Ranc Care Homes Limited

Brentwood Care Centre

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

The inspection took place on 3 December 2015 and was unannounced.

Brentwood Care Centre provides accommodation and personal care for up to 112 older people and people who may be living with dementia. The service does not provide nursing care. At the time of our inspection there were 99 people using the service.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safe because the management team and staff understood their responsibilities in managing risk and identifying abuse. People received safe care that met their assessed needs.

There were sufficient staff who had been recruited safely and who had the skills and knowledge to provide care and support in ways that people preferred.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

People's health and social needs were managed effectively with input from relevant health care professionals and people had sufficient food and drink that met their individual needs.

The adaptations and design of the premises met people's needs and promoted their independence but improvements needed to continue to the decoration of the premises.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was following the MCA code of practice.

People were treated with kindness and respect by staff who knew them well.

Staff respected people's choices and took their preferences into account when providing support. People were encouraged to enjoy pastimes and interests of their choice and were supported to maintain relationships with friends and family so that they were not socially isolated.

The management team encouraged and supported staff to provide care that was centred on the individual.

The provider had systems in place to check the quality of the service and take the views and concerns of

people and their relatives into account to make improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

There were sufficient staff who had been recruited appropriately and who had the skills to manage risks and care for people safely.

Staff understood how to protect people from abuse or poor practice. There were processes in place to listen to and address people's concerns.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Is the service effective?

Good

The service was not consistently effective.

The adaptations and design of the premises met people's needs and promoted their independence but improvements needed to continue to the decoration of the premises.

Staff received the support and training they needed to provide them with the information to support people effectively.

People's health, social and nutritional needs were met by staff who understood their individual needs and preferences.

Where a person lacked the capacity to make decisions, there were correct processes in place to make a decision in a person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood and appropriately implemented.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring in the way they provided care and support.

Staff treated people with respect and were attentive to their

needs.

Staff knew people well and understood how to support them if they became distressed.

Is the service responsive?

Good

The service was responsive.

People's choices were respected and their preferences were taken into account when staff provided care and support.

Staff understood people's interests and encouraged them to take part in pastimes and activities that they enjoyed. People were supported to maintain family and social relationships with people who were important to them.

There were processes in place to deal with people's concerns or complaints and these had developed so that the information was used to improve the service.

Is the service well-led?

Good

The service was well led.

The service was run by a competent management team who demonstrated a commitment to provide a service that put people at the centre of what they do and make improvements where necessary.

Staff received the support they needed to provide people with good care and support. Staff morale had improved.

There were systems in place to obtain people's views and to use their feedback to make improvements to the service.

Brentwood Care Centre

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 3 December 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor had expertise in dementia care.

We reviewed all the information we had available about the service including notifications sent to us by the registered manager. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including family members, advocates and the local authority. An advocate is someone independent of the service who will support an individual to have their voice heard and their views considered when decisions are being made. We used this information to plan what areas we were going to focus on during our inspection.

During the inspection we spoke with three people who used the service and six relatives about their views of the care provided. We also used informal observations to evaluate people's experiences and help us assess how their needs were being met and we observed how staff interacted with people. We spoke with the registered manager, the deputy manager, five members of care staff and one of the housekeeping staff. We also spoke with a visiting healthcare professional.

We looked at five people's care records and examined information relating to the management of the service such as health and safety records, recruitment and personnel records, quality monitoring audits and information about complaints.

Good

Is the service safe?

Our findings

People who lived at the service and their relatives felt the service was safe. A relative told us, "My [relative] is safe here."

Staff understood their role in relation to safeguarding and knew their responsibilities to keep people safe and protect them from harm. They knew how to raise any concerns about abuse or poor practice. For example, one member of staff was able to describe hypothetical examples of what constituted abuse and they knew who they should report to with their concerns. Where safeguarding concerns were identified, they had been dealt with appropriately by the service. Evidence of investigations undertaken and records of meetings with the local authority showed that people were supported and protected.

