

Croft Carehomes Limited

Croftland Care Home with Nursing

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 29 October and 7 November 2018 and both days were unannounced. At our previous inspection in 2017 we found the service was not meeting the Regulations on safe care and treatment and good governance. Following the last inspection, the registered provider sent us an action plan to show what they would do and by when to improve the key questions safe, effective and well led to at least good. At this inspection we checked to see whether improvements had been made and found the registered provider had rectified the breaches we found at the last inspection. There were areas which required further improvements and they needed to demonstrate improvements had been sustained.

Croftland Care Home with Nursing is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The manager had been registered since 2015. 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.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

The registered provider had rectified their previous breach around the safe management of medicines. Systems were in place to ensure medicines were managed safely and staff had been trained to support people with their medicines. Staff had their competence to administer medicines checked.

Each person had a personal emergency evacuation plan (PEEP) which detailed how the person would need to be supported in the event of an emergency, the safety plan, route, equipment, staff support, for a named individual in the event the premises must be evacuated.

We found the environment to be maintained to a high standard and was extremely clean with good infection control practices in place. Staff were observed to follow good practice guidelines in the management and prevention of infections.

The service used standardised risk assessments and risk reduction measures to ensure people's needs were met safely. We had concerns in relation to the lack of specialist seating for those people with postural instability, but the registered manager acted promptly to our concerns.

Staff received an induction and training to ensure they had the skills to meet the needs of most of the

people who lived there. Specialist training on managing behaviours that challenged and around postural stability was required so staff could gain skills in these areas.

Staff supported people to eat their meals in an appropriate and sensitive manner and people told us how much they enjoyed their meals. People's nutritional and hydration needs were met,

The home was compliant with the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and had applied for authorisations to the local authority and were awaiting the outcome for several requests. People were supported to have maximum choice and control of their lives although further work was required to ensure decision specific mental capacity assessments and best interest decisions were in place for all decisions.

We found all the staff to be caring in their approach to the people who lived there and treated people with dignity and respect. Staff knew the people they supported very well.

Care plans were personalised and reflected people's current needs and preferences. However, the service was in transition between paper to electronic records which meant the records were not always complete and both had to be used. Some of the care records contained the information staff needed to provide people with the care and support in line with their preferences.

The registered manager had improved their systems of governance since the last inspection and with the support of a deputy manager was ensuring the required improvements were made. We received positive feedback from professionals to confirm they ensured timely referrals to meet the health and social care needs of people living 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?

The service was not always safe

Staff had not all had training in how to manage people with behaviours that challenged including acceptable restraining techniques.

There was a lack of specialist seating to ensure people's seating requirements had been met.

Staff understood their responsibilities around protecting people from abuse and they knew how to report it if they suspected it was occurring.

People's medicines were administered by staff who had been trained and had their competence checked once in line with best practice.

Requires Improvement ●

Is the service effective?

The service was not always effective.

The home was compliant with the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS). There were some decision specific capacity assessments in place, but for some people they were missing for some decisions.

Staff supported people to ensure their hydration and nutritional needs were met and prepared meals to their preference.

Staff received a review of their performance annually and were regularly supervised. Staff were provided with a range of training opportunities, although they had not been trained around restraining techniques.

Requires Improvement ●

Is the service caring?

The service was caring.

People were supported to be as independent as possible in their daily lives.

Good ●

Staff interacted with people in a caring and respectful way.

People were usually supported in a way that protected their privacy and dignity.

Is the service responsive?

The service was not always responsive.

People's care needs were assessed prior to the service being delivered. Care plans detailed the support people required although you had to search for this information between paper and electronic records.

There were some activities on offer and a dedicated activities coordinator. However, there were times when there was very little occupation for people to ensure their mental wellbeing.

People and their relatives know how to raise concerns and complaints.

Requires Improvement ●

Is the service well-led?

The service was well-led.

Staff told us the registered manager was extremely supportive and listened to the staff. The deputy manager was proactive in ensuring the service continued to improve.

The registered provider had employed a consultant who had undertaken a robust audit which had identified issues for improvement. The registered manager could demonstrate how they acted upon the recommendations.

