Brendoncare Foundation(The)

Brendoncare Meadway

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?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Brendoncare Meadway on 4 and 5 April 2016.

Brendoncare Meadway is a care home providing accommodation and personal care for up to 13 older people. When we visited there were 10 people using the service. The service is located close to the town of Winchester.

The service had a registered manager in place. 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. The service is required by a condition of its registration to have a registered manager.

Records relating to people's care and treatment were not always accurate, complete and up to date. This included the decisions taken in relation to the care and treatment provided. A plan was in progress to review people's care plans and provide training for staff in the completion of new care planning documentation. However, although staff knew people well, there was a risk if people were cared for by staff unfamiliar with their needs where people's records were not accurately completed there could be a risk of people experiencing unsafe or inappropriate care and treatment

People told us they felt safe living at Meadway. People were safeguarded as staff understood the indicators of abuse and how to act on any concerns. Staff had completed relevant training and had access to written guidance on reporting procedures. The registered manager acted on concerns raised.

Risks to people had been assessed and action was taken by staff to ensure identified risks were managed safely in line with people's preferences and decisions. The provider took action to address risks to people from environmental hazards and emergency situations such as evacuation in the event of a fire. Staff practised how to support people safely in accordance with their individual needs should an evacuation be necessary.

There were sufficient staff to meet people's needs. Additional staff were being recruited to support people at the busier times of the day to ensure people's needs were met promptly. Recruitment procedures were in place and followed to protect people from the employment of unsuitable staff.

Some people managed their own medicines. People who were supported with their medicines by staff told us they were satisfied their medicines were properly managed. Staff completed training in medicine administration and procedures were in place and followed to ensure people's medicines were managed safely.

Staff received an induction into their role and supervision and annual appraisal of their work. Staff

completed training including professional development training to enable them to meet people's needs competently. People received their care from staff who received appropriate support to carry out their role.

Staff had undertaken training on the Mental Capacity Act 2005 and understood the principles of the Act. All of the people accommodated had the capacity to consent to their care and treatment at the service. Restrictions were not in place and people could leave the service if they wished to go out. Entry to the service was restricted by a keypad for the security of people and premises.

People and their relatives were very complimentary about the chefs and the quality of the food provided. People confirmed their preferences and dietary needs were catered for. People were asked to give their feedback about the food provided and the chefs acted on this to provide a varied and individually tailored menu.

Staff arranged for people to be seen by a variety of health care professionals to meet their healthcare needs as required.

People and their relatives told us staff were kind and caring and 'bright helpful and cheerful'. People enjoyed the relaxed atmosphere in the home and felt they had choice and control in their daily lives. Staff respected people's decisions and treated people respectfully. People used residents meetings to express their views and to make suggestions which they told us were acted on.

People told us they received care that was responsive to their needs and preferences. People were supported to maintain their independence and confirmed they received the level of support appropriate to their needs. Activities were provided in the home and people also enjoyed their own hobbies and interests. People were involved in planning activities and outings and told us they were satisfied with the level of activities provided.

The provider's complaints process was displayed in the home. Although no written complaints had been received, people and their relatives told us they were confident the registered manager would listen and respond.

There was a positive, open and inclusive culture, staff's views were sought and they felt listened to. This enabled staff to feel they could raise issues if they needed to in order to ensure people received good quality care. The provider's values were shared with staff through training, leading by example and a recognition scheme. People confirmed that staff treated them respectfully and their individual needs and preferences were met in line with the providers' values.

There were processes in place to enable the provider and registered manager to monitor and audit the service for the purpose of identifying any areas for improvement for people. Records demonstrated that actions resulting from audits were not always identified and fully completed. The registered manager took action to remedy this during our inspection.

An accident and incident system was in place and analysis of incidents reported resulted in improvements to people's care and their environment.

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 safeguarded from the risk of abuse. Staff had received relevant training and understood their roles and responsibilities in relation to protecting people from the risk of harm.

Risks to people had been identified and actions were taken to ensure their safety.

People were supported by sufficient staff to meet their needs safely. Additional staff were being recruited to ensure people's needs were met promptly.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were appropriately supported in their role.

Staff understood the principles of the Mental Capacity Act 2005. People were supported to make their own decisions.

People enjoyed a varied diet which reflected their preferences and dietary needs.

Staff supported people to access health care services as required.

Is the service caring?

Good

The service was caring

People were cared for by kind and compassionate staff.

People told us they had choice and control in their daily lives and their decisions were respected by staff.

People privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive

People told us they received care that was responsive to their needs and preferences.

People were supported to maintain their independence and confirmed they received the level of support appropriate to their needs.

The provider had a complaints process in place people and their relatives were confident the manager would act on concerns raised.

Is the service well-led?

Requires Improvement

The service was not always well led

Records relating to the care and treatment needs of people were not always accurate, complete and up to date, including records of decisions made and the care and treatment provided to protect people from unsafe care and treatment. This could place people at risk if they were cared for by staff who did not know them well.

There was a positive, open and inclusive culture, staff and peoples' views were sought and they felt listened to.

There were processes in place to enable the provider and registered manager to monitor and audit the service to drive continuous improvement. Action plans from audits were not always completed to show they had been analysed and the identified improvements had been made to the service people received.

Brendoncare Meadway

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 4 and 5 April 2016 and was unannounced. The inspection was completed by one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the home, what the home does well and what improvements they plan to make. We obtained this information during the inspection.

During the inspection we spoke with six people and the relatives of two people. Following the inspection one person's relative contacted us to give feedback about the service. We spoke with the registered manager, the provider's head of quality and compliance, three care staff, and one chef.

Following the inspection we spoke with a senior practitioner from the older people with physical disabilities team. They had no concerns about the service.

We reviewed records which included three people's care plans, people's medicine administration records, three staff recruitment and supervision records and records relating to the management of the service. These included; staff training records, staffing rotas for the period 15 February to 4 April 2016, quality assurance records and accident and incident reports.

At the last inspection on 20 June 2013 no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home. Staff had completed training in safeguarding people from abuse and told us about how they would recognise and respond to allegations or concerns. The provider's safeguarding policy and procedures, which included the local authority multi-agency safeguarding procedures, were accessible to staff for guidance.

A staff member told us about how they had notified a concern to the registered manager and this was investigated. They said "I found the experience of going through something like that helped me to be more aware and highlighted how easy it is to report. The procedures were followed and worked". When people were vulnerable to abuse, action was taken to protect them from harm. Staff were confident that the registered manager would act on any concerns. People were supported by staff that understood the indicators of abuse and acted on concerns to minimise the risk of re-occurrence for people.

Risks to people's health and welfare had been assessed and plans put in place to instruct staff upon how to keep people safe. People had care plans in place for example, in relation to risks associated with, moving and positioning, skin damage, poor nutrition and risks from falls. People at risk of falls had been identified and actions had been taken to minimise people's risks from falling. For example; a person who had experienced falls had their medicines reviewed to assess if these were affecting their mobility. They were referred to the specialist falls clinic and a trip hazard was removed from their room.

The registered manager monitored all falls in the service by reviewing individual incident reports and reporting these as part of the provider's incident monitoring system. One person told us how it was important to them to remain independently mobile even when this presented some risks to them and said "You've got to take risks, I fell at night. I use my walker so my alarm is attached to it and they (staff) answered the bell". People were supported to stay safe whilst respecting their choice to take managed risks.

The provider had assessed and acted upon risks to people's safety in the home. For example; the provider had taken action to make improvements to the garden so people would be protected from uneven surfaces which presented a falls hazard. People's support needs in the event of an emergency evacuation had been individually assessed. Their support level was identified by a coloured dot on their bedroom door which enabled staff to identify their needs promptly in an emergency. Records showed information about people's support needs in an emergency was kept on each floor of the building for prompt access. A staff member told us how they practised evacuating people through 'mock' training sessions. This enabled them to know the route and support levels each person required.

Everyone we spoke to said that when they required assistance staff attended. A person said "Yes I think staff are available when I press my bell they come". People told us there were sufficient staff to meet their needs safely. Some people told us at times staff did not always deal with their requests as quickly as they would like. We were given examples of how people had to wait at times for staff to return to help them make their bed or supply a requested item. One person said "I feel they could do with another carer on. I am not impacted badly but I do get irritated when I have asked for something and it doesn't get done I think they

need more help. There isn't enough popping in". We spoke to the registered manager and head of quality and compliance about this feedback. They told us the provider had agreed funding for additional care hours at times of the day they had identified staff were stretched and had to prioritise people's needs. The registered manager confirmed they had recruited to some of these hours and were in the process of recruiting further staff. The provider had introduced a care dependency assessment tool to ensure staffing levels met people's identified needs and this was being completed for the home at the time of our inspection.

