Grace House Care Home Limited

Grace House Care Home Limited

Inspection report

71 Lodge Hill Road
Lower Bourne
Farnham
Surrey
GU10 3RB

Tel: 01252726406
Website: WWW.GRACEHOUSEFARNHAM.CO.UK

Date of inspection visit:
09 January 2018

Date of publication:
05 February 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 09 January 2018 and was unannounced. Our last inspection was in October 2016 where we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities 2014). These related to governance and the processes for obtaining consent from people. At this inspection, the provider had taken action to meet the requirements of the regulations.

Grace House is a residential home providing care and support to up to 21 older people. People living at the home had physical disabilities, frailty and some people were living with dementia. At the time of our inspection, there were 18 people living at the home.

Grace House 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.

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.

People had access to a wide range of activities that were tailored to their interests. Staff took time to find out about people's interests and identified activities based on these. People were complimentary about the food on offer at the home and the provider regularly asked people's feedback on food, activities and the care that people received. Staff provided support to people in a way that respected their right to consent and in line with the legal process set out in the Mental Capacity Act 2005.

Care was planned in a person-centred way. People's care plans contained important information about their needs and what was important to them. People's wishes for end of life care were clearly documented. Where people faced individual risks, appropriate plans were implemented to keep them safe whilst promoting their independence. Staff supported people in a way that encouraged them to maintain and develop skills. People were regularly offered choice and involved in decisions about their care.

Staff supported people safely following incidents. Staff understood their roles in safeguarding and responded appropriately where they identified concerns. The provider analysed all accidents and incidents and responded to any trends that they found. The provider was open and transparent when dealing with relatives, healthcare professionals and CQC. Regular audits were carried out to monitor the quality of the care that people received.

People's medicines were managed and administered safely, by trained staff. Staff supported people to access healthcare professionals whenever this was required. The provider had built links with local community organisations and agencies. People were supported by kind and respectful staff who were

mindful of people's privacy and dignity whilst providing care.

People were supported by staff that were trained to carry out their roles. Staff felt supported by management and had regular one to one meetings with their line managers and regular team meetings. Staff were able to make suggestions about the running of the home that led to improvements for people. There were clear leadership structures at the home and systems were in place to enable effective communication between staff.

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.

Risks to people were routinely assessed with clear plans to keep people safe. Where incidents had occurred, staff responded appropriately.

Staff understood their roles in safeguarding people from abuse.

People's medicines were managed and administered safely. The provider had robust systems in place to reduce the risk of infection control.

There were enough staff to safely meet people's needs. The provider had carried out appropriate checks on staff to ensure that they were suitable for their roles.

Is the service effective?

Good

The service was effective.

People's legal rights were protected because staff followed the correct legal process as outlined in the Mental Capacity Act 2005.

People were served foods that they liked and that met their individual dietary needs.

People were supported to access the healthcare that they needed and staff worked alongside relevant agencies to meet people's health needs.

People received a thorough assessment before coming to live at the home and individual needs and choices were documented and met.

People were supported by staff that had received appropriate training to carry out their roles with confidence.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff that they got on well with.

People were routinely involved in their care and staff offered people choices each day.

Staff provided support in a way that encouraged people's independence. People were supported to maintain or develop skills.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities' that reflected their interests.

People's care was planned in a person-centred way. People's wishes regarding end of life care were documented.

People were informed about how to raise a complaint and the provider regularly asked people for feedback.

Is the service well-led?

Good

The service was well-led.

Regular audits were undertaken to measure the quality of the care that people received. The provider regularly implemented improvements to the service.

There was clear leadership at the home and staff told us that they felt supported by management.

The provider had developed links with local organisations and agencies and people benefitted from these.

The provider maintained communication with relatives, professionals and CQC in an open and transparent way.

Grace House Care Home Limited

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 09 January 2018 and was unannounced.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We used information the provider 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.