We discussed with the manager the situation surrounding a specific safeguarding alert that had been raised relating to concerns about an incident that had affected one person. We examined the records of the incident, the person's care records and the outcome of the subsequent investigation by the local authority. Throughout the investigation of the incident the manager had kept us informed of what was happening.

People's care records contained risk assessments that related to their needs. We saw that people had individual manual handling risk assessments that clearly identified for staff what type and size of hoist sling the person required. As part of an initiative to reduce risk to people's health, the local hospital were working with staff to increase their understanding of how to use nationally recognised tools to assess risk. These included the Waterlow assessment to identify people at risk of developing pressure ulcers and the Malnutrition Universal Screening Tool (MUST) assessment to identify people at risk of health issues relating to poor nutrition. Risk assessments were reviewed so that any changes to the individual's needs could be taken into account and the risk re-evaluated.

The provider had systems in place to recruit staff that helped keep people safe because relevant checks were carried out before a new member of staff was employed. Checks were carried out on the suitability of applicants which included taking up references and Disclosure and Barring Service (DBS) checks were carried out to confirm that the member of staff was not prohibited from working with people who required care and support. The management team understood the importance of employing the right people who knew how to provide good care and keep people safe.

Staff told us that staffing levels were assessed for each of the different units according to the needs of the people in that area of the service. For example we saw that there were three care staff and one senior member of staff on one unit and five care staff and one senior on another where people had more complex needs. The deputy manager explained that part of their role was to go round each unit and check staffing levels.

During the day of our inspection we saw that staff were receiving Mental Capacity Act and Records training. This resulted in staff being taken out of some of the units and other staff moving across to fill the gaps. Although this caused more changes of staff on the units than there would normally have been, we noted

there were still sufficient staff to meet people's needs. Some relatives told us that they felt there should be more staffing on Buckingham unit where people had more complex needs relating to dementia. We saw that staff on this unit were busy but we also observed that they took time to talk to people and were able to address issues such as anxiety or distress.

We saw that people were confident when talking to staff and they were confident they could raise concerns or make comments, for example one person told us they were satisfied with the day staff but had issues with the night staff. They said, "The day staff are fine and there are special ones, they are lovely" but they had issues with the night staff because they did not like the smell of their food being heated in the microwave. This was discussed this with the manager who said they would address the issue with the night staff.

The provider had systems in place for the safe receipt, storage and administration of medicines. The senior member of staff in charge of each unit had responsibility for ordering medicines and checking them in when they were delivered from the pharmacy. Medicines arrived already dispensed in individual 'pods' and there was clear information about what medicines were in these individual sealed pots. These were stored securely and we saw that staff administering medicines followed safe procedures. People's prescribed medicines were clearly recorded in their care plans and staff demonstrated an understanding of what they had been prescribed for. Regular audits were carried out by senior staff to check that procedures were being followed and records were completed appropriately.

Good

Is the service effective?

Our findings

Staff knew people well and were able to demonstrate a good understanding about people's individual needs. For example one member of the care team spoke with relatives about their family member's food intake as well as their mood and was able to update them on GP tests and appointments. A member of the care team told us about the people who received care and support on the unit where they were working. They spoke in a way that was person centred and demonstrated an understanding of and empathy for people with dementia.

Staff told us about the range of training that they had received to support them in their role. They said they had completed the mandatory courses such as manual handling, first aid, food hygiene, fire awareness and infection control. They also had training around the specific needs of people who lived at the service such as dementia awareness, mental health and end of life care. Staff were able to demonstrate a good understanding of how dementia affected individuals and how they provided person centred dementia care.

Staff received supervisions to support them to carry out their roles. Staff told us they had individual face-to-face supervisions and on the day of our inspection two people had a joint supervision specifically to discuss a project to support people to maintain good health. A member of staff told us that there were regular staff meetings and that they felt listened to and well supported by the management team. The manager explained that managers also received support through quarterly managers' meetings to share good practice across all the provider's locations.

