Tilford Care Home Limited

Tilford Care & Nursing Home

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 01 December 2017 and was unannounced. This was the provider's first inspection since they registered with CQC in December 2016.

Tilford Care & Nursing Home is a nursing home providing care to people older people, people with physical disabilities and complex medical conditions. Some of the people who lived at the service were also living with dementia. The home is registered to provide support to up to 42 people and there were 38 people using at the service on the day of our visit.

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

People received appropriate support to meet their clinical needs. Staff worked alongside healthcare professionals to meet people's needs. Risks relating to people's medical conditions were routinely assessed and appropriate plans were implemented to keep people safe. People received their medicines safely from trained staff. Nursing staff had access to appropriate training and clinical supervision to keep them up to date with current practice. The provider had systems in place to reduce the risk of cross contamination and responded robustly when we identified an infection control concern.

People were supported by staff that understood their roles in safeguarding them from abuse. Staff had been trained to carry out their roles and had regular meetings with their line managers. Where any incidents had occurred, staff responded to these appropriately. The provider monitored accidents, incidents and complaints. People and their relatives were aware of how to raise a complaint and the provider responded to any concerns appropriately. There were sufficient numbers of staff to keep people safe and the provider carried out the appropriate checks on all new staff to ensure that they were suitable for their roles.

People received person centred care from kind and compassionate staff. Care plans contained important information about people's needs as well as their routines and what was important to them. A thorough assessment was carried out before people came to live at the service. People told us that the staff that provided care to them were kind and caring. Care was provided in a way that involved people and helped them to maintain their independence. Staff were respectful of people's privacy and dignity when providing care. The provider prepared appropriate plans where people received care at the end of their lives and staff were trained in this area.

The provider regularly sought feedback from people and relatives about the quality of the care that they received. People gave feedback about food and activities that was responded to by the provider. People's dietary needs were met and people were prepared food in line with their preferences. People gave us positive feedback about the food that they received. There were regular activities taking place at the home

and these reflected people's interests.

There was clear leadership at the service and the provider had systems in place to enable effective communication between staff. People, relatives and staff had regular meetings where they could have their say about how the service was run. The provider carried out regular audits in areas such as documentation, dignity and infection control. Where improvements were identified, these were added to the provider's ongoing plan to improve the service and were actioned by staff. The provider kept accurate and up to date records to ensure people received the right care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people were assessed and appropriate plans were implemented to keep people safe.

Staff responded appropriately to accidents or incidents and the provider monitored these to identify any trends.

Staff understood their roles in safeguarding people from abuse and responded appropriately to any concerns.

People received their medicines safely from trained and competent staff.

Staff observed safe infection control practices and regular checks and audits were carried out in this area.

Is the service effective?

Good

The service was effective.

People's dietary needs were met and the provider knew people's food preferences and met these.

Staff had appropriate training and supervision to carry out their roles. Clinical staff had the right support and training to keep them up to date with current practice.

Staff worked with healthcare professionals to meet people's needs. People's needs were thoroughly assessed before living at the home.

Staff provided care in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were supported by kind and compassionate staff that knew them well.

Staff involved people in their care and provided support in a way that promoted people's independence.

Staff were respectful of people's privacy and dignity when providing care.

Is the service responsive?

Good

The service was responsive.

People received person-centred care and their needs were regularly reviewed to identify any changes.

Staff recorded people's wishes about end of life care. Staff knew how to provide appropriate and sensitive care at these times.

People had access to a wide range of activities that matched their needs and interests.

The provider had a clear complaints policy in place and complaints were responded to appropriately.

Is the service well-led?

Good

The service was well-led.

There were clear leadership structures and systems in place to ensure effective communication between staff.

Regular meetings took place to involve people, relatives and staff in the running of the home.

Regular surveys were conducted to assess the quality of the care that people received. The provider carried out a variety of audits to identify any improvements.

The provider maintained accurate and up to date records and regularly audited these.

Tilford Care & 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.

This inspection took place on 01 December 2017 and was unannounced.

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

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

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with seven people and three relatives. We also observed the care that people received and how staff interacted with people. We spoke with two operational managers, two nurses, one senior carer, five care staff and the chef. We read care plans for five people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at four staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records of menus, activities and minutes of meetings of staff and residents.

Good

Is the service safe?

Our findings

People told us that the care they received was safe. One person said, "Yes, I am very safe here. It's a good home." Another person said, "Yes, I am safe. I prefer staying in my room and they let me do that. A relative told us, "I have not observed any issues that should concern me since [person] has been here." Another relative told us, "I feel that [person] is very safe and well looked after here."

