

Inniscastle Care Limited

# Victoria House Residential Home

## 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?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This was an unannounced inspection carried out on 12 and 13 October 2017. Our last inspection took place on 15 and 20 February 2017 when the service was overall rated as 'Inadequate'. Four breaches of the regulations were found. At the last inspection we found the service was not always safely managed and there was sufficient numbers of staff to meet people's needs. Environmental risks were not always well managed. People did not receive choice of food and drink and staff. Consent was not always recorded appropriately. The provider had not always submitted notifications to the CQC and audits had not identified the concerns we raised. We asked the provider to take action to make improvements.

Since that inspection this service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection we found that improvements have been made and action taken. The service is no longer rated as inadequate overall or in any of the key questions and is now out of Special Measures.

Victoria House Residential Home is a 'care home'. 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. The care provider, Inniscastle Care Limited, is registered to provide accommodation for up to 41 persons who require personal care only in one adapted building. At the time of our inspection there were 28 people using the service.

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.

We saw the service was clean and had appropriate infection control processes in place.

Each person we spoke with told us they felt safe. Relatives expressed no concerns about the safety of their family members and they were complimentary about the level of care provided. The service had appropriate safeguarding policies and procedures in place, with detailed instructions on how to report any safeguarding concerns to the local authority. Staff were all trained in safeguarding vulnerable adults and had a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

We saw the service had systems in place for the safe administration and recording of medicines. We raised some small issues around medicines, their storage and recording. All people taking medicines had a medication administration record in place, which included a photograph to ensure medicines were given to the correct person. During the inspection most records we observed had been filled out correctly and all medicine amounts tallied.

All staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We checked whether the service was working within the principles of the MCA. We found that the provider had followed the requirements in DoLS authorisations and related assessments and decisions had been appropriately taken.

Staff spoke positively about the training available. We saw all the staff had completed an induction programme and on-going training was provided to ensure skills and knowledge were up to date. However, records showed some staff had passed the provider's recommended refresher timescales for some courses.

Staff confirmed they received supervision with their line manager, which along with the completion of team meetings, meant they were supported in their roles. Records we saw backed up what staff had told us.

Observations of meal times showed these to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people and encouraged them throughout the meal. We saw nutritional assessments were in place and special dietary needs catered for.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. Both people who used the service and their relatives were complimentary about the quality of the staff and the standard of care received.

Care files contained completed pre-admission assessments and accurate and detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, along with a range of personalised information which helped ensure their needs were being met and care they received was person centred.

Everyone we spoke to was positive about the variety and frequency of activities available. We saw the activity schedule catered for all interests and abilities and included involvement from external agencies. A large number of activities and events had been the result of suggestions made from people who used the service. The staff actively documented activities and displayed photographs of the different events that had taken place around the building.

The provider had recruited an additional member of office staff to review and complete audits and checks within the service. They had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a weekly and monthly basis and covered a wide range of areas including medication, care files, infection control and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

## 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.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe.

The environment was mostly safe from the risk of infection.

Most medicines were stored, handled and administered safely by staff who had received training and their competency assessed.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Staff reported that sufficient and regular training was provided to enable them to carry out their roles successfully however we found some gaps in training for some staff.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced in the care plans.

The service worked closely with other professionals and agencies to ensure people's health needs were being met.

People were supported with their nutritional needs.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

People living at the home and their relatives and visitors were positive about the care and support provided.

Throughout the inspection we observed positive interactions between staff and people. Staff members were friendly, kind and respectful and took time to listen to what people had to say.

People were able to make choices about their day Staff had an understanding of the importance of promoting independence.

**Good** ●

### Is the service responsive?

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way.

Care plans and other records were regularly reviewed, with involvement from the person themselves, their family or other representative.

People were positive about the activity programme at the home which was varied and provided choice.

Complaints were responded to appropriately.

Good 

### Is the service well-led?

The service was not always well-led.

Audits and monitoring tools were in place and had improved since the last inspection and used regularly to assess the quality of the service. They had not identified some of the smaller concerns we raised on the days of inspection.

