Denestar Limited

Willerfoss House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 24 February 2016 and was unannounced. We previously visited the service on 10 December 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide accommodation for up to 26 people who require assistance with personal care, some of whom may be living with dementia. The home is situated in Withernsea, a seaside town in the East Riding of Yorkshire. The service is close to local amenities and transport routes. Private accommodation is provided in single rooms, some with en-suite facilities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection people told us that they felt safe living at Willerfoss House. People's needs were assessed and risk assessments put in place to reduce the risk of avoidable harm. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities for protecting people from the risk of harm.

Medicines were administered safely by trained staff and the arrangements for ordering, storage and recording were robust.

Staff had been employed following robust recruitment and selection processes and received a range of training opportunities. Staff told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

People were supported to eat and drink enough and, where necessary, supported to access healthcare services. People were supported to make decisions and their rights were protected in line with relevant legislation and guidance.

People using the service were positive about the caring attitudes of staff. We observed that staff were kind, caring and attentive to people's needs and people's privacy and dignity were respected.

Care plans were reviewed regularly so that staff were aware of people's changing needs and we saw that there were systems in place to assess and record people's needs so that staff could provide personalised care and support.

We saw that the registered provider had a robust quality assurance system for the service, which included

audits, overall assessments, service reports and a business plan. The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns.

We observed that records were well maintained, there was clear organisation and leadership with good communication between the registered provider, registered manager and the staff team.

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.

Assessments were undertaken of risks to people who used the service and staff and written plans were in place to manage these risks.

There were processes in place to help make sure people were protected from the risk of abuse and staff we spoke with were aware of safeguarding vulnerable adult's procedures.

There were systems in place to safely manage and administer medicines to people using the service.

There was a safe recruitment process in place to ensure only people considered suitable to work with vulnerable client groups were employed.

Is the service effective?

Good

The service was effective.

We found the provider understood how to meet the requirements of the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and met and people told us they were happy with the meals provided by the service.

There was an effective recruitment, induction and training process to equip staff with the skills and experience needed to carry out their roles.

Is the service caring?

Good

The service was caring.

People's individual care needs were understood by staff and people were encouraged to be as independent as possible.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Staff were observed being professional, attentive, and unrushed when providing care and support.

Is the service responsive?

Good

The service was responsive.

People felt able to make comments and raise concerns and there were systems in place to gather feedback and respond to complaints.

Visitors were made welcome at the service and people were encouraged to take part in suitable activities.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences and this enable them to provide a personalised service.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission. People felt the service was well run and told us they were happy there.

Staff were supported by the registered manager. There were clear lines of communication within the staff team and staff felt comfortable discussing any concerns with their registered manager.

The registered provider had a comprehensive quality monitoring framework in place. The registered manager carried out a variety of quality audits to ensure that the systems in place at the service were being followed by staff and to monitor the safety and well-being of people who lived and worked there.

Willerfoss House

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 at Willerfoss House took place on 24 February 2016 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. The registered provider submitted a provider information return [PIR] prior to the inspection. 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.

As part of the inspection process we contacted the local authority's safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the service. They told us they had no concerns about the service.

During the inspection we spoke with the registered provider, the registered manager and six care staff. We also spoke with 13 people who use the service and four visitors/relatives. We spent time looking at records, which included the care files for two people who used the service, the recruitment, induction, training and supervision records for three members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at Willerfoss House, if the staff assisting them had the right skills and if they felt the premises were safe and secure. All the responses we received were positive about the service. Comments included, "Oh yes, it's A1 here" and "I'm very safe here."

Visitors we spoke with said they felt their relatives were safe at the service. We asked staff how they kept people safe. One staff member told us, "We share information in handover from each shift. This includes information about each person and how they have been," another said "We make sure we use the right equipment for each person."

