Wotton Rise Nursing Home Limited

Charnwood House Nursing Home

Inspection report

49 Barnwood Road
Gloucester
Gloucestershire
GL2 0SD

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14 June 2016
15 June 2016

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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

The inspection took place on 14 and 15 June 2016 and was unannounced. This was the service's first inspection since the new provider purchased the care home at the end of October 2015.

Charnwood House can provide accommodation and nursing care to up to 35 people. At the time of the inspection 17 people lived there. Some areas of the environment had been improved to make it safe and cleaner. As the service establishes itself further environmental improvements are planned by the provider

The service had two registered managers who shared responsibility for it's management. 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.

There had been many improvements to this service since October 2015. These had predominantly focused on people's safety and ensuring they were cared for by staff who were kind, compassionate and skilled. Very few of the original staff group still worked at the care home and staff already known to the new provider had been moved there. Where staff had been newly recruited, robust recruitment practices ensured they were suitable to look after vulnerable people. Care practices had therefore improved and this had resulted in improvements in people's health and well-being. People had been provided with appropriate care and access to health care professionals. Two health care professionals spoke about the improvements in one person's health in particular. Records for other people showed improvements in their weight, wounds and condition of their skin and their general well-being.

People's care was planned with them or their relative/representative if they were not able to do this. Care plans gave staff detailed guidance on how a person's care should be delivered. These were updated regularly or as needs and care delivery altered. Family and visitors were made welcome and able to visit at any time unless there were formal restrictions in place to safeguard a person. People were able to raise areas of dissatisfaction and have these addressed. The care home was advertising for an activities coordinator and until this post was filled care staff were providing opportunities for people to partake in social activities each afternoon. There were mixed comments about the activities provided but the management were aware these needed to be better personalised. Links with the local community were to be encouraged and formed as the service became more established.

The service benefited from strong leadership, both from the registered managers and the senior nurses. Staff worked well as a team and shared the visions and values of the registered managers. The provider monitored all systems, processes and practices to ensure these resulted in good care for people and met with the necessary regulations and legislation. The views of people and their relatives were already sought and the management were open to suggestions and ideas. Over the next 12 months it was planned to gather further views from people and relatives but also the views of other visitors, such as visiting professionals and

the 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. People were protected against risks that may affect them. Environmental risks were also monitored, identified and managed.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met and people had access to health care specialists when they needed it.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff. The service planned to improve its systems and staff training further to ensure a fully personalised approach to care was possible at all times.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Good

The service was able to be responsive. Care plans gave details about people's care needs and how their care should be delivered so staff had up to date information about this. People had opportunities to socialise and partake in activities. The care home wanted to personalise activities more and were advertising for an activities co-ordinator to help with this.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led. People were protected by the way the provider monitored the service's systems, processes and staff practices.

New management arrangements were in place and staff were behind these and committed to providing people with a good standard of care.

The management team made themselves available to people, relatives and staff and were open to their suggestions and views.

Charnwood House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 14 and 15 June 2016 and was unannounced. The inspection was carried out by one inspector. This was the first inspection of the service since it was purchased by the new provider in October 2015.

Before visiting the care home we reviewed the information we held about it since the new management arrangements. This included a review of all statutory notifications since October 2015. Statutory notifications are information the provider is legally required to send to us about significant events. We also sought the views of commissioners and visiting health care professionals on the service provided by the new provider. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who lived at the care home and asked for their views on the services provided to them and the care they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six members of staff and the registered manager. We also spoke with two relatives and three visiting health care professionals. We attended one staff hand-over meeting.

We inspected various documents and records relating to the people who lived there and the staff who worked there. These included four people's care records and three staff recruitment files. We reviewed the service's main staff training record and staff duty rosters. We reviewed records kept in relation to the

management of medicines including five people's medicine administration records. We looked at the care home's complaints record and how people's concerns had been responded to.

We also inspected various records and documents relating to the running of the service. These included a selection of quality monitoring audits, records relating to accidents and incidents and daily staff hand-over records. We completed a tour of the internal environment and outside space.