As part of our inspection we spoke with 11 people and 1 relative. We also observed the care that people received and how staff interacted with people. We spoke with the registered manager, the deputy manager and 3 care staff. We read care plans for 3 people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at 4 staff recruitment files and records of staff training and supervision. We saw records of quality

assurance audits. We also looked at records of menus, activities and minutes of meetings of staff and residents.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Grace House. One person said, "Safe? Yes, it's like being at home I've nothing to worry about." Another person said, "This is an extremely good place, no one need worry about coming in here." A relative told us, "[Person] had several falls at home as the rooms were cramped, but has not had any falls here."

Risks to people were managed safely. Staff routinely assessed individual risks to people in areas such as falls, choking, pressure damage or behaviour. Where risks were identified, staff implemented appropriate plans to keep people safe. For example, one person was at high risk of falls due to a medical condition that made them unsteady on their feet. To manage the risk staff supervised the person when moving and ensured they used their walking frame. The person had rails installed in their room to hold onto to balance. The person also had a sensor mat in their room to alert staff if they got up at night. We noted there had been no recent falls for this person whilst these measures were in place.

Staff responded appropriately to accidents or incidents. Staff recorded all accidents and incidents and the provider reviewed the actions taken. Incident records demonstrated that staff responded appropriately and further actions were taken to prevent incidents reoccurring. For example, one person had fallen recently and sustained a minor injury. Staff provided first aid and monitored the person closely after the incident. The person's risk assessment was reviewed and additional hourly checks were implemented to ensure that the person was safe. The registered manager analysed and reviewed incidents and responded to any trends that they identified. For example, one person had fallen five times in one month. Each time, the person's risk assessment was reviewed and additional measures were implemented. The person was supported to move longer distances in a wheelchair to prevent further falls. The person was also seen by their GP and had a crash mat put next to their bed at night to reduce the impact of any fall from bed.

Staff understood their roles in safeguarding people from abuse. All staff had been trained in safeguarding and demonstrated a good understanding of the signs of abuse, as well as the procedures for escalating any concerns that they might have. One staff member said, "I would report anything to my manager or I could contact you [CQC]." Where there had been a recent safeguarding concern, records showed that staff responded appropriately and the provider worked alongside the local authority safeguarding team and healthcare professionals to ensure the person's safety.

People received their medicines safely. One person said, "They're very strict on keeping your medications safe, it's a good thing they are very hot on it." Staff had been trained in how to administer medicines and their competency had been assessed. Staff were observed following best practice, such as checking people's identity against names and photographs on medicine administration records (MARs) before administering medicines to them. Staff checked the medicines were correct before dispensing them into a pot and taking them to people. Staff were patient and told people which medicines they were administering and offered a choice of drinks. Staff then signed the MAR to document that medicines had been administered.

MAR charts were completed accurately with no gaps. The provider regularly audited MARs to further ensure

their accuracy. People's medicines were stored securely and staff checked the temperature of storage areas to ensure medicines were stored in line with the manufacturer's guidance. Staff followed a clear routine for ordering medicines with the pharmacy to ensure that stock was up to date. Where people were prescribed 'as required' (PRN) medicines, we noted there were not clear protocols in place for staff. The potential risk from this was minimised because staff knew people well and were able to describe when they would administer these medicines to people. The people who received PRN medicines were able to inform staff verbally if they required them. After the inspection, the provider submitted evidence to show that this had been addressed and PRN protocols were in place.

People were protected against the risk of the spread of infections. The home environment was clean with no malodours. The provider employed cleaning staff and they were observed cleaning the home during our visit. Cleaning tasks were signed off and checked each day and the provider conducted regular audits of infection control. People's linen was regularly cleaned and systems were followed that reduced the risk of cross-contamination. Staff were observed washing their hands before and after supporting people. Staff were also observed using personal protective equipment (PPE), such as aprons and gloves, before providing care to people. Hand sanitizer was available throughout the home and we observed staff and visitors making use of it.