Staff told us there were sufficient staff to meet people's needs. They confirmed that when people's needs had changed additional staff were employed to meet these needs. The registered manager told us they supported people as required and said "I am an extra pair of hands, I can always put my uniform on". Staff vacancies were covered by existing staff wherever possible one staff member said "We call on existing staff to cover shifts we don't like to use agency but we would not go short staffed, if required the manager will come in". We checked the staffing rotas for the period 15 February to 4 April 2016; we saw that staffing arrangements were as described. This meant people experienced a consistency of care from staff who knew them.

Staff were recruited safely. In staff files we saw evidence of the required checks to ensure staff were safely recruited. These included; criminal records check, a full employment history with an explanation of any gaps in employment, satisfactory references from previous employers and photographic proof of identification. The provider operated an effective system to protect people from the employment of unsuitable staff.

Some people chose to manage their own medicines following a self-administration assessment. This supported people to remain as independent as possible. Other people told us they were satisfied with the way their medicines were managed by staff in the home. One person said "The whole management of medicines is excellent stuff, like that is managed very properly."

Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs (CD's). Providers are required to have procedures in place to ensure they are safely managed and that staff follow these to keep people safe. We checked the arrangements for the storage, recording and administration of CD's. We found these to be appropriate and that legal requirements were met.

People's other medicines were safely stored in their rooms in locked cupboards. Arrangements were in place to receive and dispose of medicines safely. Staff had received medicine administration training and had their competency assessed before they were allowed to support people with their medicines. We observed a staff member supporting a person to take their medicines safely in accordance with their prescription and documenting when the person had taken their medicines. People's medicines were managed safely.

Good

Is the service effective?

Our findings

Staff completed an induction into their role that enabled them to carry out their responsibilities effectively. Their induction included them shadowing experienced staff to learn about people's needs. New staff were then shadowed by senior staff to check their competency to carry out their role and support people effectively. The Care Certificate sets out the learning outcomes, competences and standards of care that care workers are expected to achieve. The Care Certificate was completed by staff who were new to care. A staff member told us they had been "very well supported" by the deputy and registered managers throughout this process.

Staff were required to complete mandatory training as determined by the provider. This included safeguarding, moving and handling, infection control, health and safety, dementia awareness, the Mental Capacity Act 2005, dignity in care practice and tissue viability. Staff completion of the required training was monitored by the registered manager and the provider to ensure staff were adequately trained. Records showed staff were booked to attend training to address any shortfalls identified. A staff member described to us how the training in dementia had helped them improve their understanding of a person's communication needs and how to respond.

Staff we spoke with told us they were supported by the deputy and registered manager in their role. Records showed that formal processes such as supervision and annual appraisals were regularly completed. Staff had access to continuing and professional development, and the provider worked with an external agency to deliver a range of training topics and professional qualifications in health and social care. One staff member we spoke with was delighted to be completing a health and social care qualification and told us they were being supported by the provider to achieve this. People were supported by staff who received training, professional development and support in their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had completed training in the MCA (2005) and were able to demonstrate they understood the key principles. Staff told us about how they supported people to make decisions and remember important information if they became forgetful to enable them to express their own preferences and choices. People told us staff asked them about their decisions and respected these. For example; a person said "I can go to sleep anytime I want I go to bed about 7, I get up when I want and my breakfast comes up to me." People's rights to make their own decisions were supported and respected.

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 told us no one living at the home required a DoLS. They said people had the mental capacity to consent to their care and treatment and there were no restrictions in place to prevent people leaving the home should they wish to. For example, the front door had a keypad for security of entry only; this meant that people would be free to leave when they chose. People we spoke with confirmed they had made the decision to live at the home and were able to go out, although some people required support due to their mobility needs. The registered manager had completed training in the MCA (2005) and DoLS and understood their responsibilities to ensure people's rights were upheld if their needs changed and a DoLS became necessary.

People spoke positively about the quality of the food provided. A person said "The most important thing here is the food; they (chefs) are excellent. They meet individual needs and choice. It is good nutritious food". The home employed two chefs who were praised by the people we spoke with. A person's relative said "In great praise of the kitchen staff; both are brilliant they fuss around the residents noticeably and they go to a lot of trouble and provide a very varied menu".

People were regularly asked for their feedback on the quality of the food and their preferences. One person returned their weekly menus to the chefs with their comments and told us "I also pass on recipes". A chef explained how they used people's feedback to inform the menus and told us they could always be 'surprised' by people's choices and enjoyed incorporating different foods into the menu. People told us their preferences were catered for and prepared so they could enjoy food even when it presented some risks. For example; the chef 'shaved' strawberries to eliminate the pips and made a watercress butter to create a safer texture. People's food preferences and needs were met.