Good

Is the service safe?

Our findings

People were kept safe. Risks were identified and managed so as to reduce harm to people. There were enough staff to deliver people's care, to give people additional time when needed and to keep them safe by effectively managing risks to people. The registered manager explained that staffing was adjusted if needed. One person had been particularly unsettled at one point and an additional member of staff had been put on duty during this time to attend to their enhanced needs. One person spoke with us about an incident that had frightened them and said, "the staff came immediately". Following this actions had been taken to reduce the risk of the incident reoccurring. Another person told us they "liked to be safe at all times" and confirmed they felt this at Charnwood House. One relative told us the staff had quickly identified the areas that potentially could harm their relative and said, "They [staff] are attentive all the time". The registered manager discussed some of the actions they had taken since October 2015 to improve people's safety. This had predominantly focused on eradicating poor practice and ensuring those who worked at Charnwood House were appropriately skilled and recruited.

People were protected from those staff who may not be suitable. On taking over the care home the management team introduced staff who already worked for them or who were known to them or their own staff. At the time of the inspection very few previously employed staff worked at the care home. All recruitment files reviewed showed that appropriate checks had been carried out before new staff had started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers. Employment histories were requested and the reasons for any gaps explored at interview.

There were arrangements in place to help protect people from abuse and intended harm. Staff were aware of how to recognise abuse and what to do if they encountered this or suspected an abusive act had taken place. The management staff took a zero tolerance approach to any form of abuse taking place either from within its own staff group or from an outside source. The statutory notifications we had received demonstrated that they took appropriate action to protect people when needed. All safeguarding concerns were shared openly with all appropriate agencies so that those agencies could also meet their responsibilities in safeguarding people. This meant the managers adhered to their own safeguarding policy and Gloucestershire County Council's Multi Agency Policy and Procedures. Staff were also aware of the need to safeguard visiting children. They were aware of relevant policies and procedures in relation to this.

People received their medicines safely and the systems in place resulted in the safe management of all medicines. Staff who administered medicines were knowledgeable and had their competencies in this task reviewed. Medicines were stored safely and administered directly from the safe storage areas. Records relating to the management of medicines were well maintained. This included people's individual medicines administration records (MARs). Staff were responsible for maintaining these when they administered people's medicines. The provider had experienced problems with the maintenance of these records when agency staff had been used. To manage this situation the provider liaised with managers of

agencies and increased their monitoring of people's MARs. These actions and a reduction of the use of agency staff had resulted in no gaps in staff signatures on MARs since February 2016. We saw staff giving people explanations about their medicines and they were able to answer people's specific questions. For medicines prescribed to be given "as required" there were appropriate protocols in place to give staff additional guidance on how and when this medicines could be administered. We saw specific care plans in place when people were on pain relief, also for staff guidance.

People lived in a safe environment. The new provider had made several improvements and arrangements to ensure this was the case. The maintenance and management staff carried out monthly checks on all aspects of health and safety within the care home. This was formally recorded. On reviewing records relating to this we noticed the checks being done on window restrictors were not being recorded so the registered manager told us they would add this to their record. Actions to improve the environment were taken immediately after the purchase of the care home and not many additional actions had been identified in subsequent monthly checks.

A fire risk assessment had been completed and all fire safety requirements put in place. This included arrangements for the safe evacuation of people if this were needed. The water system was also monitored for risks related to Legionella. Staff were responsible for the safe running of their own work areas. For example, the laundry and kitchen staff adhered to the provider's expectations and safety procedures. The kitchen had been fully cleaned and systems put in to place. This had resulted in a rating of "5" being awarded by the Food Standards Agency two months prior to this inspection. This is the highest award that can be given for cleanliness and safe food management. The provider had existing contracts in place with various service providers and maintenance companies and these had been extended to include Charnwood House. For example, this included a specialist company to service and maintain the passenger lift. The new provider had a new internal safety door fitted to this. Contracts were in place to service and maintain all other lifting equipment such as care hoists and slings. Similar arrangements were in place to maintain the water storage systems, nurse call system, emergency lighting, fire alarm and fire safety equipment.

