Crawshaw Hall Healthcare Limited

Crawshaw Hall Medical Centre and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 March 2018 and was unannounced. Crawshaw Hall Medical Centre and Nursing Home is a 'care home' that provides accommodation for up to 50 people, some living with dementia. At the time of this inspection 47 people were using the service.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

At our last inspection on 9 January 2017 the service was rated 'Requires Improvement' overall. We found a breach of the regulations relating to the safe management of medicines and rated the key question 'Safe' as 'Requires Improvement'. We asked the provider to make improvements in this area and they kept CQC informed of the changes that had been made.

At this inspection we found the provider had taken action to monitor and manage risks surrounding medicines. People received their medicines as prescribed by health care professionals. The home was no longer in breach of the regulations.

At the time of the inspection the home had a manager in post who was going through the process of registration with the Care Quality Commission (CQC). They subsequently became registered on 22 March 2018. The previous registered manager had stepped down to become the deputy manager and clinical lead at the home in July 2017. A registered manager is a person who has registered with the CQC 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.

All of the staff we spoke with said they enjoyed working at the home. They said they received good support from the manager, provider and nursing staff. They felt their contributions in meetings were recognised and management staff listened to what they had to say.

People told us they felt safe living at the home. Training records confirmed that staff had received training on safeguarding and there was a whistle-blowing procedure available and staff said they would use it if they needed to. There was a good staff presence at the home and staff were attentive to people's needs.

Action was taken to assess any risks to people and risk assessments and care plans included information for staff about action to be taken to minimise the chance of accidents occurring.

Staff had the knowledge and skills required to meet people's needs. The manager and staff had a good understanding of the Mental Capacity Act 2005 and acted according to this legislation.

People told us they enjoyed the meals provided to them and they could choose what they wanted to eat. People were supported to maintain good health and they had access to healthcare professionals when they needed them.

People had been consulted about their care and support needs. These needs were assessed before they moved into the home. Care plans and risk assessments included detailed information and guidance for staff about how people's needs should be met.

People's privacy and dignity was respected. There were activities for people to partake in if they wished to do so but improvements were required around this and we have made a recommendation about this in the 'Responsive' section of the main body of this report.

The home had a complaint's procedure in place and people said they were confident their complaints would be listened to and acted on.

The provider recognised the importance of monitoring the quality of the service. They sought the views of people using the service, their relatives and friends through residents' and relatives' meetings and satisfaction surveys. The manager and senior staff worked with professional bodies to make improvements at the home.

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.

The service had safeguarding and whistle-blowing procedures in place and staff had a clear understanding of these procedures.

Appropriate recruitment checks took place before staff started work.

There were enough staff available to meet people's needs.

Risks to people had been assessed and reviewed regularly to ensure their needs were safely met.

Medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

People were protected from the risk of infections.

Is the service effective?

Good

The service was effective.

Assessments of people's care and support needs were carried out before people moved into the home.

Staff completed an induction when they started work and received training relevant to the needs of people using the service.

The manager demonstrated a clear understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and acted according to this legislation.

People's care files included assessments relating to their dietary support needs.

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

Is the service caring?

Good

The service was caring.

Staff treated people in a caring, respectful and dignified manner and staff had received training on equality and diversity.

People and their relatives, where appropriate, had been involved in planning for their care needs.

People were provided with appropriate information about the service.

Information and private documents were securely locked away and could only be accessed by authorised staff.

Is the service responsive?

Good

The service was responsive.

People had care plans and risk assessments that provided guidance for staff on how to support them with their needs.

People's care plans included sections on their diverse needs.

People were provided with a range of activities but improvements were required and we have made a recommendation around this.

People and their relatives knew about the home's complaints' procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

People received appropriate end of life care and support when required.

Is the service well-led?

Good

The service was well-led.

The home had a manager in post who became registered with the CQC shortly after the conclusion of the inspection.

There were appropriate arrangements in place for monitoring the quality and safety of the service that people received.

The provider took into account people's and their relative's views through resident's and relative's meetings and surveys.