Risks to people were assessed and plans were implemented to keep people safe. Care plans contained detailed risk assessments that identified risks that people may face. Risks assessed included pressure sores, malnutrition and falls. Where a risk was identified, staff found appropriate ways to reduce the likelihood and impact of any harm. For example, one person was at risk of pressure sores. Their risk assessment identified that, 'I am at risk of pressure sores due to poor mobility'. To manage this risk, staff applied prescribed creams to the person daily and checked their skin for signs of breakdown. The person had a pressure mattress in place and was repositioned regularly. Where people had specialist equipment in place to manage risk, such as hoists or air mattresses, regular checks were carried out to ensure these were working correctly.

When accidents or incidents occurred, staff took appropriate actions to make sure they didn't happen again. The provider kept a record of all accidents and incidents which included the actions taken in response. Records showed that the actions staff took were appropriate to reduce the risk of an incident happening again. For example, one person had suffered a fall and staff were not present. Staff assisted the person and checked them for injuries. The person's risk assessment was reviewed and increased checks were put in place to monitor the person's safety. The person was reminded to use their call bell and staff made sure it was within their reach. Following this, the person had not suffered another fall.

The provider was able to identify patterns and trends in accidents and incidents so that lessons could be learnt and effective plans put in place. Management analysed the central record of accidents and incidents and held discussions with people, relatives, staff and healthcare professionals where appropriate. For example, changes in one person's behaviour led to six incidents in one month. The provider reviewed the person's risk assessment and involved healthcare professionals to address the changes in behaviour. Healthcare professionals provided advice and reviewed the person's medicines which led to a decrease in incidents involving this person.

People were supported by staff that understood their roles in safeguarding them from abuse. There was a safeguarding policy in place and staff had been trained in how to recognise abuse and what to do if they had concerns. Staff demonstrated a good understanding of safeguarding procedures when we spoke with them. One staff member told us, "I would go to my manager and we have an operational manager if I want to go higher. We can call safeguarding (team) or police or CQC." Records showed that staff fed back to management where appropriate, such as in response to incidents. There was one open safeguarding at the time of inspection and we saw evidence of the provider working with the local authority safeguarding team and healthcare professionals.

People received their medicines safely. Medicines were administered by trained nurses who had their competency assessed before administering medicines to people. Nurses were observed following best practice; they checked that they were administering medicines to the correct people, checking the medicine administration record (MAR) to ensure the name and photograph matched the identity of the person receiving medicines. The nurses were unhurried and allowed people the time they needed to take their medicines. People were offered choices with regards to drinks to take their medicines with. Staff filled in MARs after administering medicines and records showed these were completed accurately with no gaps. Where people had not received their medicines, staff recorded the reason for this.

Medicines were stored securely and the provider had systems to ensure medicines were ordered regularly so that they were available when people needed them. The provider ensured that the storage environment matched the manufacturer's storage guidance and regular checks were carried out on the temperature of storage areas. The provider carried out regular audits of medicines where they checked areas such as records, storage and staff training in medicines.

People were supported in a way that reduced the risk of the spread of infection. People and relatives told us that staff washed their hands and we observed them doing so on the day of inspection. Hand washing areas contained guidance for staff on hand washing techniques and all staff had been trained in infection control. Staff demonstrated a good understanding of how to reduce the spread of infection. One staff member told us that they washed their hands before and after supporting people and used gloves when handling soiled laundry.

The provider recruited housekeeping staff to maintain cleanliness at the home and daily checks were carried out on cleaning. Checks covered communal areas and people's rooms and in most cases were effective. However, we identified three rooms where checks on mattresses had not identified that the covers had deteriorated. This heightened the risk of infection as the covers could not be effectively cleaned. We raised this with the provider and they replaced all the mattresses immediately. They identified that changes were required to their checks and implemented these following our inspection. The provider also showed us evidence of plans that were already in place to upgrade all mattresses to a new provider. The new mattresses were less susceptible to breakdown and therefore meant the risk of this happening again was significantly reduced. We will follow up on these actions at our next inspection.

People were supported by sufficient numbers of staff to keep them safe. People and relatives told us that there were enough staff working to keep them safe and respond to their needs when needed. Staff told us that they were able to respond to people when they needed to and they did not need to rush. One staff member told us, "Yes, there is enough (staff) and we get around to everyone." The provider had a tool to calculate the numbers of staff needed to support people based on their needs. The calculated number of staff matched the rotas and we observed this was sufficient to meet people's needs. We observed staff responding to call bells promptly and being able to support people in line with their care plan. For example, one person required regular prompting to drink fluids to maintain their hydration. Staff were observed doing this throughout the day and completed charts which showed this had been carried out on a daily basis.