There were sufficient staff present to safely meet people's needs. One person said, "There's always someone on at night if you need help. You press your bell and they come." All people told us that staff responded swiftly whenever they needed help. We observed staff spending time with people during our inspection. Staff were able to spend time sitting and talking to people throughout the morning. At lunchtime, staff were able to provide the prompting and encouragement that people required to eat, as well as to engage in discussions with people at their tables. The provider calculated staffing numbers based on people's needs and records showed that the calculated numbers of staff had worked each day.

People were protected from being supported by unsuitable staff. The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, work histories, proof of right to work in the UK and health checks. The provider also routinely carried out checks with the Disclosure Barring Service (DBS). DBS is the disclosure barring service. This is used to identify potential staff who would not be appropriate to work within social care.

Good

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 people 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).

At our inspection in October 2016, staff did not always follow the correct legal process as outlined in the MCA. There was a lack of mental capacity assessments carried out before restrictions were placed upon people. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, the provider had made the required improvements to meet the requirements of the regulation.

People's legal rights were protected because staff followed the requirements of the MCA. People's records contained evidence of decision specific mental capacity assessments being carried out to establish people's ability to make decisions. Where people were unable to make specific decisions, best interest decisions were made and documented. Best interest decisions showed evidence of involvement of relatives, healthcare professionals and staff. For example, one person was living with dementia and an MCA assessment had documented that they could not make the decision to consent to their care. A best interest decision was recorded that the person should stay at the home and have their care needs met. Staff involved the person's relatives and GP in the best interest decision. As restrictions would be placed on this person, an application had been made to the local authority DoLS team.

People who were able to had consented to their care and this had been documented. People told us that staff always asked for consent before providing care to them. One person said, "Oh yes they [staff] ask and they are very helpful." We observed staff obtaining consent from people during our inspection. For example, a staff member was observed asking for consent from one person to give them their medicines.

People were complimentary about the food on offer at the home. One person said, "I have a good appetite and enjoy my food. The meals are beautifully cooked here and served up nicely." Another person said, "They know what I like and don't like, like hot curries." Another person told us, "I had a glass of wine at lunchtime I was so pleased when I came here and realised that I could have wine."

People's records documented their food preferences and they were served food in line with these. For example, one person's care plan recorded that they did not like onions. The kitchen had this information and records showed they had not been given food with onions in. Another person particularly liked sweet foods and cakes, this was also documented and the person was regularly offered sweet cakes and biscuits

and puddings that they enjoyed. People were regularly asked at meetings, surveys and reviews if they liked the food and given opportunities to have dishes added to the menu. The provider bought all food fresh from the market each week and people benefitted from fresh ingredients and home cooked meals.

People's dietary needs were met. Care plans documented people's specific dietary needs and these were met by staff. One person was living with diabetes and required a balanced diet with reduced sugar to maintain good health. This information was in the person's care plan and was also known to the kitchen. People's weights were recorded each month and any changes in weight were responded to appropriately. For example, one person was recently noted to have been losing weight. Staff identified this and implemented a plan to help the person's weight to increase. Staff regularly offered the person snacks at times when they were more likely to eat. The person did not like prescribed milkshakes for weight gain so the provider developed a personalised fortified drink, using cream and syrup, which the person enjoyed. Records showed that following these interventions the person's weight had increased and stabilised. Another person required a gluten free diet, and this was met by staff.

People's healthcare needs were met. Where people had medical conditions, these were documented and known to staff. Care records contained evidence of input from healthcare professionals. For example, one person who was living with dementia had recently been involved in some incidents relating to changes in their behaviour. Records showed regular contact with their community psychiatric nurse (CPN) in response to these incidents. The CPN had reviewed the persons medicines been consulted on the person's behavioural support plan. Staff kept a behaviour chart where incidents did occur to help inform the CPN's clinical decisions.

Care records contained evidence of people regularly seeing their dentist, optician and GP. Staff responded to changes in people's health appropriately. Where one person had recently told staff that they were unwell, the GP had visited and prescribed antibiotics. The home used a GP that was local to the home and visited regularly to monitor people's health. The registered manager told us that they benefitted from home visits whenever necessary if people needed to be seen.