Staff said they received good support from the manager and senior staff. However, some staff felt that the home should

recognise the role of a senior carer as a means for carers to progress in their careers.

There was an out of hours on call system in operation that ensured management support and advice was always available for staff when they needed it.

Crawshaw Hall Medical Centre and 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 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 13 and 14 March 2018 and was unannounced. The inspection team on the first day consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An inspector and an inspection manager attended the home on the second day of the inspection.

Before the inspection we looked at all the information we had about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events that the service is required to send us by law.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We contacted the local authorities that commission services from the provider to gain their views about the home. We used this information to help inform our inspection planning.

During the inspection we looked at the care records of seven people, staff training and recruitment records and records relating to the management of the home. We spoke with seven members of staff, eight people using the service and three relatives to gain their views about the home and the quality of the care received by people. We spoke with the manager and two members of the nursing staff about how the home was run. We also spoke with three health care professionals that were visiting the home.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 9 January 2017 we established that risks associated with the safe management of medicines were not managed. There was no guidance in place to support staff on monitoring room and fridge temperatures where medicines were stored.

These issues amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in these areas. The medicines' fridge contained medicine that required refrigeration and we saw room and fridge temperatures were monitored to ensure medications were stored safely. We saw monthly medicines audits were carried out. A medicines' audit file contained evidence that the outcomes from these audits had been shared with staff and areas for improvement had been identified and acted upon.

People told us they received their medicines when they were supposed to and when they needed them. One person told us, "I get my medication at the same times every day and they are never missed." A relative said, "My relative gets their medication on time and when I visit I note that staff are very careful in the way they give medicines."

Medicines were administered safely. Training records confirmed that staff had received training and had completed medicines' competency assessments before they were permitted to administer medicines to people. We observed medicines being administered to people during the inspection and saw that staff sought their permission and that people were gently encouraged to take their medicine.

People had individual medication administration records (MAR's) that included their photographs, details of their GP, information about their health conditions and any allergies. We looked at the medicine administration records (MAR's) for four people and checked the balances of medicines stored in their medication cabinets against the MAR and found these records were up to date and accurate. There were also safe systems for administering and monitoring of controlled drugs. We saw a controlled drugs record book. This had been signed by two members of staff each time a controlled medicine had been administered.

People and their relatives told us they felt safe and that staff treated them well. Comments from people included, "I do feel safe here and someone goes with me when I go out" and, "I feel very safe here; I've been here a while and am comfortable." Comments from relatives included, "We are all happy with our relative's safety and the responses of the staff when our relative needs help" and, "I am glad my loved one is here. They are safe here but weren't at home."

Assessments were carried out to assess the levels of risk to people in relation to falls. Where people had been assessed at risk of falling, we saw guidance was provided to staff describing the support people required when mobilising and the equipment to be used to prevent falls. For example, this included

assistance for a person with their walking frame at all times. Alarm mats were also in use to help inform staff when a person was trying to get up out of a chair or bed and were vulnerable to falling. When people had falls, we saw that they were documented and risk assessments and care plans were updated.

Risk assessments and guidelines were in place for supporting people with moving and handling, nutritional needs and skin integrity. Fluid and dietary intake was also monitored and the MUST risk assessment tool was completed in order to identify if people were at risk of malnutrition. MUST is a Malnutrition Universal Screening Tool and a five step screening tool used to identify adults who are malnourished or at risk of being undernourished.

The provider had procedures in place for safeguarding people from abuse. Training records confirmed that all staff had received training on safeguarding and staff we spoke with demonstrated a clear understanding of the types of abuse that could occur in a 'care home' setting. Staff told us the signs they would look for and what they would do if they thought someone was at risk of abuse. They said they would report any safeguarding concerns they had to their line manager or the manager. They also said they would report concerns to the local authority safeguarding team or the CQC if they felt they needed to. The provider had a whistle-blowing procedure and staff told us they would use it to report poor practice if they needed to.