The environment had been thoroughly cleaned by the new provider and systems were in place to maintain cleanliness and reduce the risk of infection. We observed staff taking appropriate precautions which included wearing protection gloves and aprons when delivering care or handling food. We saw staff washing their hands between tasks. We observed cleaning staff carrying out their tasks and the provider was able to use existing cleaning staff from another of their services when additional support was needed. Appropriate specialist contracts were in place for the management of waste. An odour was evident in the lounge despite the frequent cleaning of the carpet and replacement of armchairs so the registered manager was considering replacing the flooring in this room.

Good

Is the service effective?

Our findings

The service was effective and was able to meet people's health care needs and support people to have a better quality of life. One relative said, "They [staff] have been brilliant. They can cope with [name], they had sussed [name] out quickly. They have a quiet approach which [name] responds to and they have not needed to use [name of sedating medicine]". One person who lived at the care home told us "they care for you quite well and the food has improved". Another person also agreed that the food had improved.

One health care professional made a comment about the two lead nurses. They said they were "very on the ball". This was in relation to their knowledge of people's health needs. They told us they had noticed improvements in the person they had come to assess since the new management arrangements. Another health care professional spoke about their past concerns about the same person's health and also made comment about the improved care under the new provider. They said, "I had given up on any improvement in [name]" but "there's been a miraculous improvement". Records collating the progress of people's pressure ulcer wounds also showed that many had completely healed and others were improving since October 2015.

People received care from staff who had been trained to meet people's needs and who received support to do this well. Many care staff working for the provider had worked as nurses in their own countries but had chosen not to register to be a nurse in the UK. The provider told us they preferred recruiting staff with this background as they came with an established knowledge of health related care. They told us they then provided them with additional training which they considered necessary for all staff to have when working for them. The staff recruited from the UK were predominantly experienced care assistants. We spoke to one member of staff who had been retained by the new provider. This care assistant had already completed a recognised qualification in care at a level which enabled them to supervise other staff. They said, "The training now provided is really good". Two other care staff agreed that the training given to them provided them with additional knowledge they needed. They all agreed that the support they received from the managers and lead nurses was "very good".

The service's main training record showed all staff to be up to date with mandatory training and any other training their role required. Mandatory training was completed by all staff, whatever their role. This included subjects such as safe moving and handling, food hygiene, safeguarding people from abuse, the Mental Capacity Act and Deprivation of Liberty Safeguards, infection control, dementia care and fire safety. All care staff had then completed many additional subjects for example, end of life care, diabetes, stroke care, feeding via a percutaneous endoscopic gastrostomy (PEG – tube inserted by a doctor directly into the stomach) and person centred care. The Provider Information Return (PIR) stated that further training in end of life care was to be organised in the next 12 months. One nurse confirmed that update training was being organised for the nurses in the use of syringe drivers (used sometime to administer people's medicines at the end of their life).

Training had been linked to the original Skills for Care Induction Standards (CIS) modules but now linked into modules used in the nationally recognised care certificate. The care certificate lays down a framework

of training and support for new care staff. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed. Modules within this can be used to update the knowledge of existing staff. Nursing staff also completed additional training in areas of required competency, for example, administration of medicines, catheter management and management of pressure ulcers and wounds. Nurses registered with the Nursing and Midwifery Council (NMC) were also responsible for maintaining their own standards of competency as required by the NMC and which was checked by the provider.

People received care for which they consented. Staff were very aware that they needed to obtain people's consent before they delivered care. We observed people being asked for this and staff waiting to receive people's agreement before they provided care. In the staff hand-over we attended the nurse in charge of the shift explained to the staff that a urine test was required for one person. They also explained that if the person refused to comply with this they must respect their wish. They explained that if this were the case, they would explain to the person, again, why it was needed so they were able to make an informed decision about their care. In one person's care file staff had recorded when one person had refused personal care and where they had agreed for it to be delivered. Where the person had refused care staff had gone back later and offered the care at different times of the day.