People received a thorough assessment before coming to live at the home. Assessments covered people's needs in areas such as personal care and nutrition and their mobility. Where needs or risks were identified, appropriate plans were implemented to meet them. For example, one person spent a lot of time in bed and required the use of a wheelchair. After assessment, they were allocated an easily accessible room. The provider contacted healthcare professionals to get a bed and equipment to reduce the risk of the person developing pressure sores. People's preferences and choices were documented in line with best practice and this information was recorded on a one page profile to guide staff about people's favourite foods and activities.

The adaptations and design of the home met people's needs. People had enough space to move around the home with walking aids. We observed people using walking frames and wheelchairs and they were able to move around corridors at the home. Rails and bars were installed throughout the home to provide people with something to hold onto for balance. There were stair lifts in place to enable people to get upstairs. The home was well lit and there was clear signage in place. This helped people with visual impairments or those living with dementia to orientate themselves within the home environment.

People were supported by staff that were competent in their roles. One person said, "They know how to treat the people with dementia." Staff told us that they felt confident supporting people with the training the provider gave them. One staff member said, "We do lots of training, I did first aid training recently." The staff member told us that this had given them confidence in how to respond in the event of someone choking

and they were able to describe how they would respond if someone they supported began to choke. The provider maintained a record of training and kept track of when it was due to be refreshed. Records showed that staff were up to date in mandatory areas such as health and safety, fire, safeguarding and infection control. Training was delivered that was specific to the needs of the people that staff supported. For example, staff supported people living with dementia and people living with diabetes and records showed that staff were trained in these areas.

Staff had regular contact with their line managers. Staff had one to one supervision regularly where they discussed people's needs as well as any training requirements that they may have. An appraisal system was also followed where staff discussed their development. We observed a supervision meeting taking place during our inspection and it was used to discuss the MCA, choices and safeguarding. Records showed that staff had all had recent supervision meetings.

Good

Is the service caring?

Our findings

People told us that they were supported by kind and caring staff. One person said, "They [staff] work very hard here, there's no nastiness. It's like being in your own home, that's what it feels like." Another person said, "I'm very well looked after, the carers are marvellous and sweet, we are very lucky." A relative told us, "The staff are great, full of fun. When [person] went into hospital she couldn't wait to get back here."

During the inspection we observed interactions between people and staff that demonstrated kindness and compassion. In the morning, we observed staff giving people manicures. During this planned activity, the staff member interacted warmly with people. People chatted with the staff member and laughed. At lunchtime, staff spent time talking to one person and asked after their welfare when administering their medicines. Another person was celebrating their birthday on the day of our visit. People and staff were observed wishing the person a happy birthday and enjoying a lunch that the person enjoyed with wine. The positive feedback from people was also matched by records of compliments that the provider had received. A recent compliment card from a relative read, '[Person] seems very happy and enjoys having a chat and a laugh with you.'

People were involved in their care. One person said, "I have the choice of having a bath or a shower, I like my bath so always choose that." People told us that staff offered them choices with regards to personal care, activities, food and drinks. Staff were observed asking people if they wished to take part in a manicure activity on the day of our visit. Staff were also seen offering people choices of drinks and snacks during the day. Records showed that people had regular meetings where they were asked about menus and activities at the home. The provider kept a record of people's preferences and staff were knowledgeable about these. For example, one person preferred orange squash instead of a hot drink and staff knew this about the person and gave them squash to drink.

People's religious and cultural needs were met. Where people practiced a particular faith, this was clearly recorded in their care plan. People benefitted from regular visits from ministers, such as representatives of the Church of England and the Catholic church. A church visit took place on the day of our inspection and staff were observed informing people and offering them the opportunity to attend. People were also offered support to attend church and where they wished to, this was added to their care plan.

Staff knew the people that they were supporting. Staff were knowledgeable about people's needs, backgrounds and preferences. For example, one person liked to watch specific television programmes at certain times of day. A staff member was knowledgeable about this and we observed the staff member chatting to the person about the programmes. People's backgrounds and life stories were in their records. One person used to work in a secretarial role and this was in their care plan. A staff member knew this about the person as well as information about their relatives and where they had lived before coming to the service.