Training records evidenced that staff had completed training on safeguarding adults from abuse in the last two years. The staff who we spoke told us that they would report any incidents or concerns to the registered manager. They told us, "When I started, I completed safeguarding training. Abuse can be financial or neglect" and "I would report anything to my team leader, registered manager, provider or ring social services."

The 'provider information return' (PIR) told us the registered provider had a 'safeguarding and whistleblowing policy'. We were able to view these policies and saw they included details about relevant legislation and guidance on best practice. We saw safeguarding concerns and actions taken were recorded on a monitoring log, which included details about the name of the person involved, an outline of the issue and details of any action taken. The safeguarding log also included the East Riding of Yorkshire Council (ERYC) Safeguarding Adult's Team risk tool for determining if a safeguarding referral needed to be made to them. This meant people were protected from the risk of abuse.

Care files recorded risk assessments in relation to moving and handling, risk of falls and the use of bed rails. Risk assessments identified the level of risk involved and recorded the details of any equipment and the number of staff the person required to assist them. We observed staff assisting people to mobilise on the day of the inspection and noted that this was done safely. Other risk assessments were in place to assess risks which included pressure care, nutrition, continence, mobility, medicines and the environment. We saw risk assessments were reviewed regularly. This showed that any identified risks had been considered and that measures had been put in place to try to manage these.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records of accidents and incidents, which showed the procedure for completing accident forms for people using the service, staff, any near misses and incidents.

We saw clear instructions on how any information relating to accidents should be recorded, which included following the Mental Capacity Act 2005 (MCA) principles for example; gaining consent when checking for any injuries. The MCA legislation is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Accident and incident forms recorded the date and time they occurred, the person involved, a summary of the event, any injuries sustained, medical attention needed, action taken and the outcome. This showed us that accidents and incidents were well managed at the service.

We saw the registered provider's emergency evacuation procedure and plan for emergency situations and major incidents such as fire, flood, building collapse and gas leaks. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

We saw that the registered provider monitored the maintenance of the building. This meant that the service had in place a current fire safety procedure, which clearly outlined what action should be taken in the event of a fire. Fire signage was visible in the building and a fire safety risk assessment had been carried out so that the risk of fire was reduced as far as possible. The service completed fire drills and fire door checks on a monthly basis and weekly checks of the fire alarm system and emergency lighting. Personal emergency evacuation plans (PEEPs) were in place for each person who lived at the service. This advised the emergency services about the assistance each person would need if they needed to be evacuated from the building.

The registered provider had in place employers liability insurance and contract agreements for pest control and the transfer of waste. Maintenance records showed that all necessary checks were carried out on portable appliances, the electrical installation, lifting equipment, call bells and gas appliances. This ensured they were safe and in good working order.

We checked the recruitment records for three members of staff and these evidenced that only people considered suitable to work with older people had been employed. We saw that prospective employees submitted an application form and provided documents confirming their personal identity. We saw two employment references and a Disclosure and Barring Service (DBS) check had been obtained by the registered provider. A DBS check is a legal requirement for anyone over the age of 16 applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. Newly recruited staff received a 'staff employee handbook', 'operational handbook' and a copy of their job description; this ensured they were clear about what was expected of them.

The registered manager told us they had a dependency tool to work out how many hours of care were needed to meet the needs of the people using the service. This had been updated in February 2016. From this we saw that the actual number of care hours provided was above the level deemed necessary to meet the needs of the people using the service.

The registered manager told us there was 19 people using the service at the time of the inspection, with one team leader and three care staff on duty during the day, one team leader and two care staff on duty during the evening and one team leader and one care staff on duty during the night. Throughout the inspection we saw staff were available in all areas of the service including the lounge and dining areas.

We looked at the duty rota from the 1 to 22d February 2016. These indicated which staff were on duty and in what capacity. The rotas showed us there was sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of care team managers, team leaders, care staff, domestics, cooks and an activity worker.