When people lacked mental capacity to make decisions and choices about their own care and treatment they were protected under the Mental Capacity Act 2005 (MCA). The (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Throughout the inspection we observed staff providing support to people so they could make their own decisions and choices when they were able to. In the case of one person this was not an easy task because of their challenging responses. Staff continued to ensure this person was supported in a non-judgemental way to make their own decisions, when they were able, and to ensure their care was delivered in the least restrictive way. The PIR stated that people's mental capacity was assessed for each specific decision made about people's care and treatment. We found this to be the case and there were decision specific mental capacity assessments in people's care records. Where decisions had been made on behalf of people, in their best interests, these were recorded. Records also stated who had been involved in decision making, which usually included the nursing staff, the person's representative and their GP.

Appropriate Deprivation of Liberty Safeguards (DoLS) referrals had also been made to the local county council. These were completed for people who had been assessed as lacking mental capacity and their liberty was deprived in order for them to receive the care and treatment they required. 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. The service had adhered to this legislation and were ensuring people's care was delivered lawfully.

People were provided with the support they needed to maintain a healthy intake of food and drink. We observed staff taking the time to ensure people were helped to eat their food and to drink. This was irrespective of whether the person spent time in their bedroom or sat in the main lounge. People had access to their choice of cold drink at all times and additional hot drinks were served at regular intervals. Snacks were also provided in-between biscuits and cake with mid-morning and mid-afternoon hot drinks. The cook present during the inspection (provider's relief cook) had a good knowledge of people's dietary needs. They were aware of who was diabetic, who required fortified foods and what consistency some people required

their food to be in. People who had swallowing problems had been assessed by a speech and language therapist (SALT). The kitchen then followed SALT's instructions and provided food in the correct consistency. We observed one person, who was on a pureed diet, also having a prescribed thickener added to each drink they had by the care staff. This showed staff were aware of this person's needs. This person had also been put on a fortified diet and had gained a little weight.

People's weights were monitored monthly or weekly depending on their level of nutritional risk. Fortified diets were used to get additional calories into people so extra butter, cream and powdered whole milk was added to the cooking process. Another person who lived with dementia and who walked for a large amount of the day was automatically receiving a fortified diet to replace the calories they used up. Their relative told us that since they had been at Charnwood House "they were eating like a horse". Their weight had been recorded on admission and would be reviewed in one month's time. The PIR stated that people's different cultural needs are identified and met. The cook confirmed that one person's specifics cultural preferences were met in relation to their food.

People had access to health care professionals as required. Care records contained evidence of referrals and visits by mental health specialists, continence assessors, occupational and physiotherapists, optical services, dentists and chiropodist. People were supported to attend external health related appointments, sometimes by their relatives or the staff.

Good

Is the service caring?

Our findings

People's care was delivered with kindness and compassion. One relative spoke to us about how kind and understanding the staff were when they visited. This had enabled the person's family to feel welcomed and relaxed when they visited their relative. One person told us the staff were "kind" to them when they attended to them. They went on to say "I'm very pleased with the staff". Another person told us they were able to speak to the staff as they walked around. One person told us how relaxed they felt because they had been made so welcome and looked after so well. We observed staff taking time to listen to people and empathise with what they were telling them. Staff showed compassion and understanding towards people. We observed people being respected at all times. One member of staff was verbally abused by a person with mental health issues and we witnessed the staff member maintain a respectful and non-judgemental stance towards the person.

We observed people responding to the staff's kindness and encouragement. The registered manager explained that it had taken sometime after they had taken over the care home to get people to be engaged with what was going on around them. We had observed people to be disengaged from the staff and their surroundings when we inspected in October 2015. During this inspection we observed an overall change in people's demeanour. People lifted their heads up when someone entered the lounge; they watched what was going on around them and responded to the staff as they moved between them. People were generally more animated and looked relaxed in the company of the staff.

