Paydens (Nursing Homes) Limited

Betsy Clara 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

We inspected the service on 25 March 2018. The inspection was unannounced. Betsy Clara 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. Betsy Clara is registered to provide accommodation and nursing or personal care for a maximum of 48 people. The home specialises in providing care to older people, people who have disabilities and some people living with dementia. At the time of our inspection there were 43 people living in the service. Betsy Clara is situated in Maidstone and is arranged over two floors.

The service had a registered manager. 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.

People were protected from abuse. Staff received regular safeguarding training, and were able to tell us about different types of abuse and what action they would take if they saw someone being abused. Risks to people had been identified and they had been involved in developing plans to minimise them. Positive risk taking was encouraged and guidance was provided to staff in order to help keep people safe. The provider had also ensured that the environment was safe for people. There were sufficient numbers of staff to keep people safe and meet their needs. The manager used a dependency tool to calculate the numbers of staff needed based upon the needs of the people living there. Staff were recruited safely. People received their medicines safely. The service had a close relationship with the local GP, who visited on a weekly basis to review each person's medicines. People were protected by the prevention and control of infection. Accidents and incidents were reported by staff in line with the provider's policy, and the registered manager took steps to ensure that lessons were learned when things went wrong.

People's needs were assessed and their care was delivered in line with current legislation. Staff had the training and skills they needed to meet people's needs. Newly recruited staff received a comprehensive induction before they started to support people and regular ongoing face to face training sessions. People were supported to eat and drink enough to maintain a balanced diet. Staff referred to and followed guidance from health professionals such as dieticians and the local Speech and Language Therapy (SaLT) team. Suitable arrangements were in place to ensure that people received effective and coordinated care when they were referred to or moved between services, such as when they went to or returned from hospital. People's needs were met by the adaptation, design and decoration of the service.

People were treated with kindness, respect and compassion. People had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. People's privacy, dignity and independence were respected and promoted. Staff were able to give examples of how they treated people with dignity when supporting them.

People received personalised care that was responsive to their needs. Each person and their relatives were involved in the development of a personalised care plan which took into account their wishes and preferences. People were supported to follow their interests and take part in activities that were appropriate to them. The service employed a full-time activities coordinator who organised activities based on the interests of people. Complaints were listened and responded to. People told us they knew how to make a complaint and were confident to do so if they needed to. People were encouraged to maintain relationships with those who matter to them People were supported at the end of their life to have a comfortable, dignified and pain free death.

The registered manager had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. Management encouraged transparency and honesty within the service. The registered manager and registered provider were also aware of their responsibility to comply with the CQC registration requirements. Systems and procedures were effective in ensuring that shortfalls in service delivery were identified and rectified. The registered manager had ensured that regular audits were carried out to review the quality of the service. People, their families, staff and visiting professionals were encouraged to be engaged and involved with the service.

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.

People were protected from abuse.

Risks to people and the environment were assessed and minimised.

There were sufficient numbers of staff to keep people safe and meet their needs.

Staff were recruited safely.

People received their medicines when they needed them from staff who had been trained and competency checked.

People were protected by the prevention and control of infection.

Accidents and incidents were reported by staff in line with the provider's policy.

Is the service effective?

Good

The service was Effective.

People's needs were assessed and their care was delivered in line with current legislation.

Staff received the training and had the skills they needed to meet people's needs.

People were supported to eat and drink enough to maintain a balanced diet. People told us they enjoyed their meals.

Staff worked together across organisations to help deliver effective care, support and treatment.

Staff were knowledgeable about the Mental Capacity Act.

People's needs were met by the adaptation, design and decoration of the service.

Is the service caring?

Good

The service was Caring.

People were treated with kindness, respect and compassion.

People were supported to express their views and be actively involved in making decisions about their care and support.

People's privacy, dignity and independence were respected and promoted.

Is the service responsive?

Good

The service was Responsive.

People's care was provided in a personalised way.

People were encouraged to maintain relationships with those who mattered to them.

People told us they were confident to raise complaints and concerns about the support they received.

People were supported to take part in activities that interested or were appropriate to them.