Staff asked for people's consent before they provided care and support. For example, we observed during lunch that members of staff asked people's permission before putting protective aprons on. One person said, "No thank you" and staff respected this.

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. The management team had a good understanding of their responsibilities under the MCA and staff understood that people may have the capacity to make certain decisions such as what they would like to eat but not others such as the impact of not taking their medicines. People's care records confirmed that assessments of people's capacity to make day-to-day decisions had been carried out.

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 found they were.

People were referred to health professionals according to their individual needs. A relative explained about their family member's specific health needs and said, "They have a good maintenance plan in place for [the

specific issue]. My [family member] sees the GP who comes in once a week and last week when [my family member] had a pain they called the geriatrician down who was in the building and ten minutes later the problem was sorted." They told us that the district nurse came in every week and their family member's condition had greatly improved and infections drastically reduced.

A relative told us that they visited daily and that they were satisfied with the care their family member received. They told us, "The majority of the carers work hard, there are some newer ones that don't do as much but it is not impacting on the care [my family member] gets." They said that their family member's health care needs were taken care of and staff informed them if there were any problems. "I came in today and the senior is going to call the GP after his rounds as [my family member] has a chest infection." Another relative told us, "They keep us informed of [our family member's] health changes."

The manager explained about a pilot study they were taking part in that was looking at people's health and how to improve health and reduce hospital admissions. A monthly multidisciplinary team meeting was held that included a geriatrician commissioned by the NHS, a consultant from the local hospital, paramedics and commissioners of services. They looked at and analysed information relating to calls to emergency services, falls, pressure ulcers and urinary tract infections. The geriatrician was also carrying out reviews of end of life care. There was one member of staff who took the role of clinical lead and whose role included liaising with GPs and social workers when people were having reviews.

The service has now joined the Prosper project, which is a scheme developed by the local authority to improve safety and reduce harm from falls, pressure ulcers and catheter infections. The scheme builds upon the skills of staff working in care services to support them to think differently about how they can support people to maintain good health, for example by testing out ideas on how to encourage people to drink more. People's care records contained a falls diary and checklist to identify when people were most at risk so that they could put in measures to reduce the risk.

A relative was complimentary about the food. They told us, "I spoke with the chef and told them that [my family member] did not like pasta and they said they would make ham, egg and chips or sausage and mash – they are very helpful in the kitchen. There is a good variety at breakfast with cereals, porridge or a full cooked breakfast."

Menus were on the tables in the dining rooms as well as on the notice boards so people knew what was available for their meal. There was a range of choices of food for people including cereals and cooked breakfast and a choice of cooked lunch. Hot and cold drinks were available throughout the day.

We observed the dining experience in three separate dining rooms over the lunchtime period. During the lunchtime meal we saw that staff spoke with people about what was available and asked them what they wanted. Staff kept a check on what people were eating and recorded this in the person's daily record so that they could monitor whether people were having sufficient to eat.

In one dining room we saw that people were chatting and there was a sociable atmosphere. One person was confused and said, "Where am I. I don't know where I am." Staff supported the person by talking calmly with them and they settled down to have lunch. There were three or four staff supporting people during the meal and each person was asked what they wanted to eat and their food was dished up to their requirements. We saw the meal was well presented and people said the food tasted nice.

We observed at lunchtime that many people were having lasagne with salad and a choice of mashed or sautéed potatoes. People said it was tasty but the lasagne was quite difficult for people to cut and many

people ate the vegetables and meat sauce but pushed the lasagne to the side. In addition some people were seen to have some difficulties using traditional knives and forks but there was no adaptive cutlery available that would be easier for people to use. We also observed in another dining room that there were no adaptive cutlery or plate guards available to make it easier for people who were struggling to use an ordinary knife and fork. The dining experience for people who had difficulties using cutlery could have been improved if they had appropriate equipment. The manager told us they would make sure this was ordered so that it was available for people who needed it. One person gave a 'thumbs up' sign when asked about the food, but added "pasta not so good."