The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, work history, proof of right to work in the UK and a Disclosure & Barring Service (DBS) check. This is used to identify potential staff who would not be appropriate to work within social care. Staff files contained evidence of up to date professional registration for nurses with the Nursing and Midwifery Council (NMC) where required. Staff told us that they waited for checks to be completed before they started work and records confirmed this.

People lived in a safe home environment. The provider carried out regular health and safety checks of the home to ensure it was safe and free from hazards. Utilities such as electricity and gas were regularly checked and the provider had certificates to assure their safety. There was clear guidance in place for in the event of a fire and all staff had received fire training. A fire risk assessment was in place as well as a plan to ensure continuity of care for people in the event of the building becoming unusable due to an extreme incident such as fire or flood.

Good

Is the service effective?

Our findings

People told us that they were happy with the food that they were served. One person said, "I have enough to eat and drink though I do not eat much." Another person said, "The food is good. A relative said, "All the residents here are given enough to eat and drink."

People's food preferences and dietary needs were documented by kitchen staff and people were regularly asked their feedback on meals. Kitchen staff knew what foods people liked or disliked and people were served food in line with this. For example, they told us that one person did not like gravy and therefore preferred an alternative choice when meals containing gravy were made. Another person liked to have a slice of toast at a certain time of day, which they were aware of. There was a selection of alternative options available each day that included vegetarian choices and people were given the opportunity to make a choice each day and when meals were served.

People's care records listed their dietary needs and how they would be met. Where people had specific dietary needs, such as diabetes or swallowing difficulties, meals were planned in line with these. For example, one person had been seen by a speech and language therapist (SALT) because staff identified they had difficulties swallowing. The SALT recommended that the person be given a pureed diet. The person's care records were updated and the person received food in line with this guidance. Kitchen staff also kept records that clearly denoted where people required pureed food, fortified meals or low sugar diets due to diabetes.

People were supported by staff that were trained to carry out their roles. Staff told us that they completed an induction course when they came to work at the home. A staff member said, "New staff work through a lot of induction." Induction involved completing training courses and shadowing an experienced member of staff to get to know people and develop an understanding of their role. The provider ensured training courses were regularly refreshed. The provider kept a record of staff training to ensure they kept track of when refresher dates were due. Records showed that staff were up to day in mandatory areas such as infection control, food hygiene, health and safety and safeguarding. Staff were observed using knowledge from their training. For example, staff had received training in moving and handling. During the inspection, we observed staff supporting one person to move in bed. This was done in line with best practice, using equipment and safe methods to reduce the risk of injury to the person. The provider also provided training specific to the needs of the people that staff supported. For example, staff supported people living with dementia and staff had received training in this area. Training was also given for specific conditions such as diabetes and Parkinson's as staff supported people living with these conditions.

Staff were supported to develop and improve their skills and competencies. One staff member said, "We have in-house training. A senior gives us training and they test our knowledge." The provider had their own in-house assessor for additional qualifications, such as Qualifications and Credit Framework (QCF) courses in adult social care. The majority of staff had completed additional qualifications or planned to through the provider's new scheme. Staff had regular supervision meetings. These one to ones were used to discuss best practice and identify any training needs. One staff member said, "Supervision is pretty regular. I do find it

open and honest." The provider also completed an annual appraisal with staff. Staff used this to measure their performance and set goals for the coming year.

Nursing staff had access to training and support to keep themselves up to date with current practice. Nurses told us that the provider supported them with revalidating their registration with the Nursing and Midwifery Council (NMC). We saw evidence of the provider giving nurses access to training in various clinical procedures such as wound care and catheters. Nursing staff displayed a good understanding in these areas when we spoke with them and people told us that they felt nurses were competent in meeting their healthcare needs.

Staff worked with healthcare professionals to ensure people's needs were met. Care records contained information from healthcare professionals. For example, one person was living with diabetes saw a diabetic nurse. Staff provided information on the person's blood sugar to inform clinical decision making and information on how to manage the person's diabetes, such as the types of foods they could eat, were in the person's care records. The GP visited regularly and people were seen quickly when staff had concerns for people's health. Where one person's behaviour had changed, staff arranged for the GP to see them and they visited the same day.