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was Well-led.

The registered manager had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff.

Management encouraged transparency and honesty within the service.

Governance systems were effective in ensuring that shortfalls in service delivery were identified and rectified.

People, their families and staff were encouraged to be engaged and involved with the service.

There were strong and growing links with the local community.

Betsy Clara Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons continued to meet 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 17 and 18 April 2018 and the inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

During the inspection we spoke with five people who lived in the service and with three relatives. We also spoke with three members of care staff, the activities coordinator and the chef. In addition, we met with the registered manager and other senior staff. We also observed care that was provided in communal areas and looked at the care records for five people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, 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 speak with us.

Good

Is the service safe?

Our findings

People told us they felt safe living at Betsy Clara. One person told us, "I feel safe living here. I would tell the boss if I had a problem." Another said, "I have bad anxiety attacks but if I can't deal with them the staff come and reassure me. That really helps me and makes me feel safe." A family member told us, "My partner has recently moved here, and I feel sure she is safe, it's secure here. I see the same faces."

People were protected from abuse. Staff received regular safeguarding training, and were able to tell us about different types of abuse and what action they would take if they saw someone being abused. One staff member said, "I would speak to the nurse or manager if I thought anything was happening. If something doesn't sit right with me I'll raise it." The registered manager knew to report concerns to the local authority when necessary, and worked closely and transparently with them during safeguarding investigations. The registered manager had informed the Care Quality Commission when concerns had been raised. Staff understood the service's whistleblowing policy and felt confident in using it if the need arose.

Risks to people had been identified and they had been involved in developing plans to minimise them. For example, where one person was at risk of a pressure ulcer, staff referred to guidance on how often they should be turned during the night. Positive risk taking was encouraged and guidance was provided to staff in order to help keep people safe. Some people were free to move throughout the service unaccompanied, and others who were at risk of falls were supported by staff who provided only the support needed. Plans were in place to support people in the event of an emergency. Each person had an individual personal emergency evacuation plan (PEEP), which provided guidance to staff on the support each person needed if the building needed to be evacuated. Staff had completed fire training, took part in fire evacuation drills and were confident to use the fire equipment located throughout the service.

The provider had ensured that the environment was safe for people. There were up-to-date safety and maintenance certificates for gas appliances, moving and handling equipment and legionella. Regular checks on water temperatures meant people were protected from the risk of scalds. The person responsible for maintaining the service carried out regular checks of the external and internal environment and fixed any faults swiftly. This meant the environment was safe for people to live in.

There were sufficient numbers of staff to keep people safe and meet their needs. The manager used a dependency tool to calculate the numbers of staff needed based upon the needs of the people living there. This tool was updated each month to take into account people new to the service and when people's needs increased or decreased. A recent review identified a person's needs had increased, and this meant an additional staff member was required during the day shift. The rota showed an extra staff member was on shift each day. Staff told us rotas were organised fairly, taking into account their personal circumstances and routines, and all permanent staff had fixed weekly hours. Sickness or other absence was covered using overtime from permanent staff or agency staff. During our inspection we saw there were enough staff as people received the support they needed in a timely manner.

Staff were recruited safely. We looked at four staff files and saw the service was following its recruitment

policy. This included keeping records of application forms and interviews, photographic identification, employment history and reference checks from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks identified if prospective staff had a criminal record or were barred from working with people that needed care and support. The registered manager ensured staff did not work with people before these checks were made. These measures helped ensure that they were suitable to be employed at the service.