When people were at risk of poor nutrition or losing weight the chefs were made aware of this and their diet was adapted to provide higher calorie content. People choosing to lose weight were also supported to manage this. Records showed information was held by the chefs about people's current nutritional needs and these were catered for. A 'nutrition and hydration week' event was held by the provider to promote healthy eating and good fluid intake. The chefs prepared food such as; homemade frozen yogurts; jellies; fruit fondues; fruit salads and smoothies to promote awareness of how fluid intake can be increased through the use of these foods. People were supported to maintain good nutrition and hydration.

People saw their GP when needed and were able to keep their own GP when they moved into the home. People had access to other healthcare professionals as required including the optician, chiropodist and dentist. The home worked with the district nurses to ensure people's healthcare needs were met in relation to; end of life care, stoma care and pressure ulcer care. Staff were trained by district nurses when they were required to provide this support to enable them to care for people effectively. People confirmed their healthcare needs were met.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by caring staff. People we spoke with told us staff were caring. People's comments included "Staff are 100% caring I have no complaints at all they are all very nice". "They are all very kind everybody is nice, not really anything they could do better". One relative said "They genuinely show care; definitely their treatment of mum is good."

We observed caring interactions between staff and people. For example; a staff member immediately noticed a person coming into the dining room was not wearing their glasses and went and got them for him. Another staff member was heard reporting on a person's progress with eating to their relative. They showed concern for the person and explained how they had introduced changes to support the person to eat more which had been effective.

Staff we spoke with were aware of people's preferences and personal histories. They told us about the activities people enjoyed and their interests and the things that people didn't like. People appreciated the caring approach of staff and told us they were 'bright and cheerful' and 'helpful'. One staff member had joined a person on a sponsored weight loss event. Other staff spent time with people, outside of their working hours to socialise and join in activities such as gardening and jigsaws. Notable days such as; Chinese New Year, Easter and St Patricks day were celebrated with special menus and place mats were created to give people information on the history of the event. A staff member said "It's just like a family home." People were supported by staff who demonstrated a caring approach.

People we spoke with told us their decisions were respected by staff. This included their day to day decisions about the times they got up and went to bed, what they ate and where they ate. People told us they enjoyed the relaxed atmosphere in the home and felt they had choice and control in their daily care. One person told us "I have put a stop on daily notes being taken about me." They went on to tell us how they agreed to recording in the event of a risk to their care and welfare but otherwise did not consider this necessary. They said "I signed a piece of paper to this effect and they (staff) respect that."

Residents meeting were held and records showed people attended meetings and gave their views and made decisions. For example; people told us they had discussed the suggestion made to have a summerhouse in the garden. People decided they did not want this and preferred an awning outside the lounge which they felt they would enjoy more this had been agreed by the provider. People told us they were planning to become more involved in decisions about the garden and had already begun to raise this with the registered manager; a person said "we will be raising this at the next meeting". People showed us the information they were given to help them make choices, this included; weekly menu's, activity schedules and letters from the registered manager to ensure people remained informed about events in the home. People were supported to express their views and make decisions about their care and treatment.

The registered manager told us all staff were completing dignity training and records showed this was booked. They planned for all staff to become 'dignity champions'. A dignity champion is someone who acts as a role model and actively seeks to ensure people receive person-centred, compassionate and dignified

care. This was aimed at promoting respectful and compassionate behaviour within the staff team. The registered manager said this would drive improvement in the consistency and quality of care people received.

People told us they were treated with dignity and respect. A person said "I am treated with respect and privacy. Staff always knock before coming in." Another person told us how they appreciated the staff approach when they were helped with a personal care task they found embarrassing. Staff we spoke with demonstrated they understood how to provide care in dignified way and we observed staff were respectful in their interactions with people.

A person commented "The top and bottom of it is if someone was thinking of coming to Meadway I would say Oh yes its really good. There is a nice atmosphere and the carer's are respectful".

Good

Is the service responsive?

Our findings

People told us they received care that was responsive to their needs and preferences. For example a person said "If there is anything I want done I ask them, I can wash and dress myself and make my own bed. I need help with a bath and they do this". Another person said "Staff do my medicines and they help me with a bath and everything". A person's relative said "I like this place and so does mum, they manage to keep it casual and unrestrictive it's not bent over with rules. They accommodate people's likes and dislikes – they do their best".