Many people who lived at Charnwood House required support to make simple decisions. Senior staff explained that the involvement of those who mattered to people was important. They went on to explain that communication with family members and formally appointed representatives (those who held power of attorney for health and welfare) was an integral part of the care process. We were told that many people required their relatives to speak on their behalf. People's preferences and choices were explored with them and if this was not possible with their relatives and recorded in their care plans. The Provider Information Return (PIR) stated that further training and support would be provided over the next 12 months to ensure systems and care was fully "person centred" (personalised to an individual's needs).

We observed relatives and friends of people being welcomed when they visited. There were generally no restrictions on when and who could visit. The only time this applied was if a best interests process had taken place to restrict visiting in order to safeguard the person from potential abuse. One relative told us they were fully involved in their relative's care decisions (this relative held power of attorney for health and welfare). They said, "I'm updated each time I visited and I'm confident they will contact me if needed".

Staff understood the importance of maintaining people's privacy and dignity. Staff knocked on people's bedroom doors before entering because they recognised this was the person's private space. When staff needed to talk to people about their care this was carried out privately and discreetly away from other people's hearing. When people required a hoist to move them this was done in a way which preserved the person's dignity; for example, a small blanket was put across one person's legs to avoid them being inappropriately exposed. All care was delivered behind closed doors.

Good

Is the service responsive?

Our findings

The service was able to be responsive to people's needs. Where possible people were involved in making decisions about their care or their representatives were actively encouraged to be involved. People's needs were assessed before they were admitted to the care home. This involved one of the registered managers or senior staff visiting the person where they were and finding out what their care and health needs were, what their preferences and choices were and discussing their expectations with them. If the person was not able to partake in this process their representative was able to speak on their behalf. If a person lived some distance from the care home and it was not practical for staff to meet them information was gathered from their representatives and professionals and care staff involved in their care.

This process enabled staff to ensure they were able to meet a person's needs. Sometimes arrangements needed to be made prior to a person's admission. This often included making sure the care home had all the necessary equipment in place and sometimes appropriate medicines.

People's needs were recorded in documents called care plans. These outlined what care people needed, the person's preferences and they laid out guidance for staff to follow. We saw detailed pre-admission assessments and care plans in people's care records. The registered manager told us it was their goal over the next 12 months to further improve the care plans so they were written in a more personalised way. They also wanted to improve the way people's representatives were involved in the review of their relatives care. One relative said, "Yes, I have been fully involved in planning care with the staff". This relative was aware of what was recorded in their relative's care plans. People's care plans reflected the information collected in the pre-admission assessment and that which was contained in additional assessments used by staff to assess levels of risk. The care plans were reviewed every month but sooner if there was a change in needs, abilities and care. The care plan was then amended accordingly so staff had up to date guidance. This also meant that health care professionals visiting the care home to carry out assessments were also able to access accurate and up to date information. Only one example was seen where one care plan did not record the detail of care staff were providing. We fed this back to the nurses who said they would add this. When people had been assessed as lacking mental capacity the care recorded in the person's care plan was referred to as being in the person's "best interests". For example, one person who lacked mental capacity had been assessed by the speech and language therapist as needing a pureed diet to prevent them from choking. As the person had not been able to consent to this diet staff had recognised the need under the Mental Capacity Act 2005 to ensure that decisions made on behalf of a person were correctly recorded and were integrated into their care plan.

People had opportunities to take part in social activities although we received mixed views on these from people we spoke with. The care home was advertising for an activities co-ordinator and wanted to personalise these further. Until this post was filled the care staff were provided with protected time each day to provide some form of social activity (usually in the afternoon). We observed one person with the support of a member of staff enjoying throwing sandbags through a hoop. This gave this person an opportunity to exercise their arms and they were enjoying this. We saw another person listening to music and being supported to dance when they stood up and joined in; others sang along. We also witnessed a balloon being

bounced between people to music. This provided people in armchairs with the opportunity to exercise. People were engaged in the activity and were having fun.