People received their medicines safely. When people moved into the service they had their ability to manage their medicines assessed, and if they needed support this was provided by staff. There were two qualified nurses working at the service at all times, one covering each floor, and the nurses were responsible for the administration of all medicines. We saw the nurses had enough time to carry out their role effectively and safely. They explained to people what their medicines were for, and allowed people to decide if they wanted to take them or not. Where people declined to take their medicines the nurses would return after a short period of time to further encourage them. If they didn't take them it was recorded accurately and the GP was informed. Some people who did not have the ability to make decisions about their medicines received them covertly, in their food for example. Staff had followed the principles of the Mental Capacity Act 2005 to ensure this was done in their best interests. There was written guidance for nurses for when 'as and when' medicines such as pain killers could be administered, and the nurses recorded reasons they were given in order to provide accurate feedback to the GP. The service had a close relationship with the local GP, who visited on a weekly basis to review each person's medicines. Any changes to medicines were recorded and shared between staff on daily handovers. These handovers were typed to ensure all staff had access to accurate information throughout their shift. Medicines were stored safely. We observed a medicine round and saw staff locking the medicine trolley when they were giving people their medicines. Other medicines were kept in a locked room with access provided to senior staff only. The room and fridge temperatures were monitored daily and were within acceptable tolerances. Unused or unwanted medicines were disposed of appropriately.

People were protected by the prevention and control of infection. The service had a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. Staff knew of the policy, and received regular training to help ensure their practices kept people safe. Staff knew how to safely manage soiled bedding or clothing. Hand sanitiser was available to staff throughout the building, as was personal protective equipment such as aprons and gloves. Guidance on how hands should be washed was available for staff, people and relatives near basins to help prevent cross infection. The registered manager carried out monthly audits of staff hand hygiene procedures. When one audit identified hand soap was missing from the sluice room, new soap was arranged immediately. People were encouraged to wash their hands before eating.

Accidents and incidents were reported by staff in line with the provider's policy, and the registered manager took steps to ensure that lessons were learned when things went wrong. This included analysing, for example, safeguarding incidents or falls, and looking for patterns and trends to help reduce the risk of future incidents. Where there were safeguarding concerns, information about lessons learned was shared effectively with staff through team meetings and supervisions so staff were aware of what was expected of them. Other incidents such as falls led to reviews of people's care plans and risk assessments to help ensure they would be safe in the future.

Good

Is the service effective?

Our findings

People and their relatives told us their needs were met and staff were skilled in carrying out their roles. One person told us, "I feel confident that the nurses know what is going on." Another said, "We have a choice of food here, and there is enough to eat." A relative told us, "I think the staff do a good job, and they know the people who live here."

People's needs were assessed and their care was delivered in line with current legislation. The registered manager met with people before they moved in to the service. A detailed assessment was carried out to help ensure staff were able to meet the needs of the person. This assessment included details about the person's physical and mental health conditions, their disabilities and other protected characteristics under the Equality Act 2010, details about their background, family situation and spiritual needs. If a person was moving from another care home or from hospital the registered manager would discuss the person's needs with staff who knew the person best. People's relatives were invited to the assessments if the person wished, and the registered manager told us how they would refer to external advocacy if the person wanted support. Some assessments were carried out jointly with care managers from the local authority.

Staff had the training and skills they needed to meet people's needs. Newly recruited staff received a comprehensive induction before they started to support people. This included mandatory training in subjects such as safeguarding and food hygiene, regular meetings with the registered manager and being allocated a more experienced member of staff as a mentor. New staff told us they valued the induction process and felt it equipped them with the skills to carry out their role. Staff received ongoing face to face training sessions. During our inspection some staff were receiving refresher training on the Mental Capacity Act 2005. Other practical training organised around the time of the inspection included infection control, tissue viability and continence awareness. Staff also completed online training, and told us they were paid overtime to complete courses if they were finished outside the normal working day. Records showed staff were up to date with their training and we found that care staff knew how to care for the people who lived in the service.

People were supported to eat and drink enough to maintain a balanced diet. People had a choice of what to eat at mealtimes and could choose between the two options on the menu or something off the menu such as an omelette or jacket potato. The menu took into account people's dietary requirements such as those who were lactose intolerant, those with diabetes and people with preferences such as one person being a vegetarian. People's dislikes were recorded, such as one person not liking fish or carrots. If people could not easily understand the options they were supported to choose by staff who referred to pictures of the food. The chef sought feedback from people about the menu, and adapted it according to people's preferences. For example, people said they thought a curry was too spicy, so the chef changed it for a different recipe. People could choose to eat at a dining table, sitting in their chair in the communal lounges or in their rooms. We saw staff supporting some people with eating in a respectful way. Staff sat with people and gave them time to eat, explaining what food was on the fork. Staff responded to people's preferences. We saw one person being supported to eat rhubarb crumble. The person turned their face away and closed their mouth after the first mouthful. Staff recognised this as the rhubarb being too sharp for the person so arranged for