We saw good interactions from the majority of staff who spoke socially with people during lunch. The dessert was popular and most people chose a chocolate pudding. One person responded to staff, "It was very nice thank you." Another person said, "I cannot complain, the food is very good and the staff are fine."

We saw from one person's care plan that they were able to eat independently but we noted at lunch that this person received support from a member of staff who explained that the person would ask for support if they were having difficulties with painful hands.

We noted that the environment in one of the units had been adapted in some ways to meet the various needs of people who lived there. We saw signage to assist people who lived with dementia to understand their environment. For example there was signage on bathroom doors that used both words and pictures; signs were of a good size and placed at eye level on doors so that they were easier for people to see. However there were no directional signs in the corridors to direct people, for example towards the lounge area, which would assist people who were forgetful to find their way. Hand rails throughout the service had a small raised area at the end of each rail that people could feel which could assist people with visual impairment to alert them that they were approaching the end of the handrail. One person's bedroom door had been painted to look like a front door complete with door knocker, letterbox and number. This supported the person to recognise their room. Bathrooms and toilets contained dementia friendly sanitary ware in contrasting colours and some bathrooms had coloured tiles to help them look less clinical.

Communal areas such as lounges and dining rooms were light, bright and airy. Seating in one of the lounges had been clustered around the patio doors, the television and another part of the room, effectively creating three separate areas for people to sit. The television was on and was at an appropriate volume for the person who was watching but not so loud that it interrupted people's conversation in another part of the room. In another unit the main lounge was very busy and chairs were arranged around the edge of the room with no clustered seating like we saw in the other unit. However, we saw that improvements to the environment were in progress, for example on the day of our inspection one of the dining rooms was not in use as it was being redecorated. Improvements had already been made and, where we saw areas where further improvements were still to be carried out such as the carpet in one of the lounges, the manager was able to demonstrate there was an action plan in place for the outstanding work to be completed.

There was a long corridor that had bench seating for people to sit and have a rest or to have a chat away from the main lounge area. In one unit we saw a typewriter on a table in the corridor to give people something to look at and touch. A separate reminiscence type lounge area offered an alternative space for people to sit. It contained an old fashioned glass fronted cabinet with crockery and ornaments and an organ, as well as a comfy sofa and a cot in the corner containing dolls and teddies that people could lift and hold.

Good

Is the service caring?

Our findings

A relative told us, "My [family member] tells me they have been kind." One person told us that staff were kind and described how staff handled them appropriately and gently when they were supporting them to mobilise.

We saw that staff treated people with dignity and respect. In one dining room a member of staff asked people if they wanted to wear protective aprons at lunch time. The staff member said in a friendly manner, "Hello my lovelies, who would like to wear a tabard? Nice new ones. I've got to put my own one on." and people smiled. However, some bathrooms were used as storage space, for example, for toilet rolls and continence products which were stored in full view rather than in cupboards. Storing continence products more discreetly would be more dignified for people who need them.

Staff knew people well and understood how to support them if they became distressed. We saw an incident where one person was trying to go into another person's room, which was unsettling for the other person. A member of staff calmly intervened and used diversionary tactics to diffuse the situation. We also saw that when a person became distressed a member of staff spoke kindly to them and patiently worked out what the problem was. The member of staff demonstrated a good understanding of the person's reality, resolved the problem and settled the person back in their chair.

We saw staff support people to eat their lunch and this was carried out in a caring manner, although we noted that one member of staff stood when supporting someone to eat until another member of staff brought a seat. On two occasions we heard staff use language that was institutional rather than person centred. For example a member of staff spoke about 'toileting' someone and another member of staff spoke of 'feeding' someone rather than saying they were supporting the person. However, these were isolated incidents and we discussed them with the manager who proposed to speak to staff to remind them of how people may perceive this sort of language.