People living at the home, relatives and staff said the home was well-led and managed and they felt supported by management, albeit some comments reflected the registered manager's presence in the communal areas of home could improve.

Team meetings and residents meetings were held to ensure that all staff had input into the running of the home.

Requires Improvement 

# Victoria House Residential 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 12 and 13 October 2017 and was unannounced.

The inspection team consisted of three adult social care inspectors, a specialist pharmacy advisor and an expert by experience (ExE). 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 ExE had experience of working with older people.

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the safeguarding and commissioning teams at Leeds City Council prior to inspection, they told us they had no present concerns.

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.

During the course of the inspection we spoke to the registered manager, senior care worker, four staff members and a visiting health professional. We also spoke to four people who lived at the service three relatives and one visitor.

We looked around the service and viewed a variety of documentation and records. This included four staff files, four people's care records, nine Medication Administration Records (MAR) charts, policies and

procedures and audit documentation.

# Is the service safe?

## Our findings

At our last inspection we rated the service Inadequate for this domain. We found the provider was in breach of regulation 12 (Safe care and treatment) and regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found medicines were not always managed safely, staffing levels were not appropriate to meet people's needs and risks were not well managed. At this inspection we found improvements had been made. However, in order to obtain a 'Good' rating we have to see a sustained period of time for improvements to have been made. We also found further areas of improvement that had not been identified by the provider.

We asked people who used the service if they felt safe living at Victoria House Residential Home. The four people we spoke with all told us they did, with one saying, "If you ring the buzzer they always come. I get on well with everyone. If I didn't feel safe I would speak to the one in charge." Another said, "I'm local, my family live around here and my daughter works here as a senior carer. There's no trouble with people hanging around." We asked relatives visiting the home for their opinion, one told us, "My father in law was here three years ago and that's why my relative chose to come here. I feel my relative is safe because of the staff and the way they look after people." Another said, "I love the place and have never seen anything to concern me."

We looked at medicines management within the home. Each person's medication was stored in a store room. Temperatures were monitored within this room but not recorded as the maximum high and low temperatures each day. We mentioned this to the registered manager who agreed to start recordings of high and low temperatures once they had the correct thermometer. We saw detailed policies and procedures were in place and a document had been drawn up which staff had signed to confirm they had read and understood these.

Each person had a Medicine Administration Record (MAR) in place, which included their photograph, date of birth, GP details and any allergies. We viewed nine MARs during the inspection and saw that all prescribed medication had been administered and signed off correctly, with a running balance documented for each medicine. We saw the specimen signature chart tallied with the staff signatures on the MAR charts. We completed stock checks of nine people's medicines. All medicines we checked had the correct amount remaining, indicating that all medicines had been administered correctly.

The service had when required medicine (PRN) protocols in place. These explained what the medicine was, the required dose and how often this could be administered. This ensured 'as required' medicines were being administered safely and appropriately. Topical medicine charts were in place, on which staff had documented where on the body creams had been applied.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We checked the controlled drug (CD) cupboard and saw this was locked with the key stored separately. We saw the cupboard was currently not bolted to the wall to the correct standard. We mentioned this to the registered manager who agreed to review the storage. We



checked the stock levels of four people's medicines and saw that these tallied with the CD register. We also noted that all entries were supported by two staff signatures as is required.

A medication fridge was also present in which medicines that required storing at certain temperatures were kept. Daily fridge temperature monitoring was in place and had been completed consistently.

We looked at the service's safeguarding systems and procedures. Safeguarding procedures were in place detailing relevant information about the various signs and indicators of abuse and how to report any concerns. The provider had a dedicated safeguarding file which contained a copy of the company policy along with local authority guidance on identifying and reporting safeguarding concerns. This ensured that anyone needing to report a concern could do so successfully.

Staff we spoke with were aware of the different ways a person can experience abuse and were clear about what action they would take if they witnessed or suspected any abusive practice. Each member of staff confirmed they had received training in this area and that this was refreshed within required timeframes. One staff member told us, "We speak about this a lot to make sure we all know what to look for." Another said, "If I think someone is acting differently from the way they normally act, I would mention it in case it's an indication of abuse."