them to have a different dessert, which they then enjoyed. Staff referred to and followed guidance from health professionals such as dieticians and the local Speech and Language Therapy (SaLT) team. One relative told us, "When he first came here he had a normal diet, then a soft food diet and now the food is pureed. The transition was dealt with very well." People who were at risk of malnutrition had their weight monitored and support was amended accordingly. People with diabetes had their blood sugar levels monitored by the nurses on a daily basis. We heard one staff member speaking to a nurse about a person who wanted sugar in their tea for breakfast. The nurse was aware of their blood sugar level and agreed they could. This meant people with complex health conditions were supported to make decisions safely.

Suitable arrangements were in place to ensure that people received effective and coordinated care when they were referred to or moved between services. When people moved between different services, such as when they went to or returned from hospital, staff ensured they shared all the necessary information. For example, we saw one person leaving for a hospital appointment. The nurse made sure the ambulance staff were provided with details such as their care and support needs, next of kin details and known allergies. A member of staff also accompanied them in case staff at the hospital had any queries. When people returned from a longer stay in hospital the registered manager would arrange to visit the ward to they could discuss any changes to the person's needs and conditions. People were supported to live healthier lives by receiving on-going healthcare support. Records showed that people had received all of the help they needed to see their GP and other healthcare professionals such as the district nurse, continence team, chiropodist, optician and dietician. People told us they had access to medical treatment in a timely manner, with one relative telling us, "I get a phone call from staff if he is unwell and they call the GP."

People's needs were met by the adaptation, design and decoration of the service. There was enough communal space to accommodate those living at the service, with two lounges on the ground floor and one on the first floor. The service had a spacious garden which was being used by people at the time of the inspection. Some people received support when in the garden and some were encouraged to access it independently. People were able to choose to spend their time in communal areas or could stay in their rooms. Corridors throughout the building were wide and bright, meaning people would be able to navigate without encountering hazards, and they were painted in different colours to help people with dementia more easily find their room. Signs for communal areas of the service, such as toilets, were labelled with pictures to help people find them. People were involved in making decisions about how their bedrooms were decorated and were encouraged to bring their own furniture when they moved into the service. People said this helped them feel more at home.

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 law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. 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 were being met. Staff were knowledgeable about the MCA, knew how to seek consent for care and knew the process to help those who lacked capacity to make decisions. One staff member said, "Just because someone has dementia doesn't mean they can no longer choose what they wear or what they eat." Staff ensured the least restrictive practice was used where

possible. Records showed DoLS applications were made for people, and where appropriate plans were put in place to keep people safe. When making decisions on behalf of people, staff ensured the involvement of health professionals, family members and others involved in the person's care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Good

Is the service caring?

Our findings

People and their relatives told us they found staff caring and treated them kindly. One person told us, "The staff are caring. I like my own company and they respect that." A relative told us, "They treat people here like individuals. They bend over backwards to help." Another said, "They are caring here. And they make the relatives feel welcome too. They know my name, and make me a cuppa."

People were treated with kindness, respect and compassion. During our inspection we watched how people and staff interacted with each other. The atmosphere in the service was relaxed and conversations between staff, people and relatives were friendly. Staff knew the people and their relatives well. One relative told us, "I can visit whenever I want to and like to visit each day. I couldn't visit on Easter Sunday and I felt bad about that. But staff knew I would so they actually called me to say that he had a lovely day. This made me feel much better." We saw staff speaking to people when they were supporting them. One each person's room door there were pictures of things that might interest them. The registered manager told us this was so staff would find it easier to strike up a conversation with newer residents. For example, one person was interested in boxing so he had a picture of boxers on his door. If people became anxious or upset we heard staff reassuring them by talking to them about their families or past events, which helped to reassure them. One person was visually impaired and was anxious when people entered the room. A notice at the entrance to their room clearly instructed staff to ensure they introduced themselves upon entering, and explained the routine of how they liked to be guided throughout the service.