The registered manager acted in partnership with key organisations to promote effective working relationships.

Requires Improvement ●

Croftland Care Home with Nursing

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 29 October and 7 November 2018 and both days were unannounced. The inspection team consisted of two adult social care inspectors, a specialist professional adviser 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. The expert by experience had experience of working in health and social care.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority contracts department, safeguarding, infection control, the fire and police service, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this 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.

We used a number of different methods to help us understand the experiences of people who lived in the home. 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 observed the lunch time meal experience in three of the communal dining areas and observed care interventions throughout the inspection.

We reviewed six care records belonging to people living there. We also reviewed the maintenance and audit

records for the home and records relating to staff and their training and development. We spoke with two people who lived at the home and six of their family members.

Is the service safe?

Our findings

At our previous inspection in May 2017 we found the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the management of medicines was not always safe. At this inspection we checked for improvements and found these had been made.

The main concern at our last inspection was around the management of covert medicines. This is where the medication is administered in a disguised form. During this inspection we observed staff administering covert medicines to one person and this was carried out correctly and with dignity and compassion. We checked the records for this person and found they were in line with best practice in the paper file although information had not yet been transferred to the new electronic record system.

We were previously concerned that staff administering medicines did not lock the medication room door and we confirmed this issue had been resolved. Staff told us they received training in administration and management of medicines and this was done annually by an external organisation. Staff were assessed on their competence to administer medicines and this was checked every three to six months through in-house training.

People told us their relatives were safe. We got a variable response when we asked whether there were enough staff. One relative said, "Sometimes I can't find a member of staff at all observing residents." Another told us, "There will never be enough staff [in social care]. It's hard to find staff at changeover time they are busy doing other things."

The provider utilised a dependency tool to work out the required number of staff and this showed the staffing levels were appropriate for the number of people. Staff told us there were sufficient staff on duty, and an additional staff member who could work between floors had been beneficial. However, there were times during our inspection where staff were busy supporting people, leaving very few staff available. In addition, on Cedar unit, there were only two staff on the rota, and although there were only nine people on this unit, we identified there were times when three staff were needed to support people. At these times staff had to ring one of the other units to request staff, and although there was an additional member of staff, for unplanned situations, there was a risk staff would not be available to support. We raised our concerns with the registered manager to ensure they had the deployment of staff throughout the building appropriate to the needs of the people on each unit.

The registered manager advised us they used agency staff only as required and usually during the night shift and during the day when they were unable to cover unplanned sickness. They used one agency who sent consistent care staff to the home. The registered manager kept a profile for each agency staff and was in discussion with the agency for more evidence of their training to ensure agency staff had been trained to be competent in their role.

We asked staff whether they used restraint at the service and were told they did not. However, we observed

and reviewed the care plan for one person in addition to discussing their care with a member of staff. This person was resistive to aspects of personal care and required expert handling to ensure care was delivered. There were situations where it would have been appropriate to use certain restrictive techniques, and we made a recommendation to the registered manager, in relation to staff training. Staff required training to keep themselves and people who used the service safe in relation to physical and verbal aggression. This included training on how to manage behaviours that challenged and restraining techniques to ensure restriction to their human rights were minimised.

Each of the care plans we reviewed contained a variety of risk assessments, including falls, bedrails, skin integrity and malnutrition. The provider had recently moved to an electronic record system and we saw risk assessments were being developed to meet the requirements of the service. For example, wheelchair risk assessments had recently been commissioned. We saw these were reviewed and updated at regular intervals and recorded the level of risk for each individual. Staff were able to tell us about actions they would take where people were identified as being at high risk which ensured risks were reduced to protect people from harm. Care plans contained moving and handling risk assessments and risk reduction plans. We had observed poor moving and handling techniques at our previous inspection and we noted an improvement in the way staff moved people at this inspection. The registered manager had reminded senior staff to ensure good moving and handling techniques were in practice.

There was a power cut during our inspection which affected the door lock systems. We observed all staff acted promptly to keep people safe. We also saw, sandwiches were prepared by staff as opposed to a hot meal, during this period. This was done calmly and without causing distress to the people at the service.