The provider had robust recruitment procedures designed to protect all people who used the service and ensure staff had the necessary skills and experience to meet people's needs. The recruitment process included candidates completing a written application form and attending a face to face interview. We looked at the recruitment records of four staff members. We found references were obtained and saw evidence that a Disclosure and Barring Service (DBS) check had been sought. This meant the registered manager only employed staff after all the required and essential recruitment checks had been completed.

Upon arrival at the service, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. The premises were clean throughout and free from any offensive odours. We saw bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available. The bathrooms were mostly well kept and surfaces were clean and clutter free. We saw one bathroom had a cracked floor. We mentioned this to the registered manager who made arrangements for this to be fixed as soon as possible. Cleaning products were stored safely.

The staff completed dependency assessments for all the people who used the service in order to determine their level of need and the number of staff required to reduce people's needs. We asked the registered manager about staffing levels and were told that numbers had dropped due to a decrease in people who used the service. The registered manager felt at present there was appropriate numbers of staff to support people with all their needs safely. We asked what arrangements were in place to cover sickness and holidays. We were told that the registered manager would contact other staff members and any gaps were usually filled this way. People told us they felt there were enough staff on duty and they were not left waiting for long periods of time. For example, one person told us, "There is always someone here, during the night as well." Our observations showed people were responded to quickly and staff did not appear to be task orientated or rushed.

We looked at how accidents and incidents were managed. An accident/incident record book was in place and all relevant information had been documented and appropriate action taken. The registered manager told us that all accidents and incidents were analysed by them for information and linked with trends or areas of concern.

Falls management was handled within the service. People were recognised appropriately when they were deemed 'at risk' of falls with risk assessments in place and referrals made to the relevant agencies when required. People's care files detailed information to enable staff to appropriately and safely support them with their mobility requirements.

We looked at the provider's safety documentation, to ensure the service was appropriately maintained and safe for people. Gas and electrical safety certificates were in place and up to date, all hoists and fire equipment were serviced within regulatory timeframes with records evidencing this. Alarm call points, emergency lighting, fire doors and fire extinguishers had all been checked regularly to ensure they were in working order. However, we found three fire doors that were labelled to be locked when not in use which were unlocked. We mentioned this to the registered manager who immediately took action.

## Is the service effective?

### Our findings

At our last inspection we rated the service Inadequate for this domain. We found the provider was in breach of regulation 14 (Meeting nutritional and hydration needs), regulation 18) (Staffing) and regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people's choices were not always respected, staff supervisions were not always completed and consent was not always appropriately recorded. At this inspection we found improvements had been made. However, in order to obtain a 'Good' rating we have to see a sustained period of time for improvements to have been made. We also found further areas of improvement that had not been identified by the provider.

People living at the service told us they enjoyed the food and were offered refreshments throughout the day. One said, "I have had nothing today but the food is okay." Another told us, "The food is nice; I have toast/toasted teacake/cereal/bacon/sausage sandwiches for breakfast. I don't eat the supper because I am not hungry by then." Relatives were also complimentary about the food with one telling us, "The food is fine, my relative never complains and they are a good eater."

We spoke with the cook who showed us information on people who were diabetic, those requiring diet control, people who had fortified and/or softened food. They described how they fortified people's food using butter and cream and how they made a smoothie for someone. They said their working hours had changed and they now worked until 6pm so that they could cook supper.

People's weight was checked at regular intervals which helped staff to monitor risks of malnutrition and support people with their diet and food intake. People's dietary needs had been considered and were being managed effectively. Food and nutritional assessments and care plans were in place. These explained each person's needs, how to support them with their diet and eating and any associated risks. For those people on a soft diet, advice sheets were in place detailing what they could and couldn't eat.