Our records showed that the manager had submitted notifications to the CQC when required. The manager told us that lessons had been learnt following a recent safeguarding concern and actions had been taken to reduce the likely hood of the same issues reoccurring. Actions taken included improving the recruitment procedure to ensure that staff were medically capable of supporting people.

Appropriate recruitment checks took place before staff started work. We looked at the recruitment records of five members of staff who had been recruited since the last inspection. We found completed application forms that included full employment history and explanations for any breaks in employment, two employment references, health declarations, proof of identification and evidence that criminal record checks had been carried out. Staff eligibility to work in the UK had also been verified.

During the inspection we observed there were enough staff on duty to meet people's care needs. Comments from people about staffing levels included, "There are enough staff here", "Yes, there is always enough staff" and, "When I call for help, it comes." A relative commented, "There doesn't seem to be a staff shortage. There are always staff around." A member of staff told us, "There are enough staff on duty and we are not rushed." The manager showed us a rota for the two week preceding the inspection and told us that staffing levels were arranged according to people's needs. They told us if extra support was required for people to attend social activities or health care appointments, additional staff cover was arranged.

There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely. We saw records confirming that regular fire drills and fire alarm system tests were carried out at the home. The home had a fire risk assessment in place that had been completed in January 2018 by an external specialist. The assessment had highlighted two areas of concern in relation to fire prevention equipment. These two matters had not been attended to at the time of the inspection but were completed by the time the inspection ended. We noted that the assessment had been sent to the local fire station with an invitation from the provider for them to raise any observations.

There were systems to manage the safety of portable appliances, electrical devices and to ensure that water in use at the home was safe for consumption and within safe operating temperatures. Equipment such as hoists, wheelchairs, mobility aids and lifts were also serviced regularly to ensure they were functioning

correctly and safe for use. We noted that all of the hoists and wheelchairs had been checked for safety and serviced by a specialist contractor in November 2017.

The home's administrator showed us the provider's and manager's systems for monitoring and investigating incidents and accidents. They told us that incidents and accidents were monitored to identify any trends. Where trends had been identified, the nursing staff and the manager had discussed them and had taken action to reduce the likelihood of the same issues occurring again.

We found the home was warm, clean and tidy and free from any unpleasant odours. One person told us, "The home is clean and my room is done daily." The home had domestic staff who worked separately from the care and nursing staff team. We saw hand-washing reminders in bathrooms and toilets and that personal protective equipment was available to staff when they needed it and placed at convenient locations around the home. We noted that infection control audits were carried out on a monthly basis.

Good

Is the service effective?

Our findings

People and their relatives told us the service was effective and met their needs. One person said, "The staff do seem well trained." A relative told us, "Staff are good at their jobs and know what they're doing."

Assessments of people's care and support needs were carried out before they moved into the home. These assessments were used to draw up individual care plans and risk assessments. Nationally recognised planning tools such as the multi universal screening tool were being used to assess nutritional risk. People's care plans described their needs and included guidance for staff on how to best support them. We saw that people's care plans and risk assessments had been kept under regular review.

Staff told us they had completed an induction when they started work and they were up to date with their training. They said they received regular supervision with their line managers. The manager told us that staff new to care would be required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. This was confirmed with a new member of staff we spoke with.

We saw a training matrix confirming that staff had completed training that the provider considered mandatory. Mandatory training included moving and handling, safeguarding, health and safety, first aid, fire safety, infection control, dementia care, mental capacity and food hygiene. Nursing staff had also received other training relevant to people's needs for example pressure sore prevention, the administration of medicines, nutrition and hydration, diabetes and care of the dying and bereavement. Records seen confirmed that all staff were receiving regular supervision with their line manager. Supervision records included discussion on standards of practice, action taken to address areas where practice did not meet expectations and acknowledgement of good practice.

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 home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager and staff team demonstrated a good understanding of the MCA and DoLS. They said that they always approached people on the basis that they had capacity to make decisions about their own care and treatment but where they did not, followed guidance in the MCA Code of practice. We saw that capacity assessments were completed for specific decisions and retained in people's care files. Where there were concerns regarding a person's ability to make specific decisions, we saw that the manager and senior staff had worked with them, their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them

in their 'best interests' in line with the MCA.