Staff promoted people's independence. People's care records contained information about their strengths and the support they needed to complete tasks independently. For example, one person was living with

dementia and needed some support to eat. Their care plans recorded that staff were to cut up the person's food and provide them with a plate guard so that they were able to eat independently. We observed this person being supported in this way to eat independently at lunch time. Care plans recorded where people completed personal care tasks, such as brushing their teeth or applying make up and staff were knowledgeable about these. A staff member said, "If residents can do something it is better for them to do it. [Person] can wash but just needs us to make sure she's safe."

People's privacy and dignity was respected by staff. People told us that staff were respectful of their privacy when they were in their rooms. We observed staff knocking on people's doors and waiting for permission before entering. Where people required support with personal care, this was done discreetly. Dignity was discussed with staff at meeting and supervisions. Staff demonstrated a good understanding of how to provide care in a way that promoted people's privacy and dignity. One staff member said, "I always close people's doors and curtains when they need help with personal care. Its also important to make sure people have a towel so that they do not feel exposed."

Good

Is the service responsive?

Our findings

People told us that they liked the activities on offer at the home. One person said, "I like activities. I'm looking forward to going for walks when the weather is better." Another person said, "I like the singers who come in, one girl plays an accordion. We go out sometimes, we might have a coffee and a bun." Another person said, "We've had a visit from a donkey, that was fun."

After our last inspection we recommended that the provider reviewed the variety of activities that were available to people. At this inspection, we found that improvements had been made in this area. People had access to a wide range of activities and outings. A weekly timetable of activities was in place and it contained activities for a variety of different interests and tastes. The timetable included games, quizzes, beauty treatments, arts and crafts, films and outings. The provider had recruited an activities co-ordinator who worked with people to identify activities that were of interest to them. We saw photographs of people participating in baking activities, flower arranging, visits from animals and watching entertainers. There were people at the home who preferred to stay in their rooms. Daily records and photographs showed that these people took part in activities on a one to one basis in their rooms.

People had access to group activities as well as their own individual activity plans. Each person had a weekly schedule that contained group activities they would like to join in with as well as individual trips or activities that matched their interests. For example, one person had recently been taken to an event at the town where they had lived. The event involved discussions about the history of the area and the person had found this very fulfilling, Staff told us that the person contributed a lot to the event, calling upon their memories of the town to answer questions and take part in discussions. People were asked about activities at meetings and given opportunities to give feedback or make suggestions. The activity co-ordinator had found ways to engage people more in activities. They brought activities to people in the lounge using small tables. This was introduced after staff noted some people were reluctant to move to a separate room for activities. Following this change, staff found that more people participated in activities at the home.

People received person-centred care. One person said, "If you want anything, they'll do it for you." Care plans provided staff with a detailed description of people's needs as well as their preferences and routines. One person was living with dementia and sometimes experienced hallucinations. Their care plan contained guidance for staff on how to reassure the person. Talking about the person's memories and life helped to divert and reassure them. This was in their care plan, along with details of their life story. Staff told us that they supported this person in this way and records showed that staff documented when they had talked to this person. Another person's care plan recorded that they liked to go to bed at 10pm each evening and would then watch television. Their care plan was clear on this and staff were aware of this person's routine. Daily records showed that this person was prepared for bed by their preferred time each evening.

People received appropriate and sensitive end of life care. Care plans were in place that recorded people's wishes and preferences at this stage of their lives. Important information, such as people's religious needs or whether people wished to go into hospital or remain at home were clearly documented. One person's needs had increased recently but they had expressed a strong desire to remain at the home with the people and

staff that they had lived with for a number of years. A plan was implemented with healthcare professionals, such as community nurses, to ensure that the person's care needs could be met at the service in line with their preferences.

People's care needs were regularly reviewed. Care plans contained evidence of reviews taking place each month or where staff identified people's needs had changed. People were involved in reviews and where any requests were made, their care plans were updated. For example, one person had requested to attend the church they had always attended at a recent review. The person's care plan was then updated and staff supported the person to attend each month.