We saw evidence external contractors were used to service and maintain equipment, for example the gas appliances and the fire detection system. We also saw evidence that moving and handling equipment had been serviced and examined in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). At our last inspection we saw slings with unreadable labels, making this difficult to include on the equipment maintenance schedule. The registered manager told us following the last inspection new slings were purchased and we saw these were on a registered locating where the slings were held.

There were only two specialist seating systems at the home and both had been purchased by families for their relatives. We observed two people were seated in chairs which were not suited to their needs, during our inspection and we raised our concerns with the registered manager. They acted very promptly in sourcing training for staff around seating and posture. They also contacted local professionals for their advice and guidance. We have made a recommendation to the registered manager to ensure they have documented evidence people requiring equipment to maintain a safe posture, have a recorded risk assessment and care plan in place which details how they are to be supported safely.

The provider had met with the fire service to look at ways to improve the way they ensure people were protected from risks associated with fire. Following an enforcement notice the provider contracted with a specialist company to undertake a fire risk assessment, which looked in detail at the service and how the service managed risks associated with fire. Staff had been trained to be fire marshals to lead on evacuation and the registered manager told us their aim was to have a fire marshal on each shift. Two fire evacuation simulations were undertaken each year and the registered provider had purchased fire evacuation sledges for each floor, which they intended to use at the simulated evacuation drill. Each person had a personal emergency evacuation plan (PEEP) which detailed how the person would need to be supported in the event of an emergency and details the safety plan, route, equipment, staff support, for a named individual in the event the premises must be evacuated. One person's PEEP was out of date, as although had been completed the month prior to the inspection, their needs had changed in between the set review date. We

saw fire drills were held on a regular basis.

Staff we spoke with understood their role in protecting people from abuse and knew how to raise concerns both within the organisation and externally, to ensure people's rights were protected. One member of staff said, "I would go to the management. Speak with the manager, document it on the computer." We saw information around the home about reporting abuse and whistleblowing. Records showed safeguarding incidents had been dealt with when they arose and safeguarding authorities and the Care Quality Commission (CQC) had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

Accidents and incidents were recorded, and the registered manager showed us how they logged and analysed them. This enabled the registered manager to identify possible trends and provide an opportunity to implement changes and learning.

We reviewed recruitment records for three staff members. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice. There had been difficulty obtaining one person's reference and there was no record to evidence they had chased this up. However, this was provided following the inspection and all other aspects of recruitment showed the system was robust.

We found the home was clean during our inspection, and systems were in place to ensure good infection control practices. Staff had access to personal protective equipment (PPE) to minimise the spread of infection. Our only concern had been in relation to access to a second sling for those people who required the use of assistive equipment to move safely. We found people had one sling, and the serial number was recorded in their care plan. We discussed this with the registered manager, who told us each person had access to a second sling. However, additional slings were kept centrally on one floor which meant staff had to go between floors to collect these when required. Staff confirmed to us, this was an issue. One said, "It's a real problem when people have showers." We recommend the registered provider looks at a more robust and effective system to ensure people have access to a second sling at all times.

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 had the appropriate legal authority and were being met. The registered manager told us 37 people who lived at the home were subject to a DoLS authorisation. They had noted conditions on authorisations to ensure where these applied they were followed. This information was held on the first section of the electronic record system, so staff were immediately aware of the requirements. DoLS authorisations had been applied for appropriately to the local authority and were awaiting the outcome for several requests. The registered manager was able to evidence they had a system in place to check the progress of applications.

We saw capacity assessments and best interest decisions in people's care files where they lacked capacity to consent, although they were not all decision specific. Some decisions specific capacity assessments were in place. For example, we saw one in relation to the use of bed rails. On the second day of our inspection a visiting nurse was administering flu vaccinations. The home had a good system for recording information about the vaccine and a document indicating they had sought consent from family members. However, there was no decision specific capacity assessment for this, which is required to meet the requirements of the MCA in terms of specific decisions. Following the inspection, we guided the registered manager to information in relation to specific capacity assessments in relation to the flu jab. Several people were cared for in bed, and we were told this was in people's best interests. However, we recommended that the documentation around this is reviewed to ensure the decisions are compliant with the MCA and show how staff have reached this decision, in consultation with family members. We were provided with the registered providers MCA policy following the inspection which contained relevant information in relation to the Act. Additional information to guide staff around the requirement for decision specific mental capacity assessments would be beneficial.