Processes were in place to assess and monitor people's nutritional and hydration needs. Nutritional screening assessments such as the Malnutrition Universal Screening Tool (MUST) were used. This is a screening tool which is used to identify people who are at risk of malnutrition. Professional involvement had been sought where necessary, with Speech and Language Therapy (SALT) assessments and correspondence located in care files. We found a discrepancy in one person's weight records. We mentioned this to a member of staff who told us they were not aware that staff had received any training in how to use the scales and that weight might not always be recorded accurately. This was mentioned to the registered manager who agreed to take action.

We looked at the staff training documentation. Staff training was monitored via a matrix with each staff member's record detailing what training sessions had been attended along with the date of completion. New staff completed an induction program to ensure they had the skills and knowledge to carry out their role. Records of training completed along with certification were located in each staff member's personnel file. However, we found records indicating 11 training records had lapsed and were now out of date. Most of these staff were now booked on a new course. We asked relatives if they felt staff were well trained. One told

us, "Yes, I think they are very good." Another said, "I would say they definitely seem to know what they are doing."

We asked staff for their opinions on the training provided. One told us, "I did induction training when I started, gave me enough knowledge to do the job." Another said, "After doing my induction training, I shadowed existing staff until I had completed other training. They provide plenty of training here." A third stated, "Staff receive in depth induction training and specific training in care planning. To ensure plans are being followed."

The staff we spoke with said they received supervision from their line manager. One told us, "It's got a lot better since the last inspection." Another said, "I have had a few this year." A third stated, "I think they are all planned in now, but yes I have had a few." We saw staff supervision records had been completed and records were kept to show when supervisions had occurred. This made it easy to recognise if anyone had been missed. We saw no gaps in supervision since the last inspection.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of providing this. We asked staff about their understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both although there was some confusion where knowledge could be improved. One staff member told us, "I know they are linked and it's about making decisions." Another said, "It's about if people have the mental capacity to make their own decisions."

At the time of the inspection, DoLS authorisations for 12 people had been applied for. We saw that the registered manager logged details about referrals, which detailed when each application had been submitted, date documents received, start date, expiry date, duration and date for review. We saw evidence that action had been taken to chase up outstanding applications. We looked at how the staff sought consent from people who lived there. Each care plan contained consent forms, which covered consent to care and treatment, use of photographs, signing care plans, people accessing their records and had been signed by either the person themselves or their representative. During the inspection we saw staff seeking consent before providing care and support, including knocking on doors and seeking agreement before commencing any transfers or support with mobilising. We saw evidence of best interest meetings and mental capacity assessments had taken place appropriately.

Our review of people's care records showed the service worked closely with other professionals and agencies to meet people's health needs, these included GP's, speech and language therapists and district nurses. We spoke with a visiting professional who told us things had got better but they were still working closely with the home to provide support. They told us how the service had dealt with a diarrhoea and vomiting outbreak a few months ago and felt there was room for improvement. When we asked further about this they told us it was not a concern for them but the process followed could have been improved to reduce the risk of infection further.

Staff told us communication had got better in the service, although there was still a lot of e-mail activity which alerted staff to any changes. Some staff felt this was not the best form of communication for them as it was sent to their personal email. Our observations showed staff clearly talking with each other and sharing important information. People's primary form of communication was recorded and adaptations to support their understanding when English was not their first language. For example, staff used English communication cards to communicate with one non British person. Another person had their care plan

translated into their language of first choice so they could read it.

# Is the service caring?

## Our findings

At our last inspection we rated the service Requires Improvement for this domain. We found people's equality diversity and human rights were not always respected. At this inspection we found improvements had been made.

The people we spoke with told us they liked the staff and found them to be caring. One told us, "Staff are lovely they are like friends, cannot grumble at all." Another said, "Care staff are great, managers are a bit bossy." Whilst a third stated, "Staff are alright to me." We spoke to visiting relatives to get their views, one said to us, "The staff are great, and cannot fault them." A second said, "Staff are great, never had a problem with any of them, staff are tremendous, they look after my relative well." A third added, "I am impressed by the care and attention people get here."