People had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. The registered manager had taken feedback from one relative who felt they were not included in the review of the support a person received as much as they wanted to be. This led to a three-monthly 'relative review' of the person and their care plan for each person using the service which helped ensure that family members and friends were fully aware of the support provided and reasons why. Relatives we spoke to said they valued these reviews with one saying, "I feel more in the loop now." Most people had family members or friends to support them during the reviews, and those who did not were supported by external advocates or care managers from the local authority.

People's privacy, dignity and independence were respected and promoted. People were able to speak to their relatives in the privacy of their room if that was their wish, and there were no restrictions to visiting times for family members and friends. People's information was treated confidentially. Care records were kept in a locked cupboard and only used when necessary. Where electronic records were used, these were kept on password protected computers. Staff were able to give examples of how they treated people with dignity when supporting them. One staff member told us, "I always knock on the door before entering someone's room. When I give someone a bath I'll talk to them about their family or what's been happening in the home to help distract them. I'll cover them with a towel and make sure the curtains are closed for privacy." The service had 'dignity champions' whose role it was to ensure staff treat people with dignity. As part of the registered manager's monthly quality assurance audit they would carry out a 'dignity audit'. This looked at how staff supported people in a dignified way, such as using the person's preferred name or if they made eye contact with the person. During one audit the registered manager had noticed a member of staff

left a person with a moving and handling belt in place, which they felt was undignified. The manager removed the equipment, and the audit findings were discussed with staff at the next staff meeting. People could choose to be supported by a male or female member of staff and rotas showed there were a good mix of staff to meet the preferences of people living at the service. People's information was treated confidentially. Care records were kept in a locked cupboard and only used when necessary.

Good

Is the service responsive?

Our findings

People told us the care and support they received was responsive to their needs. One person told us, "I have a bubble bath every two days, it's how I like it and it works well." Another said, "There are activities here, I like the music and I go down and join in the hymns at the church service." A relative said, "I am aware of the suggestions box, and if I had a complaint I'd speak to the lady in reception."

People received personalised care that was responsive to their needs. Each person and their relatives were involved in the development of a personalised care plan which took into account their wishes and preferences. Staff promoted people's equality and diversity. People had the opportunity to meet their spiritual needs by religious observance. The registered manager was aware of how to support people who had English as their second language, including being able to make use of translator services. The registered manager and staff recognised the importance of appropriately supporting people if they chose gay, lesbian, bisexual and transgender life-course identities. This included being aware of how to help people to access social media sites that reflected and promoted their choices. People were encouraged to be independent, in both the planning and delivery of care. One person told us, "I come and go as I want to, sometimes I spend time in my room, other times down here with everyone else. If I need something the girls will come to find me." Care plans detailed what the person could do for themselves and the support they needed from staff, and were reviewed regularly to make sure they reflected people's changing needs and preferences.

People were supported to follow their interests and take part in activities that were appropriate to them. The service employed a full-time activities coordinator who organised activities based on the interests of people. Feedback about activities provided was positive. One relative said, "The coordinator is very good, dad likes it when he has a music session." Some activities were group based such as bingo, visits by children from the local primary school, and musicians. Other activities were tailored to individual needs. The coordinator said, "I'll speak to people and their families to get an idea about what they like and what they used to do, and build a plan around that." They had recently arranged for one person to attend afternoon tea with their family at a local hotel as part of their birthday celebrations. Some people preferred to spend most of their time in their rooms, so the coordinator would spend one-to-one time with them. The coordinator said, "We found out one lady with dementia used to like poetry so I sit with her in her room and read to her."

People were encouraged to maintain relationships with those who matter to them. Family members and friends were welcomed into the service. Some people had lived at the service for a number of years, and staff had introduced relatives of these people to family members of people new to the service in order to offer support. The registered manager told us they would often see relatives sitting with other people if their relative couldn't visit because they were ill. One staff member said, "Families are as important to us as the people who live here." The service had a private social media page, where photographs of people taking part in events were shared. This meant family members who were unable to visit regularly could see their relatives enjoying themselves. Comments on the page indicated relatives found this service valuable.