We saw that a number of applications to deprive people of their liberty for their own safety had been sent to the local authority for authorisation and were in the process of being considered. Since the last inspection on 9 January 2017, the home had made five applications to the local authority to deprive people of their liberty. We considered the applications and noted that they had been raised properly and provided the authorising body with a full account of the reason for the application.

People were provided with sufficient amounts of nutritional foods and drink to meet their needs. People's care files included assessments of their nutritional needs, food likes and dislikes and allergies and the support they needed with eating and drinking. We saw that, where required, speech and language therapist's advice had been sought for people with swallowing difficulties and retained in their care records. We spoke with a cook in the kitchen who showed us guidance referring to people's dietary risks, personal preferences and cultural and medical needs.

We observed how people were supported at lunchtime. Most people ate independently; some people required support and some people preferred to eat their meals in their rooms. We saw they received hot meals and drinks in a timely manner. We observed staff providing support to people giving them time and encouragement to eat their lunch. The atmosphere in the dining areas was relaxed and not rushed and there was plenty of staff to assist people when required. We saw that people were provided with a choice of drinks and snacks throughout the day and these were available in the lounges on each unit. People's views about the quality of the food at the home were positive but two of the eight people we spoke with said that the portions were small. Comments included, "I enjoy mealtimes and we are not rushed" and, "The food is good quality but I find that the portion size is small."

People were supported to maintain good health and had access to health care support. One person told us, "I get to see my specialist when needed." Another person said, "A doctor is called, if I needed them." A relative commented, "They got my relative in to see a specialist very quickly and have really looked after them since their return from hospital." A member of the nursing staff said, "We monitor people's mental and physical health and when there are concerns, we refer to appropriate healthcare professionals for advice and support." This was supported by the documents we considered in care plans and we saw that they also included records of people's appointments with healthcare professionals.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. Comments from people included, "The staff are kind and caring. It's not too bad here" and, "I get good care and can more or less do what I want. No restrictions." A relative told us, "The staff seem to know everyone and their ways and preferences. They are very kind."

People told us they had been consulted about their care and support needs. One person said, "I know all about my care plan and recorded support needs and was fully involved in setting it up." Another person told us that they could access their care plan electronically if they wished. We discussed this with the manager who explained that the home's digital care plan system allowed people to access their own plan to check and ensure the information was accurate and reflected their wishes. We looked at the system and was satisfied that the system was secure and confidential and people could not access other people's plans.

Throughout the course of our inspection we observed staff speaking with and treating people in a respectful and dignified manner. Staff appeared to know people well they were able to tell us about people's requirements and what they did differently for each person. Care was delivered by staff in a way that met people's needs. For example during meal times and social activities we saw staff actively listening to people and encouraging them to communicate their needs. Staff were also observed assisting people to sit or stand with gentle physical promoting. For example, when one person was having difficulty getting up from their chair after lunch they were offered support from two members of staff.

We saw that staff respected people's wishes for privacy by knocking on doors before entering their rooms and we observed staff respected people's choice for privacy as some people preferred to spend time in their room. One person told us, "Staff treat people with complete dignity and respect and provide as much privacy as they need." Staff told us how they ensured people's privacy and dignity was respected whist personal care was provided. A member of staff told us they closed people's doors when supporting them with personal care. If other staff or relatives knocked on the door they would ask them to wait until they had finished personal care. They said they tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could by themselves. They also told us they made sure that personal information about people was locked away at all times.

Staff had a good understanding of protecting and respecting people's human rights and we noted that they had received training that included guidance in equality and diversity. We discussed this with staff and they said that the provider and manager really promoted and encouraged these values. The provider's policy was comprehensive and available to staff at the main office.