There were systems in place to manage medicines safely and only senior staff trained to give people their

medicines did so. We saw that the medication policy and procedure followed the National Institute of Health and Care Excellence (NICE) guidance and the Royal Pharmaceutical Society guidance on best practice with regard to administering medicines within a care service. The policy contained clear information on safe ways of ordering, storing, dispensing, administering and disposing of medicines. Additional medicine procedures were available for staff to follow that recorded specific instructions, for example on fridge temperatures, GP visits, handwritten medicine administration records (MARs) and the storage of portable oxygen.

We saw an instruction sheet named 'Have you checked', which gave a step by step reminder for staff to follow in relation to medicine responsibilities on each shift and a wipe clean whiteboard to record peoples antibiotic start and finish dates.

We found that people who used the service were able to communicate with the staff, including the people who had a diagnosis of dementia. In discussion with the staff we found that they had good knowledge and understanding of each person's needs. The staff told us they used this knowledge to assess if people were in pain or unwell. We saw a visual pain assessment tool was available to support people with communicating to staff their level and types of pain in areas including temples and sinus and visual aids to help identify liquid and tablet forms of medicine.

Medicine was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate pods for administration at a set time of day. Blister packs were colour coded to identify the time of day the tablets needed to be administered; this reduced the risk of errors occurring. We observed that medicines were securely stored in a medicine trolley which was clean and tidy and that a daily record of temperatures was kept for the trolley, medicine room and fridge and these were found to be correct.

We observed the administration of medicines and saw that this was carried out safely; the staff member did not sign MARs until they had seen people take their medicine, and people were provided with a drink so that they could swallow their tablets or medicines.

We checked a sample of MARs and saw that they included a photograph of the person concerned to aid recognition and details of any allergies. We saw that codes were being used appropriately to record when people had refused their medication, that two staff had signed hand written records to show they had been double-checked and that there were no gaps in recording. We saw that medicine systems were audited both weekly and monthly by the care team managers and the registered manager.

There were specific instructions for people who had been prescribed Warfarin. People who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. These records were audited each week to check that people's Warfarin medication had been administered correctly.

There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CDs record book. CDs are medicines that require specific storage and recording arrangements. We checked the storage of CDs and noted they were stored securely. We checked a sample of medicines held against CDs records and saw that the stock of medicines held matched the records in the CDs book. Two staff had signed the CDs book to record when medicine had been administered.

There was an effective stock control system in place and we saw that all medicines not in blister packs had the date of opening recorded on the packaging to ensure they were not used for longer than the

recommended period of time. The arrangements in place for medicine to be disposed of were satisfactory.

Good

Is the service effective?

Our findings

People who lived at the service told us that staff had the right skills to do the job and this was supported by the relatives we spoke with. People told us, "Yes, they are damn good staff" and "We get everything we want."

Staff told us they were happy with the training and induction provided for them. One staff member told us, "I shadowed other staff for six weekends, completed a tour of the home, had training on the fire procedures, moving and handling, personal care and spent time talking and interacting with the residents and learning about people's needs such as specialised diets."

We looked at induction and training records for three members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the service. We saw the details of the services induction programme, which included the structure of the service, tour of the building, introduction to staff and residents, key working responsibilities, fire procedures and the company values and standards. Staff had signed to say they had received the company's operational procedures, staff handbook and policies and procedures during the induction period and at week 24 of staff's induction, people who used the service were asked to give their views on the person employed. This showed us that people using the service were consulted about the staff employed.

The registered provider had an up to date policy on staff training. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. The registered manager held a training record that listed all training completed by staff so that their need for refresher training could be easily monitored.

Each member of staff had an individual training plan which recorded when they had completed training on topics such as safeguarding, infection control, moving and handling, health and safety, first aid and medicines. Records showed staff participated in additional training to guide them when supporting the physical and mental health needs of people who used the service. This training included topics such as tissue viability, dying/death and end of life care (EOL), Deprivation of Liberty Safeguards (DoLS), Mental Capacity Act 2005 (MCA), equality and diversity and dementia. During the inspection we saw 10 staff attending training on the 'Care certificate'. The Care Certificate is a set of standards that aims to equip health and social care staff with the knowledge and skills which they need to provide safe and compassionate care. We also saw training certificates in staff's files to evidence the training they had completed. These measures ensured that people were supported by qualified, trained and competent staff so their needs were effectively met.