We checked staff understanding of the MCA. One staff member said capacity is about whether, "They can make their own decision, retain information." They also told us if a person had capacity they could make an unwise decision, whatever the staff thought about the decision. This confirmed to us, this member of staff was aware of their responsibility under the Act.

We asked staff about people's dietary needs and they were able to give us a detailed account of people's

requirements. We cross referenced this information with their daily records and could see overall this information tallied. Staff had not always recorded on every occasion when additional snacks had been offered to people or supplements. Where people were supported with drinks and had their fluid monitored, there was no target amount for staff to work towards. Professional guidance from speech and language therapists and dieticians was included in people's care plans and we saw people received their meals and drinks in line with this. Staff recorded people's dietary intake and their weight was monitored and action taken if required.

We observed the lunchtime experience on all three units. We found the experience on two units were generally very pleasant. We observed staff offered a verbal choice to people but did not show plated meals to people to assist them to choose. We raised this with the registered manager, who was disappointed, as this had not been their observation in their recent mealtime audits. On Cedar unit, the lunchtime experience did not provide for a homely environment in which to eat. The serving of the main meal was completed at 1pm and the kitchen staff left with the heated trolley. Three meals were left stacked on top of the microwave. One person arrived at the table at 1.15pm while a second person arrived at 1.20pm. Their meals were served but they were not reheated. The registered manager told us they had tried to make the unit homelier by adding a new table and redecorating. We observed one person who required support and a special diet was assisted to eat at the table with care and encouragement.

Staff new to care completed an induction based on the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills and knowledge to ensure they provide high quality care and support. This demonstrated new employees were supported in their role.

All staff were required to achieve nationally recognised qualifications in level 2 with management achieving level 5. Several staff were in the process or had just achieved their award. One relative told us staff had the training required to support their relative and said, "Yes they are trained and very caring they care for the individual which is what you want to see."

We were provided with a training matrix which showed staff were offered training in a variety of topics with some training offered on line and others face to face. Some training such as medication management and moving and handling was held at the registered providers head office. The registered provider was training staff to be key moving and handling trainers and a 4-day course was planned at the end of November 2018. We also saw reference in team meetings that specific clinical training was offered to qualified staff to keep up to date such as a syringe driver course planned in December 2018. As the service was supporting people with behaviours that challenged others, staff had not been trained in areas such as restraining techniques. This was required to protect both staff and other service users from the risk of harm from those people whose behaviours could not be managed without specialist support. From our observations during the inspection and from our discussions with staff, we have recommended staff skills in this area are enhanced.

Staff received regular management supervision to monitor their performance and development needs in line with the registered providers policy of four times a year plus an appraisal. The registered manager was slightly behind in terms of time frames due to unforeseen circumstances but had booked in supervision sessions with staff to ensure they would meet their required number per year. Supervision and appraisal are used to develop and motivate staff, review their practice or behaviours, and focus on professional development.

People had access to external health professionals as the need arose and we saw from people's care records a range of health professionals were involved. A visiting dietician was present on our second day of

inspection offering advice and guidance to staff. Other professionals involved with people included GP's, psychiatrists, community nurses, chiropodists and dentists, speech and language therapy, physiotherapists and the falls team. This showed people who used the service received additional support when required for meeting their care and treatment needs.

The registered provider had a programme of refurbishments at the home and whilst we were inspecting several of the bedrooms were being painted and new flooring installed. All the bathrooms had recently been upgraded.

Is the service caring?

Our findings

When we asked relatives whether staff were caring one told us, "Yes they are kind, some of them know [person] very well." We observed staff interacted with people with warmth and respect during our inspection. This included some very positive interactions from care staff who interacted easily and pleasantly with people. However, there were times when we saw very little interaction with people.