People's needs were assessed prior to their admission. A care plan was then developed to meet their needs. A consent record was in place which detailed the support people required and their agreement to it. This included people's needs in relation to nutrition, moving and positioning, falls, continence, medicines, personal care and night-time care. Care planning included what was important to the person and how to support them to achieve that. For example; it was important to a person to maintain contact with their family; they wanted to be reminded every evening and helped to call their relative and this support was confirmed as delivered. People received person-centred care.

People told us they were supported to maintain their independence. Care plans included information about what people could do independently and any difficulties in managing this and what support was required. Such as; assistance required with dressing, hair care, dentures, jewellery and make up. A 'My daily home life summary' summarised people's choices and preferences for the day and night and including what people could do for themselves. People confirmed they received the level of assistance they required for example a person said "My mobility has depleted, I've always been able to dress myself but now I need more help and this is provided". Another person said "I make my own bed and do my medicines the food is provided, I don't press the buzzer for staff very often only when necessary, I am pretty self-contained".

Staff told us about how they used their knowledge of people to provide responsive care. For example they told us about the signs they observed in a person who had a medical condition. They noticed how the person's mobility, posture and abilities changed and the treatment and care they required. A care plan was in place to guide staff on how to respond and this was acted on. A person's relative told us how well their relative had recovered following a stay in hospital. They said "The registered manager and team pulled out all the stops. They (person) was at the time very weak. Within a few months they had recovered their strength and vigour. They have been well looked after, cheered along and well fed". Processes were in place such as written and verbal communication handovers which ensured all staff were kept up to date with people's changed needs. People received care that was responsive to their needs.

The home employed a part time activities co-ordinator and a programme of activities was in place. A person said "We do knit and natter and the occasional entertainment like golf, we like this, hitting the ball into the net with lots of cheating. We have Holy Communion and you can also arrange to go to church". Other activities included 'Oomph' an activity session aimed at improving physical mobility, social interaction and mental stimulation. People told us they enjoyed this and a staff member told us how a person had benefited from the sessions improving the mobility in her hand. Some people enjoyed their own hobbies

and interests such as gardening; reading, sewing and knitting. People we spoke with were satisfied with the level of activities and were looking forward to the summer outings and garden party they were currently planning at the residents meeting.

The provider had a complaints policy and procedure and this was displayed in the home. No complaints had been received; however relatives and people told us they felt confident to speak with the registered manager if they had any concerns. A person said "I am not the complaining type but I would talk to the manager and I know she would be in here like a shot". A person's relative said "I feel the manager would Listen and act she calls us to talk about situations and she responds". A system was in place for people to raise their complaints and concerns and people were confident these would be acted on.

Requires Improvement

Is the service well-led?

Our findings

Records relating to people's care and treatment were not always accurate, complete and up to date. This included the decisions taken in relation to the care and treatment provided. For example; a person had experienced a fall on leaving the home. The registered manager, the person's relatives and staff were aware of this incident and had assessed this incident as unlikely to reoccur due to a number of factors. However, the person's records had not been updated to reflect the assessment of risk and the decisions taken to ensure the person remained safe. People may not be protected from harm were information about risks and the actions required to keep people safe are not recorded and available to guide staff including new staff who may not know people well.

One person's care plan included a completed risk assessment for eating, drinking and swallowing. The information in this assessment was found to be incorrect. The registered manager confirmed the risk assessment had been completed incorrectly but this had not been amended to reflect the person's current needs. One person had been identified by staff as having a pressure ulcer, this was responded to and treatment had been given by the district nurses. The person's records had not been updated to reflect the diagnosis by the district nurses, the treatment received and an evaluation of the wound following treatment. Some people's daily monitoring records relating to their food and fluid intake were found to be incomplete. For example a person had been identified as losing weight. We saw action was being taken by the chefs and staff to support the person with their nutritional needs. However, the monitoring record of their food intake had not been fully completed in line with the actions identified on their care plan to manage the risk to the person from poor nutrition and weight loss. A person's fluid intake record was not fully completed. This was in place to support the management of the risk to the person from dehydration and infection. Where records were incomplete or inaccurate people could be at risk of not receiving the care they required to meet their identified needs. This risk could be increased when people were cared for by new staff who did not know them well.