We asked people who lived at the service if staff treated them with dignity and respect. All confirmed that they did. Relatives also told us that this was the case, with one saying, "I cannot speak highly enough of the staff." Another told us, "Oh yes, I see them having a laugh and a joke together." We asked the staff how they maintained people's dignity and respect. One said, "We always make sure people are dressed properly and we knock on doors before entering. We always have to ask for their permission before doing anything with them." Another gave us examples about people's rights and choices. They said, "I treat people how I would want my family to be treated."

Over the course of the inspection we spent time observing the care provided in all areas of the service. People looked clean, appropriately dressed and well groomed. We saw staff interaction with people was warm and friendly. For example, staff members were observed ensuring they were at eye level with people when engaging in conversation, even if this involved bending or kneeling down. Appropriate physical contact by the staff was observed, such as hand holding or placing their arm around someone whilst speaking discreetly with them. Throughout the inspection people responded positively to the interactions with staff and the care being given.

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "I let them do as much as they can for themselves, if they can wash themselves I let them but make sure they know I am here if needed." Another told us, "I get people involved in doing things for themselves such as brushing their teeth and hair. I help them but encourage them to be independent."

The care files we viewed contained an equality and diversity profile which covered marital status, ethnic group, religion and sexual orientation. The profile also contained a section for people to record any special requests or requirements they had such as cultural or religious wishes and needs.

People's end of life care was dealt with in a sensitive way. When appropriate, people had documentation in place to ensure their ends of life wishes were considered. This included decisions around resuscitation. We saw compliments from families thanking the service for the care and support offered to them when facing the final days of their loved ones lives.

## Is the service responsive?

### Our findings

At our last inspection we rated the service Requires Improvement for this domain. We found care plans were not always fully completed and did not match other sections of the care records. Activities did not happen when the activities coordinator was absent. At this inspection we found improvements had been made.

We saw that people received care that was personalised and responsive to their individual needs and preferences. Prior to any new admission a pre-assessment was carried out with the person and their relative(s). Each care plan was detailed and captured people's support needs and wishes so that staff knew exactly how each person wanted to be cared for.

Each person's care file contained information on areas such as the person's emotions, what made them feel comfortable, favourite food and drink and how they liked to spend their day. There was also a document listing things that were important to the person, which included details of where and how they wanted to be supported. These documents had been used to formulate the care plans for each person and provided guidelines for staff on the provision of care.

We also saw evidence of a person centred approach within the main care files. Assessments had been completed in a range of areas including communication, memory and understanding, hygiene and personal care, family contact and social company. In each instance people had been asked to state what they preferred, what they were able to do, what they needed assistance with and what was important to them in that area. Each document then explained how the service intended to meet those needs.

People we spoke with told us they had been involved in planning and reviewing their care. One relative told us, "I was involved in the initial assessment; they asked me lots of questions." Another said, "Care plan reviews have happened a few times and they ask if I want to come." We saw records of family involvement in both initial care planning and reviews of care plans, with formal reviews taking place every three months or sooner if any issues of note or major changes had arisen. Additionally staff members reviewed each person's needs on a monthly basis documenting if any changes had occurred.

We asked staff how they knew what was important to the people they cared for. One told us, "We have time to get to know people so we know when they are not their normal selves." Another said, "We speak with each other a lot and we can always go to look at the care records." We asked staff to tell us about some individuals who lived at the home. Staff were able to list important and specific things about people. This showed us staff knew people well.

The service had a number of activities they did with people. All staff had a responsibility for organising and facilitating the activity programme. During a person's initial assessment it identified their likes and dislikes and how they liked to make decisions about things they would like to try. Two people we spoke with did not get involved in the activities and preferred to do their own things in their rooms such as watch DVDs. Two further people told us there were plenty of activities going on including chair exercises, bingo, entertainers, trips to the shops, church, reminiscence, quizzes, singing and celebrations. People told us they had enough

to do. Most of the relatives agreed with this. We observed a music and exercise activity in the morning in the red lounge and a musician with keyboard in the blue lounge in the afternoon and people were involved and appeared very happy.