The 'provider information return' (PIR) told us 'supervisions/appraisals focus on all aspects of requirements to deliver an effective service for the benefit of each individual resident.' The staff told us they had regular supervision meetings and annual appraisals with the management team. They told us that they found the supervision sessions beneficial as they could talk about their concerns. One member of staff told us, "Yes I have regular supervision for if I need to talk about anything."

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the 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. The registered manager displayed a good understanding of their role and responsibility regarding MCA and DoLS and told us they were in the process of completing assessments and submitting applications for DoLS for six people that used the service.

Staff we spoke with were aware of the MCA and its requirements, one staff member told us, "MCA is about giving people the choice to make their own decisions and not doing it for them. We use laminated cards for the MCA principles to remind us of this and what to do." The PIR we received told us that staff had completed training in MCA and DoLS. We were able to verify this in the training records.

People using the service or their representative had signed to show that they agreed with their plans of care and support. Staff had taken appropriate steps to ensure people's capacity was assessed and we saw that care plans recorded people's ability to make decisions. For example, one person's care plan recorded that their capacity fluctuated due to a diagnosis of dementia. Another care plan recorded that the person had someone acting as their Lasting Power of Attorney (LPA) for property and financial affairs. A LPA is a legal document, which gives the appointed person the legal right to make decisions, within the scope of their authority (health and welfare decisions and/or property and financial affairs), on a person's behalf.

Staff we spoke with demonstrated that they were aware of what care each person required to meet their needs. Staff were able to say which people had input from the district nursing team or dietician; they also knew what health needs each person had and what action was needed from them to support that person. Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. We saw that the staff completed food and fluid charts when people were deemed at risk of poor nutrition or dehydration.

We saw that there was appropriate signage to support people using the service to identify toilets, the dining room, the television lounge and the quiet reading lounge. Bedroom doors had photographs to help people recognise their own room and we saw 'snapshot boards' in people's bedrooms that included personal information on likes, dislikes, bathing preferences and mobility needs.

Our observations of the service showed that people were settled and relaxed within the service and individuals were able to walk around freely and interact with each other and staff as they wished.

People told us they liked the meals at the service and the main lunchtime meal we saw being served smelt and looked appetising. Comments included, "The food is good" and, "It's gorgeous, the food is lovely it's really good, you couldn't say anything bad about it."

There was a menu board with the choices for lunch recorded in written and picture format. Picture menus can help people with a cognitive impairment to choose a meal. The registered manager told us there were

two choices of main meal available at lunchtime and lighter meals available in the evening. The cook asked each person individually the day before what they would like for their lunchtime meal and we noted this recorded if the person required any specialist food such as modified, diabetic, gluten free and any thickened fluids. The dining area had a hot drinks machine that people could access and we saw cups, saucers, sugar and milk available.

Good

Is the service caring?

Our findings

We observed that staff were caring and considerate of people who used the service. Comments included, "The staff are lovely" "The girls are great" "They are gems" and, "They always have a chat with you."

We observed that staff had a warm and gentle approach to people who lived at the service. There was physical closeness between people and care staff such as holding and touching hands, but only when it was apparent that this was something the person welcomed. One relative told us, "(Name) is physically very sensitive and the staff are so gentle with them."

Visitors and relatives came to the service throughout the day and that they were made welcome by staff. It was apparent that these were regular visitors who had a good relationship with the staff and the registered manager. Relatives told us, "I come every day in the morning and then at tea time to help (Name) with their tea. I've been coming every day for four years and everyone is very caring" and "The care is excellent here, I am very happy."