Throughout our inspection we saw members of staff who carried out their roles with a cheerful and considerate approach. One member of staff took a tea trolley round in one of the lounges and spoke with every person, giving them plenty of time to respond and including relatives and other staff in the jocular conversations. Another example was a member of the domestic team who was washing skirting boards in the corridor. They told us, "I also clean the brass around the name plates, it is people's home and it should be nice for them."

Staff were polite and we saw interactions between staff and people that demonstrated warmth and concern. When staff sat and chatted with people they demonstrated good communication skills, for example sitting on the same level as the person, making eye contact and using appropriate touch such as placing their hand gently on the person's arm to get their attention. Staff spoke with people in a friendly manner, using their names and sometimes calling them 'love' or 'darling' but people appeared happy with this as we saw from their smiles.

We observed many kind and caring interactions between staff and people, for example a member of staff asked one person, "Do you want to come with me for a cup of tea?" The member of staff used the person's name and then walked along the corridor with the person, allowing them to walk at their own pace and when they started flagging the member of staff asked, "Hold my hand?" and they did. As they walked along they chatted and the member of staff knew what the person liked to talk about. Another staff member asked a person, "Would you like to share my chocolate?" and there was some friendly banter between the two of them.

We saw signs of well-being such as people chatting with one another and with our inspection team. One person who did not have verbal communication skills laughed and smiled whilst using facial expressions and gestures to communicate with a member of our team.

We noted that people were supported to be well presented which could assist with raising self-esteem. For example, people's clothing was clean and well maintained, where people wore glasses they had been polished and those who had a hearing impairment were supported to wear their hearing aids.

One person liked to go outside to have a cigarette and a member of staff went with them to support them and to keep them company. We heard light hearted banter between them.

Good

Is the service responsive?

Our findings

A health professional told us they were visiting two of their patient's for the first time and they were pleasantly surprised at how well they had settled in in such a short space of time. They told us, "I was met by the deputy who gave me a run-down of how they were doing. They are encouraged to spend time together; they are having tea and biscuits. I am delighted."

The management team had carried out an extensive exercise to make each person's care plan more individual and person centred. As part of this process they had looked at the keyworker system and provided training for staff around how to complete care plans. Keyworkers carried out a daily evaluation of the care plans for each person they had keyworker responsibilities for. The manager explained part of their vision for the coming year was to put in a more structured process for keyworkers and a steering committee had been set up to carry out supervisions to discuss this with staff so that they were clear about their keyworker responsibilities.

People's individual care plans were reviewed and updated regularly. This included a 'resident of the day' system which focussed on one individual each day. Relatives were invited to come in to discuss their family member's care and support with the person's keyworker and the senior member of staff. The person was also treated to pampering sessions of their choice and their room was given a 'spring clean'. Staff told us the relative of the day process helped the person to feel special and gave them and their relatives the opportunity to discuss anything relating to the person's care and support in a relaxed manner.

People's care plans contained a one page 'map of life' which gave staff at-a-glance information about the individual. The person's key worker was clearly identified and staff were required to sign the care plans to confirm that they had read and understood the person's care needs. The care records were well organised and up-to-date. Each record contained information that would assist staff in providing person centred care. For example, the person's grab sheet and communication profile which gave staff concise, easy to read guidance included the information about how the person liked to say 'yes' and 'no'. We saw clear information in one care plan about the person's preferences and behaviours that affected their eating habits. The person had lost weight and measures had been put in place to fortify food and to continue to monitor the person's weight. The detailed care plan was written sensitively taking into account their preferences as well as their needs.

Staff were able to describe the ladybird scheme used by the service where a picture of a ladybird was placed on some people's doors to remind staff discreetly that the person had requested that their personal care was provided only by female staff. This demonstrated that the service respected the person's wishes to have their personal care provided in a way that was dignified for them.

Communication was seen to be good between members of staff and relatives, who were encouraged to be involved in the assessment process and decisions about their family member's care. A relative had told us that they had concerns about their family member's medicines. They said they were worried that they had let stocks run low and were unsure if their family member was getting their medicines on time. We saw a

senior member of staff discuss the issue with the relative. The staff member demonstrated a calm and reassuring approach and showed the relative the relevant records and talked through their concerns whilst demonstrating a good understanding of the person's needs.