People were able to raise a complaint if they wished. One person said, "I've got no problems, if there was something not quite right I'd talk to the boss lady." There was a clear complaints policy displayed within the home and people told us that they were aware of how to raise a complaint if they had any concerns. People told us that they interacted with the registered manager regularly and felt confident that if they had to raise an issue, it would be dealt with. At the time of inspection, there had been no complaints. The registered manager took a proactive approach and records showed that people were regularly encouraged to give feedback through meetings and surveys.

Good

Is the service well-led?

Our findings

People told us that the service was well-led. One person said, "[Registered manager] comes up to see me and we have a chat sometimes." Another person told us, "As far as I'm concerned it seems well run." A relative said, "Our doctor said if they had a parent who needed a care home they'd try Grace House for a place first."

At our inspection in October 2016, we identified that there was a lack of robust audits carried out. There was a lack of structure to auditing and records were not always kept up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, the provider had made the required improvements to meet the requirements of the regulation.

Regular audits were carried out to monitor and assure the quality of the care that people received. A new electronic system had been implemented that ensured that audits were tracked and reminders were generated where audits had not been carried out. We saw records of regular audits of areas such as infection control, care plans, medicines and health and safety. Audits were robust in identifying improvements. Where improvements were identified, these were actioned by staff. For example, a recent infection control audit had identified a need to ensure external bins were regularly cleaned. This was added to the cleaning tasks each week and completed by staff. A recent health and safety audit had identified that some water temperature checks had not taken place as planned. This was addressed with staff and records were updated and checked.

There was an ongoing plan to improve the service that people benefitted from. The provider had implemented a number of improvements since our last inspection and had an ongoing plan to develop the service. We noted that a number of refurbishment works had been undertaken and communal areas of the home were nicely decorated. The provider had introduced electronic care records and had utilised these to ensure documents and audits were up to date. A new activity co-ordinator had been introduced and had improved the activities and outings on offer to people. The provider sent CQC a provider information return (PIR) before the inspection. This documented the provider's plans for the service and by the time of our visit, the improvements listed were completed or underway. For example, the PIR listed improvements to the home environment, activities, increased audits and the introduction of electronic records and these were all seen during our inspection.

There was clear leadership at the home and staff felt supported by management. One person said, "[Deputy manager] is very good as well. She is good at her job and stepped up to work in the office, that's good." The registered manager and provider had created a new deputy manager role to delegate tasks to and increase management support for staff. The deputy manager provided additional leadership and support with auditing and supervision of staff. Staff told us that they felt supported by management. One staff member said, "We can raise anything we want. They [management] never ignore us."

Staff were involved in the running of the service. One staff member said, "Staff meeting is every three months. If someone has a suggestion or an idea, there is a change." Records showed that staff meetings

took place regularly and these were used to pass on important messages. They also gave staff a chance to provide suggestions to management. At a recent meeting, staff had discussed changes to which shift administered people's medicines in the morning. Staff identified that sometimes it was easier for the sleep in staff to administer medicines as they were fresher in the morning and less likely to make an error.

The provider was open and involved local agencies and community organisations. The provider had signed up to local health initiatives to improve people's health and wellbeing. The provider had signed up to a new 'red bag initiative' that was designed to make hospital admission smoother for people. It involved a red bag being at the home that staff could put essentials such as clothing and toiletries in if a person was admitted to hospital. The bags included forms that would provide hospitals with the important information that they needed about people. We also saw evidence of links with local churches, clubs and societies that people benefitted from. For example, one person had recently visited a local historical society that the provider had arranged for them.

The provider was open and transparent. Records showed regular contact with relatives and professionals. Where incidents had occurred, the provider routinely informed relatives and documented that they had done so. Relatives told us that communication from the home was good and med this. As part of their registration, the provider has a duty to notify CQC of important events and incidents, such as serious injuries and allegations of abuse. We noted that where appropriate, notifications had been sent to CQC.