We saw that staff and the registered manager interacted with people and visitors in a positive way. One relative told us, "(The registered manager) is brilliant and guides me through things I need to know with (Names) care and (Name of staff member) is on the ball with everything."

The registered manager told us that the people using the service were part of their extended family. They had been supporting people living at Willerfoss House for almost 26 years and it was clear that they had developed meaningful caring relationships with the people they supported in this time. Staff explained to us how they enjoyed spending time with people who used the service. They told us, "We have time to sit and talk to people and this sometimes carries on after your shift has finished" and "Recently we have been coming in early to help play dominoes, cards and do some knitting."

People told us that staff respected their privacy and dignity. Staff told us that they knew how important it was to respect people's dignity and to maintain their confidentiality. They said that they maintained privacy and dignity by "Making sure people are appropriately covered when helping with personal care" and "Respecting people's privacy if they are with their family or friends."

We saw a survey on privacy, dignity and choice had been completed with people using the service in July 2015. 14 out of 14 surveys had been returned with all people feeling able to express themselves and feeling listened to.

We found that people who used the service were immaculately dressed in clean, smart, co-ordinating clothes and were wearing appropriate footwear. There was a board in the entrance hallway that displayed photographs of which staff were on duty. This meant that people knew who would be supporting them each day.

We noted that care plans contained information about people's wishes and views and we observed staff

supporting and encouraging people using the service to make decisions and have choice and control over their support. We observed that people were supported to maintain their independence. One member of staff said they supported people to remain independent by "Asking people if they would like any help with things first." We observed members of staff saying to people, "Would you like some help?" and "Would you like me to help you" rather than providing help without checking with them first.

We saw that information about available advocacy services was held at the service. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Good

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. They were aware of people's preferences and interests, as well as their health and support needs; this enabled staff to provide personalised care to each individual.

People and their relatives told us, "They staff always speak to (Name) asking if there is anything they want" and "I like to sit in the window and watch what's going on outside and if there are any little birds and squirrels. I prefer to sleep in my comfortable chair on a night – and I do that." We observed one person was asked how they were feeling during the inspection and if they wanted to remain in bed or get up. The person chose to stay in bed and this was respected by staff. They told us, "I am very well looked after." This showed us that people's choices and decisions were respected.

Assessments were undertaken to identify people's support needs and comprehensive care plans were developed outlining how these needs would be met. The two care plans we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes. Care plans included individual information about a person's previous lifestyle, including memories, places visited, marriage, childhood and working life. For example, we saw one person liked nature and had been a foster carer. We saw that care plans included a section for people to sign to record they were aware of the contents.

People who we spoke with told us that their care was centred on them. Relatives told us they had been involved in developing their family member's care plan and were involved in reviews. One relative said "We are always involved in (Names) care and any reviews." Care plans we looked at were reviewed and updated regularly as people's needs changed.

It was clear that care workers knew people's personalities, wishes and care needs. Staff told us they got to know people by reading their care plans and talking with them. Staff told us, "We do spend time with people and learn about them" and "I learn about people through their care plans."

There was a handover meeting at the start of each shift and we saw that each person using the service was discussed, any medical issues, people's skin integrity and visitors. We saw that handover logs were used by staff to record this information about people who lived at the service. The form also recorded any messages in respect of people's medicines and information received from or about involvement with health professionals. This system ensured that care staff had up-to-date information enabling them to provide responsive care as people's needs changed.

There was evidence of activities available to people using the service The registered manager told us they had employed a new activity worker for two hours every day from Monday to Friday. The activity worker was starting on the day of this inspection and we observed the activity worker being introduced to the people using the service in a residents meeting. The registered manager asked everyone individually what activities they would like to do and what trips they would like to go on. We observed people being given time to think

about things and discussions about places people may have visited in the past.

We saw notices displayed for dates when a hairdresser and singer would be at the service and in the quiet reading lounge there was calming music playing and books and jigsaws available. The registered manager told us the library visited the service every four weeks to change the books for people.