Each day there were two activities co-ordinators on duty to support people with both organised activities and individual interests. We saw that there was a planned programme of activities which was displayed so that people were aware of what was available. During our inspection we saw staff supporting people with craftwork and making decorations. If people did not want to join in with these activities, staff found other things to interest people. One member of staff used a pack of old-time photographs to form the basis of conversations with people. The member of staff showed a person a photograph of an old mangle and said, "Did you used to have one of those? It must have been hard work." and the person smiled. Staff talked about the importance of engaging people in individual activities including things to do for people who stayed in their rooms, for example they asked a person if they wanted a manicure.

A relative told us that their family member enjoyed the socialising. They said, "There's a nice social side here and it keeps [my family member] stimulated." They told us there was a meal at the local pub the following week and families were also invited.

In the afternoon we saw a member of staff supporting people to play a game of skittles in one of the lounges. The staff used a warm, friendly approach and attempted to engage each person in turn, using their name and encouraging them individually to participate. The atmosphere was light-hearted and there was a lot of laughter. The member of staff included everyone who wished to join in. Three people chose to read newspapers but they were happy to watch the game. One person told us, "I get up when I want and have breakfast and then go to the lounge and read my paper."

Staff told us they had recently had someone visit the service with a small Shetland pony and people enjoyed the experience. This was reported in the local newspaper and was a huge success with people who lived at the service.

There was a process in place to deal with concerns and complaints and we saw that recent complaints had been recorded appropriately and the manager had used the process of dealing with complaints as a learning experience to improve practice. We looked at the records relating to two recent complaints. For example, we examined what actions had been taken following an outbreak of a notifiable illness. Relatives had raised concerns that the communication had not been good enough and they felt they had not been kept informed. The manager explained that the outbreak had not occurred in all the units of the service and they had informed relatives in units affected. They arranged a meeting to inform relatives of the facts and what they had learned from the incident was that people and families needed information communicated clearly and this had not happened because they had tried to reduce anxieties by only sharing information with relatives and people in areas affected by the outbreak, which had resulted in concerns for relatives of people in other units. We examined another example of a complaint from a relative which related to differences between an individual's wishes and relatives expectations. The manager requested input from health professionals to assess what was the best way to resolve the issue and recorded the outcome of the complaint.

Good

Is the service well-led?

Our findings

Relatives were positive about the management team and spoke well of the deputy manager who was visible throughout the day on all floors of the service.

Relatives told us that there had been some issues in the past and gave examples of issues they had experienced between four months and two years previously but they said things had improved. They praised the deputy manager who listened to what relatives had to say. "The deputy manager is always at the end of the phone and has turned things round."

People had opportunities to raise issues informally with senior staff and the management team. There were also opportunities to raise issues at quarterly meetings for people who lived at the service and their relatives. There had been some recent changes to how meetings were held and each unit had separate meetings. We saw the records of the four most recent meetings and noted that issues raised by relatives were explained. A member of the management team stated that relatives should not leave the service feeling that their family member was not being looked after and they were encouraged to raise any issues with the manager.

Staff told us they were well supported by senior staff and the management team and they knew what was expected of them.

The management team and senior staff carried out a range of checks including health and safety audits such as fire systems and equipment. Other audits included monitoring people's care records to check they had been reviewed and were completed appropriately,

Notifications about incidents were submitted to the Care Quality Commission (CQC) when required and contained sufficient information about how incidents were managed and measures that were in place to reduce the risks of further similar occurrences. The manager communicated with CQC about safeguarding referrals and kept us informed of any updates.

There were systems in place for managing records. People's care records were well maintained and contained appropriate information. The management team and senior staff reviewed, assessed and updated care records according to changes in people's needs. All documents relating to people's care, to staff and to the running of the service were kept securely when not in use. People could be confident that information held by the service about them was confidential.