If people could not express their views, the home ensured that the person's relative was involved. We noted that on the occasions when relatives or other supporters were unavailable, people had access to a professional representative who acted as an advocate. An advocate is a specially trained person such as an Independent Mental Health Advocate or Independent Mental Capacity Advocate who can help if a person does not have capacity to make particular decisions and would benefit from having an independent 'voice'.

People and their relatives were provided with appropriate information about the home in the form of a service user guide. This included the complaints' procedure and services the home provided and ensured people were aware of the standard of care they should expect. The manager told us this was given to people and their relatives when they started using the service.

Good

Is the service responsive?

Our findings

People and their relatives told us the service met their care and support needs. Comments from people included, "I am treated as an individual and the staff are very good with me"and, "I feel I get the care I need." A relative said, "I am happy with the way the staff and management are. My relative is getting the care that meets their needs." Another relative said, "My relative is better off here than at home and they are getting the care that they need."

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plans. People's care files included plans and risk assessments that described their care and support needs. Some included guidelines for staff from health care professionals such as occupational therapists on how to best support them with their needs. They also included historical and personalised information about the person and their families, their communication methods, their likes and dislikes and interests and preferences. It was evident during the inspection that staff knew people well and understood their needs. Members of staff were able to describe the people living in the home and their support needs in detail. They also told us that care plans were easy to follow and were always kept up to date. We saw that people's care plans and risk assessments were reviewed regularly and reflected any changing needs.

People's care plans also referred to any diverse needs such as their religious, cultural and spiritual needs. The manager and senior staff told us the home encouraged people to express themselves and they would be happy to support people to do whatever they wanted to do. The manager said that some people could communicate their needs effectively and could understand information in the written format provided to them, for example the service user's guide and the complaint's procedure. Where people had a disability, they told us these documents were provided in different formats. We noted that people with poor eyesight were provided with documents and guides in large print. The manager also said they could also meet other people's needs by providing documents in different written languages. This approach was in line with the Accessible Information Standard that was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. NHS and adult social care services are legally required to follow this standard.

Although we noted that people were provided with a range of social activities that met some of their needs, comments from people about this were mixed. One person said, "I find there's not much to do and I'm not aware of a member of staff who just organises activities" and, "There are things to do but I'm not really interested and find them a bit babyish." We observed some activities being provided on the second day of the inspection and these included quizzes and ball games. The home employed an activities coordinator but they were part time and worked at the home three days a week. We spoke with staff about this and they told us they provided activities in the absence of the coordinator such as bingo but their ability to do this depended on other support and care they were providing to people. One said, "The activities coordinator does a good job but could really do with working full-time. We often don't get the chance to get involved in this because of our other duties." Another said, "Sometimes people just enjoy our company and a good chat but we can struggle to do this as regularly as we want to because of pressures of work."

We recommend that the provider make improvements in this area to ensure that people have the opportunity to engage in meaningful activities on a regular basis and take steps to train the activities coordinator around the provision of activities for people at all levels of capability.

People said they knew about the home's complaints' procedure and they would tell staff or the manager if they were unhappy or wanted to make a complaint. They said they were confident they would be listened to. One person said, "I have no complaints so far but if I was upset about something, I would say. I'm sure it would be sorted out." We saw a complaints' file that included a copy of the provider's complaints' procedure and forms for recording and responding to complaints. We noted that three complaints had been raised since the last inspection on 9 January 2017 and the records showed that when concerns had been raised these were investigated and responded to appropriately and where necessary discussions were held with the complainant to resolve their concerns. We saw the manager and senior staff had reflected on and used complaints to help improve the standard of care provided. For example additional training for staff had been provided to make sure care provided was in line with people's needs. We also saw a number of compliments had been received in relation to the quality of accommodation and the standard of care provided.

Where people required support with care at the end of their lives, we saw there were end of life care plans in place. People's next of kin had been contacted and they were actively involved in planning care and expressing their wishes. The plans provided staff with details about the person and their current care needs. There was guidance for staff on what to do if the person deteriorated and who to contact.