There was a complaints policy and procedure available in the entrance hall of the service. This described what people could do if they were unhappy with any aspect of their care and support. Checks of the information held by us about the service and a review of the registered provider's complaints log indicated that there had been no formal complaints made about the service in the last 12 months. People using the service told us they felt able to raise complaints or concerns if needed. Relatives told us, "I've never had to complain" and "I feel I can tell the manager if there is anything wrong and that's how it should be."

Good

Is the service well-led?

Our findings

We sent the registered provider a 'provider information return' (PIR) that required completion and return to CQC before the inspection. This was completed and returned within the given timescales.

There was a registered manager in post who was supported by two care team managers. People we spoke with knew the registered manager's name. Staff were aware of, and knew the name of, the registered provider who had a hands-on approach to the running of the service and visited on a regular basis.

We asked for a variety of records and documents during our inspection. We found these were well maintained, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We observed that there was a good level of organisation at all levels within the service; staff we spoke with knew what they were doing and what was expected of them. We saw that there were clear lines of communication between the registered manager, the care team managers and the care staff. The registered manager knew what was going on within the service at an organisational level and about the specific needs of people using the service.

The staff we spoke with told us that they were well supported by the registered manager. They told us, "The manager is fine. I have never had any problems" and "The home is well-led. I was recently assisting someone to the bathroom and they became ill. The registered manager supported me and talked me through it." Staff we spoke with felt the registered manager was approachable and listened to opinions. This led to a good atmosphere within the service.

Staff were given an in-depth 'operational handbook' at the start of their employment which provided them with clear information on legislation, national guidance and the companies policies. The registered manager held regular staff meetings so that staff could talk about any work issues and there were up to date policies and procedures regarding work practices that staff could easily access. We saw that the last staff meeting was held in January 2016 and topics discussed included people using the service, care files, supervisions and understanding roles. Care staff we spoke with confirmed this, they told us, "We have regular meetings, we had one a couple of weeks ago." This showed us that the registered manager was using staff meetings to discuss information with care staff and to support improvements within the service.

People using the service were given a comprehensive 'Welcome pack' that included a 'Statement of purpose'. This recorded that the aim of the service was to 'Ensure each individual service user receives care and treatment that is safe, effective, caring, responsive and well-led'. We saw the minutes of the resident meetings and the ones held in May and November 2015 showed that discussions had taken place about the meals, activities, and entertainers coming to the service.

The registered manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the care and support they received. We saw that the registered provider had a comprehensive quality assurance framework in place. This was linked to each domain of the CQC's regulations and set out how the service would meet this and what audit tools would be used to do this, the timescales and any outcomes and evidence. At the start of each year [March] an overall service report led to a 'business plan' for the next year, which set out the objectives, who was responsible and the timescales.

Quality audits were undertaken to check that the systems in place at the service were being followed by staff. We reviewed the audits for the year 2014 / 2015 and saw that surveys had been completed with people using the service in April 2015. 14 surveys were sent out and 14 were returned. The results had been evaluated and the findings had indicated that, due to memory impairments, some people were unable to retain information on who their keyworker was. We saw action had been taken with photographs of each person's keyworker placed in their room. Other surveys had been completed and evaluated with staff, stakeholders and relatives/friends.

We saw additional audits were completed and covered areas such as medicines, infection control, reviews of people using the service, health and safety, meals and nutrition and care files and staff files. Overall assessments of the audits were completed. This was so any patterns or areas requiring improvement could be identified. We concluded that this was an effective system for monitoring the quality of care and support provided and driving improvements with the service.

We asked the registered manager how they kept up-to-date with relevant changes in legislation and guidance on best practice. We were told that they attended the East Riding Care Sector Forum which provided quarterly meeting with keynote speakers, received information bulletins from the CQC and the local safeguarding board and subscribed to the Caring Times magazine. We also saw the service had an 'Investors in people' award. Investors in people are a standard for people management. The standard defines what it takes to lead, support and manage people well for sustainable results.