We looked at how complaints were handled. The service had policies and procedures in place to deal with formal complaints. The policy provided directions on making a complaint and how it would be managed, this included timescales for responses. The registered manager told us the service had received three formal complaints since the last inspection. These complaints had been fully processed in line with the providers' policy. People we spoke with were knowledgeable about what to do if they had any concerns and felt confident these would be dealt with effectively. Comments from family members and visitors supported this.

The registered manager held a file which contained compliments cards, letters and emails. We noted the service had received a number of compliments in the past year; these were from other professionals and family members. We looked at a sample of these and noted positive comments which complimented staff on their professionalism and the service for the standard of care received by their family members.



## Is the service well-led?

### Our findings

At our last inspection we rated the service Inadequate for this domain. We then found the service was in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. However in order to obtain a 'Good' rating we have to see a sustained period of time for improvement's to have been made. We also found other areas of improvement that had not always been identified by the service.

At the time of this inspection 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. The provider had a clear management structure in place. Each shift was overseen by a shift leader as well as the registered manager. We found the registered manager was proactive and had obtained support from a specialist member of staff. The provider visited the service at regular intervals and made checks to understand how the service was being run.

The staff we spoke with felt that the service overall was well-led and managed and they felt supported. One told us, "We are a good team and I think we all work together." Another said, "I enjoy my job, I think we all do." The shift leader was reported to be visible on the floor, one staff member said, "They are nice and approachable. If we need anything they are around somewhere." Some other members of staff mentioned the absence of the registered manager in the communal areas. They told us they spent a lot of time in their office so visually they did not always have a strong presence. One of the relatives we spoke with told us, "The management are very helpful. They have sorted anything I needed."

Staff and relatives told us there was a positive culture within the service One relative said, "It's a nice, friendly place, and all help each other and are mates together. Everything is always done neatly. Staff are marvellous. It's like a big family. You are always well looked after", and another said, "Atmosphere is fine, it's a friendly place, there is no carry on/fall outs, pleasant place. In fact, the chiropodist that comes and the district nurse have both told me this is the best place they visit, staff chat and it's homely" and, "It's a really good atmosphere, relaxed and friendly. They had a 100th birthday party for my relative; let us have the green lounge for the event. The place runs smoothly, there are never any problems. Meals are on time, if anyone needs a drink or the toilet staff are ready to help, people who require help always get it such as a hoist etc, and it's handled in a dignified manner."

We saw that team meetings were completed with staff. Meetings were scheduled to take place at regular intervals. Ground rules had been set up and agreed for all the meetings, to ensure they ran effectively and everyone was able to participate. We saw that minutes had been taken and action plans generated.

The provider's policies and procedures were stored both electronically and as hard copies. These included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated regularly and staff notified of any changes; this meant that the most up to date copy was always available and staff were made aware of any changes to practice.

The provider used a range of systems to assess the quality of the service; this included gaining the opinions of people using the service and their relatives by sending out questionnaires. The registered manager told us that the questionnaire was sent out annually and was designed to look at people's view on the home's response to complaints, people's satisfaction with the décor, the attitude and approachability of staff, as well as asking for feedback on what they could do better and what people would like to see and do. We looked at the most recent relative questionnaires sent out in February 2017 and noted the vast majority of responses indicated people were happy with the service provided.

We saw systems in place to monitor the quality of the service. The registered manager told us the provider had employed a quality performance team member since the last inspection. This person was responsible for carrying out audits and analysing areas such as falls, accidents/incidents and safeguarding alerts. The registered manager said they would be alerted by the person of any trends and themes that may require further follow up or investigation.

Internally the service completed a range of audits covering all aspects of home maintenance and service provision. Environmental audits were carried out weekly looking at lighting, general maintenance, cleanliness and condition of furniture and equipment. Further domestic and environmental audits were also completed to ensure walls, floors, furnishings throughout the home were in good condition, clean and free from stains. Other areas audited on either a weekly or monthly basis included meal times, mattresses, infection control, care plans and medication. All audits contained actions points along with information about what had been done to address any issues.