We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms in some of the care files we looked at. Where people did not want to be resuscitated, we found DNACPR forms had been completed and signed by people, their relatives [where appropriate] and their GP to ensure people's end of life care wishes would be respected. A DNACPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. However the process for completion must be correct otherwise the form can be deemed invalid. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time.

The service supported and encouraged the use of technology to assist and support people. During the inspection we saw the use of technological aids to assist staff to support people such as the use of moition sensors to assist in the prevention of falls. The service had also invested in the use of a digital care planning system that was accessible to people and their relatives, if appropriate.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the running of the home. Comments from people included, "The home seems like it is well managed" and, "The owners and manager are all wonderful and really good people. They run a good home." A relative said, "The staff and manager are easy to talk to and I am happy with the way the home is managed."

The home had a manager in post who at the time of the inspection was going through the process of registration with the CQC. They became registered after the inspection on the 22March 2018. The manager was also a director of the provider company. A senior administrator and two clinical managers, who were both registered nurses, supported the manager. The manager was knowledgeable about their responsibilities with regard to the Health and Social Care Act 2008. They had sent notifications to the CQC when they were required to do so and demonstrated good knowledge of people's needs and the needs of the staffing team. There was an on call system in operation that ensured management support was available when staff needed it.

All of the staff we spoke with told us they enjoyed working at the home and said they were happy with the support they received from senior staff and the manager. However, care staff expressed mixed views about the opportunities to progress careers in the home. Some care staff said that there was no way to achieve promotion within a care-givers role as, unlike other establishments, the home did not recognise the role of a senior carer. They said that this was a potential disincentive to care staff who wanted to progress to a more senior and responsible role. When this was raised with the manager at feedback during the inspection they said, "We will look at this but have recently instigated a way for carers to progress and have liaised with a local NHS trust to train suitable carers to become Nursing Associates." Nursing Associates are regulated by the Nursing and Midwifery Counsel and support Registered Nurses to work in partnership to deliver high quality care.

Positive comments from staff included, "The manager and the nurses are brilliant and very supportive" and, "Staff morale is good. We are all well supported and the manager and owners listen to what we have to say." A less positive comment from staff was, "I wish that the carers who have spent years here and are performing a senior role were better recognised and looked after."

We saw minutes from a staff meeting in March 2018 where a new member of staff said that they felt welcomed and supported. The minutes showed that staff were able to raise concerns over the condition of people and any suggestions to improve people's health. At the same meeting we noted that management used the session as an opportunity to remind staff of important issues around people's mental capacity and the relevant guidelines and policies.

The owners took into account the views of people using the service and their relatives about the quality of care provided at the home through surveys and formal meetings. The manager said they used feedback from the surveys to make improvements at the home. A residents and relatives survey had been carried out in December 2017 and we noted that action had been taken in response to the feedback received. For

example, changes had been made to the decoration in parts of the home and some items of furniture had been replaced. This meant that the service responded to people in order to provide support and care that was reflective of their wishes. At a meeting in November 2017 we noted that residents were able to talk their preferences for holding a charity coffee morning and the dates for forthcoming Christmas parties.

The provider and manager had effective systems in place to assess and monitor the quality of service that people received. We saw that regular audits had been carried out at the home in areas such as medication, infection control, health and safety, falls, incidents and accidents, care files, staff training, supervision and appraisal, safeguarding and concerns and complaints.

The manager showed us an assessment that included an environmental safety improvement plan that the owner had commissioned in January 2018. They told us that recent improvements included decoration of parts of the home and that there were plans for another part of the home to be redecorated and refurnished. The plan also incorporated non-essential safety improvement suggestions and we noted that the manager had created a programme of improvements that incorporated many of the suggestions raised in the plan.

Staff from the home regularly attended safety forums run by the local authority. They told us they had used some of the learning from the forums to make improvements at the home. For example, we noted that learning around the local authority's revised safeguarding policy was disseminated to other staff at a staff meeting on the 4 March 2018. A member of staff said, "We use staff meetings to discuss developments with residents' conditions but also to remind staff about important policy and safety matters."