We asked the registered manager how they assured themselves the care staff provided was compassionate and person centred. They told us "We go around, we check on staff. We listen outside doors. We do a person-centred audit. We discuss person centred care at induction and through training." Staff were able to tell us what person-centred care was and how they provided it ensuring care was centred around the person. People's individual rooms were personalised to their taste with personal items, photographs and décor. People had memory boxes outside their rooms with memories of their past lives and loved ones, although some of these were empty.

Care plans recorded people's preference as to whether they wanted their bedroom door locked when they were not in their room and if they wanted a key to their door. Staff we spoke with understood the importance of maintaining people's privacy and dignity. The registered manager told us they undertook a dignity and privacy audit and every 3-4 month they chose staff randomly to audit. They were confident staff protected people's privacy and dignity.

People were encouraged to do things for themselves in their daily life. Care plans detailed what people could do for themselves and areas where they might need support.

Staff told us they showed people a choice of clothing or meals to support them to make every day decisions if they communicated non-verbally. Care plans contained details of how to recognise people's emotions using non-verbal cues.

We saw staff were reminded about confidentiality and the General Data Protection Regulation (GDPR) in a nurse meeting to ensure staff were mindful of how they protected personal data in line with the regulations.

Is the service responsive?

Our findings

The registered manager undertook preadmission assessments to gather information to enable them to develop and individualised care which captured the person's physical and mental health needs. Care plans were evaluated monthly or before if there was any relevant or significant change in a person's needs.

The registered provider had recently moved to an electronic care record system and information was held both in paper copies and electronically at the time of the inspection. Not all information had been transferred onto the electronic system, which meant some of the electronic records we reviewed lacked specific details. For example, parts of people's records had been transferred but there was information missing in some such as dates people were referred to external specialists. For those that had been transferred onto the electronic system information was often duplicated in different sections. For one person, who had a recent improvement in their health, the information had not been updated in all areas, which was confusing but our discussions with staff confirmed they were supporting this person appropriately. We made a recommendation to the registered manager, to systematically transfer the data in each record, to ensure staff have the required information and the records represented an accurate and contemporaneous record of a person's needs without the need to search for information.

The electronic care planning system was accessed by care staff to record daily care. This included details about care information such as positional changes to prevent pressure ulcers. We checked this person's repositioning chart over a period of two weeks and found that staff had documented repositioning on average every two hours. The registered manager told us they were proud of their record in preventing the development of pressure ulcers as the only recent issues in relation to tissue viability had not been acquired at the service.

The registered provider employed an activities coordinator at the service and were trying to recruit an additional activities coordinator as they recognised the importance of providing social stimulation to improve people's wellbeing. As a temporary measure a member of care staff was picking up additional hours to provide support and the home purchased the services of external entertainers. One to one activities were provided for those people unable to take part in group activities. However, in some records, we saw very little recorded in terms of meaningful occupation. We observed doll therapy in use in one of the units with an array of soft toys for people to cuddle. The units were all very different and at times were lively and at others were very quiet with very little occupation.

The registered manager was aware of the Accessible Information Standards although they did say they were unaware they had provided information in large print for people who might be visually impaired. This standard ensures people who have information or communication needs relating to a disability, impairment or sensory loss can access services appropriately and independently, and make decisions about their health, wellbeing, care and treatment. The standard requires the service to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and they receive communication support if they need it.

The registered provider had a complaints policy in place and we saw information was available for people on how to make a complaint. The registered manager kept a record of any complaints raised at the home. Since the beginning of the year there had been 18 complaints and 10 concerns. This showed there was a system in place to respond to, and monitor concerns raised about the service. However, on the relatives' survey from September 2018, although most people had ticked they had never had to complain, one person had recorded their complaint had taken too long to resolve and another indicated they had not received an outcome. In the first half of the year there had been 35 compliments recorded and we were told all compliments were passed onto staff. The registered manager discussed a recent complaint with us. They explained to us what they were doing to try and resolve the difficult situation and assured us they would act on any recommendations made following the conclusion of the complaint.

The registered manager advised us they had been provided with end of life training from the Clinical Commissioning Group. We saw some end of life care plans in the files we reviewed but they were not present in all the files. The registered manager said, "We are on with them now. It's very difficult to get families to discuss it. It's part of the red bag scheme. (This national scheme ensures continuity of care as health-related paperwork and personal belongings travel with the person to hospital in a dedicated red bag). We've been chasing families to discuss end of life."