One person told us they did not like the colouring provided to them however, they later showed us, with much pride, the pictures they had completed. Another person said, "It's a dead loss and they told us they were "bored". The registered manager told us ways of providing more stimulation for this person were being explored. We observed that when the television was on people who sat at the back of the lounge could not hear this. This was pointed out to us by one person who sat at the back. We fed this back as an observation to the staff who told us they would look at what they could do to address this. Another person told us they enjoyed the activities staff put on. The activities board had pictures showing various activities one of which had been a visit by a miniature pony. An external entertainer visited monthly and sang people's favourite songs with them.

The garden and patio area had been cleared of rubbish and made safe by the new provider. Pots of summer flowers had been planted and one member of staff told us people and their relatives had enjoyed using the area. There were not may links with the immediate community although the Provider Information Return (PIR) stated that as the service gets more established they aim to encourage more links with the care home to be able to bring more variation to people's days. A link with the local church was already established and they visit monthly and provide a short service and communion.

There were arrangements in place for people, relatives and visitors to raise a complaint. Complaints were recorded, investigated and the registered manager told us their aim was to resolve areas of dissatisfaction. One recorded complaint had been made by a relative who had been unhappy with the hairdressing provided and the toiletries supplied by the care home. An apology had been given to the relative and better communication about the issues raised had been established so as to avoid further dissatisfaction. The registered manager told us that management staff and senior staff were always present in the home if people wished to discuss areas of dissatisfaction or concern. The complaints procedure was on the noticeboard in a prominent position.

Good

Is the service well-led?

Our findings

The service was well-led. The two registered managers shared the responsibility of managing the care home, although it was also a family run business. They were supported by senior staff who shared their visions and aspirations to deliver good care. The registered manager present at the inspection said, "I give them [people, relatives and staff] easy access to me". They said, "I'm in the home every day and when I'm not here senior staff can contact me and if someone wants to see me I'm not far away and will come down". The registered manager told us they made their expectations clear to the staff who worked for them but they also respected them and ensured they were treated well. One member of staff told us about the improvements they had noticed under the new management. They said, "residents are happier and the staff who work here now do not have poor attitudes". Two other staff told us the registered manager/s were "very approachable" and the "senior nurses are very supportive".

The registered manager told us they knew exactly what was going on in Charnwood House. As reported above they were in the care home daily and there were effective communication arrangements in place between them and the senior nurses. We observed staff to be following the instructions and guidance of the senior nurses. We also saw the senior nurses helping the staff and working alongside them. There was good team work in place and staff were seen to be respectful of each other. One relative spoke about how well staff worked together and how things ran so well. They said [of the two senior nurses on duty during the inspection] "you can tell they're the bosses".

Meetings with staff were carried out in small groups rather than one large staff meeting for example. The registered manager told us they found this to be more practical and more effective and they could speak to staff about their areas of responsibility in particular. Staff also received regular support sessions and time to speak with managers on a one to one basis.

Regular checks on the care home's systems, processes and practices were carried out as part of the provider's quality monitoring programme. We reviewed various audits which were completed throughout the year and where their findings had been recorded. Where action had been needed to address a shortfall or to improve an existing arrangement these were addressed immediately. The audits we reviewed did not therefore show that many actions had been needed following an audit. The registered manager explained that this was because when they noticed something they "dealt with it immediately". We did observe that the audit format used did not allow for actions to be recorded as completed. The registered manager told us they would look at altering the format so they did record when the action was taken. The registered manager explained that staff practices were always being observed by them and their senior staff. It was evident that this process was in place from the action that had been previously taken when poor practices had been observed. Staff competencies were not formally recorded and the Provider Information Return (PIR) stated that a formal process was to be introduced in the next 12 months.

The views of people and relatives had already started to be sought and for example, feedback from questionnaires sent out in April 2016 told the management that the social activities were "fair". This was therefore an area which they wanted to personalise more. The PIR stated that further views from people and

relative would be obtained over the next 12 months as well as those of other visitors such as visiting professionals and the staff.