Complaints were listened and responded to. People told us they knew how to make a complaint and were

confident to do so if they needed to. People had the opportunity to complain anonymously by using a suggestions box at the entrance of the service. Complaints were investigated transparently by the registered manager, and they told us they considered complaints and feedback to be learning opportunities.

People were supported at the end of their life to have a comfortable, dignified and pain free death. People were asked about their wishes and these were recorded in their care plan. Staff worked closely with the local hospice, GP and family members to ensure people's wishes were respected. Nurses had access to anticipatory medicines to be used as people approached the end of their life and used a pain assessment tool for those with dementia who may not be able communicate their needs. Family members were supported, and the registered manager said, "You can't change what is going to happen, but you can change what it is like for the family." Relatives could be supported by a volunteer, whose relative had previously lived at the service and who wanted to support other relatives through their bereavement. This included support with arranging funerals or emotional support. When a person passed away, staff held a memorial service so staff, people and relatives could pay their respects.

Good

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well-led. One person told us, "There is a new manager, he's quite jolly." Another said, "Everything seems to work okay here." A relative told us, "The new manager is very friendly, I think there are meetings with the families to discuss any worries, or any activity suggestions."

There was a registered manager employed at the service and they had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. They told us they spent the majority of their time out in the service, observing practice and speaking to people and their relatives. They told us, "We carry out audits of staff practice, such as moving and handling or how they are treating people with dignity. But I also regularly put on my uniform to help out and that's how you can see what's happening." Staff received regular supervision, and when issues with practice were identified they were discussed with staff during these supervisions or at staff meetings. Staff were positive about the working environment. One staff member said, "Working here is like being in another family. Staff feel like family, and you treat people who live here like they're your gran or granddad." We saw staff working collaboratively with each other, and there were processes in place to ensure they were clear about their responsibilities. There was a nominated nurse who was in charge of each shift. Each morning a meeting took place with senior staff from the kitchen, maintenance, nursing, the activities coordinator and administration which made sure information was effectively shared between different departments. We observed one of these meetings, where the person responsible for the maintenance of the building discussed issues with the hot water system. Staff across different departments organised a contingency plan for the morning, which helped ensure people's needs were met, such as being bathed on a different floor.

Management encouraged transparency and honesty within the service. When there were incidents, outcomes of any investigations were shared with families in line with the registered manager's Duty of Candour responsibilities. The Duty of Candour is to be open and honest when untoward events occurred. One staff member said, "The manager will always say what went wrong and how we can do things better. At least we're told and not kept in the dark." The registered manager and registered provider were also aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those wanting to find out information about the service can be informed of our judgements. The provider had conspicuously displayed their rating in the service reception and on their website.

Systems and processes were effective in ensuring that shortfalls in service delivery were identified and rectified. The registered manager had ensured that regular audits were carried out to review the quality of the service. These included auditing the accuracy of medicine records and storage, audits of the environment and audits of care records. Where one care record showed a PEEP did not include the up-to-date information on a person's physical condition, this was updated immediately. The registered provider carried out regular audits of the service, which looked at documentation, health and safety, privacy, dignity

and respect and staffing. These checks were designed to ensure care and support was consistently provided in the right way.

People, their families, staff and visiting professionals were encouraged to be engaged and involved with the service. The registered manager had arranged for a survey of people and their relatives to be carried out, and feedback from the responses was positive. One person suggested outings when the weather got better, and the registered manager told us this had been passed to the activities coordinator to be organised. Some people used the suggestions box to request changes to the menu. Health professionals were asked to complete a survey about their opinions of the service, and feedback included, "Staff were well informed" and "Care staff, administration staff and nurses made themselves available and were willing to assist."

The registered manager worked effectively and transparently with key organisations such as the local safeguarding team, staff from the clinical commissioning group and other professionals such as occupational therapists and physiotherapists. Professionals told us staff responded positively to suggestions and followed through on any action plans agreed Regular contact with other agencies also meant people's needs could be responded to quickly.