Is the service well-led?

Our findings

At our previous inspection we found the service was not meeting the Regulations in terms of good governance as the systems in place had not been effective at ensuring improvements were made. We found improvements had been made and the service was no longer in breach of this Regulation. We found both the registered manager and the deputy manager had a good overview of some aspects of the service they delivered. They had taken on board guidance provided following previous inspections to drive improvements to rectify the breaches identified at the previous inspection. However, we found there were areas which required further improvement and the registered provider was required to demonstrate they could sustain the improvements they had made.

Most staff told us they felt supported by the registered manager and deputy manager. Comments included, "They are brilliant. Helped me and supported me."

A daily walk round was completed by the registered manager when on duty and they told us they had spent more time on the units since the last inspection to increase their visibility. From the information we reviewed we could see the registered manager completed a range of audits to assess the quality of the service provided. These included a medication audit. The registered manager had undertaken several mealtime observations over the month. No issues had been highlighted from this. The deputy manager completed audits of people's weights and told us people were weighed weekly or monthly dependent on their needs. We saw the audit and the weight review sheet which showed us weights were monitored and referrals made where it was noted people had lost weight.

Audits included mattress checks, wheelchairs, slings, beds, legionella, water temperature and maintenance checks. In addition, the registered manager undertook audits of the premises, health and safety, bedroom audit and finances. The home had access to three maintenance officers which they could access immediately if the need arose.

The registered manager told us lessons were learnt by the home when things went wrong. This included discussions at team meetings. They told us they were encouraging staff to whistle blow if they were concerned about the care provided by their colleagues. They said they were trying, "To educate staff so they don't think they are getting people into trouble." They were keen to promote a culture of openness, where staff felt able to speak out to ensure the identification of areas which needed to improve.

The registered manager told us the provider had also engaged the input of an external consultancy to assist them in improving the governance systems throughout the organisation. They had completed a detailed audit and made recommendations for the registered manager to follow.

We asked the registered manager how they ensured the service they provided followed current good practice guidance. They told us attended good practice events provided by the local authority. They also attended Skills for Care events and were booked to attend the registered manager meeting, they received alerts from NICE, and could evidence they had used the information in relation to medication, falls, diabetes

and blood borne virus. They ensured staff were aware of patient safety notices and we saw a notice up in the kitchen area of the units in relation to the use of thickeners. This demonstrated the registered manager has cascaded information to the relevant people to promote safe care and treatment. We noticed the cascading of safety notices had been highlighted by the consultant and our discussions with the registered manager demonstrated they were aware of the importance of such notices, to ensure the safety of people living at the home.

The registered manager recognised an area which required improvement was around staff training in how to manage behaviours that challenged, particularly as they supported several people with such behaviours. They told us they were already looking into more training with the registered provider on this topic. They had already recognised the need for staff to de-escalate situations by recognising behaviours before they escalated.

Staff meetings were held regularly, and we were provided with the minutes of the latest nurses meeting held in September 2018. Recent topics discussed included confidentiality, training, care planning and the electronic care plans and the outcome of the contracts and commissioners visit. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people. The minutes demonstrated this was an opportunity for staff to offer their views about how the service was performing. However, one member of staff told us there were meetings for non-clinical staff, but these were rare. Although when they did attend, they had been useful and had included a review of the service, complaints and praise.

The most recent relative's survey had been sent out in September 2018. The registered manager showed us a summary of the results. We saw 45 surveys had been sent out and 24 completed surveys were returned and most of feedback was positive, although very few people had made comments. Resident meetings were held at the home which offered people an opportunity to influence their care provision.

We found the management team worked in partnership with community professionals to promote the wellbeing of the people living at the home. They worked with partners such as the local authority and the Clinical Commissioning Group to ensure good working relationships which benefitted people using the service.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications as required. There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster displaying the ratings from the previous inspection on display at the entrance of the home and the rating, along with a link to the CQC report was also available on the registered provider's website.