One person had a Do not Attempt Cardiopulmonary Resuscitation (DNACPR) decision recorded in their care plan. The decision had been made by a healthcare professional and signed as agreed with the person's relative. It was not evident from the record this decision had been discussed with the person to make them aware of the Doctors professional decision, in case they wished to seek a second opinion. The person was described by the registered manager as having the capacity to be consulted about this matter. Records about the legal authority of the person's relative to be consulted on their behalf were not accurate. We spoke to the registered manager about this who addressed this immediately with the person's relative.

We discussed these shortfalls with the registered manager and the provider's head of quality and compliance. They told us the provider had introduced a new care planning system and care staff were being 'taken on a journey' in respect of care planning. This included training and auditing of care plans to support staff in learning the new system and making improvements in their record keeping. We saw this was underway at the time of our inspection. However, staff were still failing to ensure that records relating to the care and treatment needs of people were accurate, complete and up to date, including records of decisions made and the care and treatment provided to protect people from unsafe care and treatment. This was a

breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A system was in place to drive continuous improvements to the service. The provider had a business plan in place to identify planned improvements to the service during the current year. We saw the improvements identified were underway. For example; improvements to the environment, staff training and care planning. A monthly audit system focused on different aspects of the service to monitor the quality of the service provided. This included; health and safety, catering and nutrition, infection control, medicines management and dignity. We looked at the results of some of these audits for example; the medicines records audit, infection control, the dining room experience and the care rating audit based on people's responses to the 2015 quality assurance survey. Some audits showed improvements had been identified and activities planned to achieve improvement had been completed. Other audits were not fully completed such as the care rating audit with identified actions and completion status. This audit identified improvements were required in; engaging people in the quality assurance survey, laundry service and people's understanding of when they can receive visitors and waiting times in the dining room. The registered manager identified the improvements required and planned actions to achieve them during our inspection. However, this meant there was a delay in acting on people's feedback to make improvements to the service.

There was a positive, open and inclusive culture within the home. Staff told us the registered manager was accessible and responsive. Staff spoke positively about the experience of working in the home and a staff member said; "I thoroughly enjoy my job the set-up is very good if you have a problem there is always someone on call I find the management structure is good". People told us the culture was good and a person said "Very nice atmosphere, the staff are very good and there is a positive outlook from all staff – no one is snappy or difficult".

The provider promoted their core values of; individuality, independence, privacy, dignity, personal choice, fulfilment, social inclusion and respecting and involving service users. This was achieved through training, leading by example and a recognition scheme to acknowledge particular contributions from staff in demonstrating the values. For example, one staff member at the home had been recognised for their caring and empathic approach. Staff we spoke with understood the values and told us how they put these into practice. A staff member said "We individualise each resident, respect their choices, ensure they are safe, secure and happy in the environment, ask their needs and respect their beliefs and cultures". People confirmed that staff treated them respectfully and their individual needs and preferences were met.

The registered manager supported staff to be clear about their role and responsibilities. Records showed this was achieved through staff supervision, team meetings and by taking action to address staff performance when improvements were required. For example; a staff member told us about an improvement they had been asked to make which they understood and accepted and acted on.

The registered manager told us they were proud of "getting the team working together" and improving the standard of care following a period in 2015 without a registered manager in post. Minutes of team meetings showed there was a focus on continuous improvement. People's care and care practices had been discussed and areas for improvements were identified. Staff awards and praise for staff were included as part of the meeting. A staff member said "When we say something (at team meetings) it is always taken up. I raised that staff weren't always checking if clothes were dirty prior to hanging them and since then we have no dirty clothing hung up".

The provider visited the home monthly to carry out a review of the service. Records showed the reviewer checked actions from the previous visit and identified further improvements where needed. For example; actions from the previous visit had been completed and care plan audits were underway as part of an

ongoing improvement action. This ensured progress towards improvement actions were monitored and addressed by the provider.

Accidents and incidents were logged and reviewed by the provider as well as the registered manager. This ensured the provider's accountability to identify trends and manage actions appropriately to reduce the risk of repeated incidents, as well as addressing the initial cause of the accident or incident appropriately. For example; improvements had been made to the garden following an accident. Falls monitoring was in place to enable the registered manager and provider to identify patterns and trends for each individual and the measures required to prevent reoccurring falls. We saw that action had been taken as identified. An effective system was in place to monitor and mitigate the risks to people from falls, accidents and incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to people's care and treatment were not always accurate, complete and up to date. This included the decisions taken in relation to people's care and treatment provided. Regulation 17 (1) (2)(c).