity to attend group meetings with the registered manager and other staff, which were quarterly. We saw the minutes of the meetings for August 2016 where a number of topics were discussed; such as the laundry, activities and the kitchen. People had been given opportunity at the end of the meeting to ask questions and the responses recorded. A system called IPAD was positioned in the main reception area. Relatives told us they could record comments on this, on a daily basis if they liked. The registered manager told us the results were collated and sent to them for compliments and/or actions to be completed.

On the home's website there was a lot of information about the home. This included a calendar of events, residents meetings, what type of services were provided and what the accommodation consisted of. There was a lot of information about the running of the home and the wider company.

Staff told us they worked well as a team and felt supported by the registered manager, deputy manager and senior staff. One staff member said, "I've been well taught and supported here to help people." Another staff member told us, "I do love my job."

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meeting for August 2016. The meeting had a variety of topics which staff had discussed, such as; risk assessments, food hygiene, security and accidents. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home. The minutes of the meeting showed staff were given time to express their views, with explanations given, if possible, or suggestions for moving forward.

The registered manager and deputy manager were seen walking around the home. They knew the names of all the people, relatives and visitors. They gave support to staff when asked and checked on people's needs. The registered manager and deputy manager were visible throughout the day showing compassion and respect to people.

There was sufficient evidence to show the registered manager had completed audits to test the quality of the service. These included infection control, bedrail audits and fire equipment. Where actions were required these had been clearly identified and signed when completed. Any changes of practice required by staff were highlighted in staff meetings, in the communication book and shift handovers so staff were aware if lessons had to be learnt.

The registered manager was required to complete what was described as a quality of life walk around and check each day. This consisted of recording how many people the registered manager had long conversations with and staff feedback. They also had to complete a premises check for health and safety purposes. We saw how this was recorded on the computer data base each day. This information was used to inform the day to day work of staff and plan progress on such items as replacement furniture required.

The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet and local multi-agencies. This home is part of a larger company so the registered manager had the opportunity of meeting with other home's managers, area staff and head office staff on a regular basis. This was welcomed by the registered manager as extra resources for advice and support.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.