People's needs were assessed before they came to live at the home and assessments captured people's preferences and choices. We saw evidence of assessments in people's records and information from these were added to care plans. Assessments were carried out in line with best practice and identified clinical needs or risks in areas such as nutrition, pressure care, continence and mobility. Assessments also captured people's preferences with regards to food, activities and interests.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff were knowledgeable about the MCA and followed the correct legal process. People's care records contained mental capacity assessments that related to specific decisions. Where people lacked capacity, a best interest decision had been documented that involved relatives and healthcare professionals. When restrictions were to be put in place to keep people safe, the provider made applications to the local authority DoLS team. Staff had received training in the MCA and were knowledgeable on the process and the principals of the MCA when we spoke with them.

Good

Is the service caring?

Our findings

People told us that the staff that supported them were caring. One person said, "They (staff) are kind to me and they help me." A relative told us, "I think that the staff are caring and they do their best to care for all the people here."

During the inspection we observed interactions between people and staff that showed that staff were committed and caring. Staff interacted with people kindly and respectfully. We observed two staff supporting one person in bed. The person needed to be repositioned and told staff they were thirsty. The person had some difficulty verbalising and staff gave the person time to express themselves and they got in close to the person to enable them to communicate effectively. Staff gave the person a drink and gave them time before supporting them to reposition. Throughout the day staff engaged with people using a calm tone and a smile. Staff came down to people's eye line when speaking with them, explained things to people and offered them choices. Staff were committed to providing compassionate care to people. One staff member said, "I think it's excellent. We are really caring; it's like an extended family. We're going to a funeral soon for a resident who we all loved".

People were involved in their care. Staff were observed offering choices to people throughout the day. People were offered choices when being given drinks and at mealtime staff offered them a choice of meals. Staff were observed visiting people in their rooms to ask if they wished to attend a musical activity in the morning. People were regularly asked for their feedback on food and activities and this was documented so that it could be used to inform future choices. Where people had difficulty expressing themselves, staff used appropriate methods to communicate with them to enable them to make choices. For example, one person found it difficult to communicate verbally due to their medical condition. Their care plan stated that they used facial expressions to communicate with staff. Staff were observed asking the person if they would like a drink and the person smiled and nodded their head to indicate that they did, as outlined in their care plan.

Staff knew the people that they were supporting. During our inspection staff were able to give us information about people's needs. One person liked to eat at a certain time of day and had a plan in place to gain weight. A staff member was able to tell us this about the person as well as their medical condition and risks relating to their nutrition. People's care records contained very detailed life histories and staff were knowledgeable about these. One person's records said they used to work in the film industry and detailed their family background. Staff knew about this person's previous employment when we spoke with them.

Staff supported people to maintain independence. One person told us, "I do some things by myself and they (staff) help me." We observed staff encouraging people to do things for themselves patiently. One person had difficulty mobilising and we observed two staff calmly talking to them as they walked down a corridor with their frame. At lunch time, staff provided supervision and encouragement to people. People that were able to, ate independently with prompting from staff where required. People had access to equipment, such as adapted cutlery, that enabled them to dine with minimal staff support. People's care records recorded their strengths and what they were able to do and staff provided care that was considerate of this. For example, one person who was living with dementia was able to wash and dress themselves. The

person had been used to living alone before coming to live at the home. The person had a room that was in a quieter part of the home and their care plan recorded that staff were to prompt and encourage them with personal care. Staff told us that they supported the person in this way, providing supervision to ensure that they were safe. Staff understood the importance of promoting people's independence. One staff member said, "We encourage people to do what they can and talk to them or show them how to do things."

People were supported in a way that was respectful of their privacy. We observed staff providing care considerately with respect for people's dignity. Staff knocked on people's doors and asked permission before entering. Where one person was unable to provide permission, a staff member was heard letting the person know that they were opening their door and providing the person with time to receive them in their room. Staff had received training in this area and demonstrated a good knowledge in how to promote people's privacy. One staff member told us, "When I go to a room I make sure I knock and tell them what I am there to do. I close doors and curtains and ask permission each time."

Good

Is the service responsive?

Our findings

People told us that they received care that was responsive to their needs. One person said, "They take care of everything about me and I am happy." A relative told us, "Yes we are consulted on the care that they provide for [person]."

People's care plans were detailed and covered all aspects of their care needs as well as their routines and preferences. For example, one person liked to get up in the late morning and their assessment captured this. Records showed this person got up at the time they had requested and staff provided encouragement with personal care and documented this. Care plans were appropriate for people's needs. Guidance for staff on how to communicate with people and meet their needs in a person centred way was detailed in care plans. One person was living with dementia and needed regular reassurance and reminders about the day, season and weather. The person had photographs that were used as prompts and references for the person to show them what weather was expected for the day. The person then chose their clothing in line with this. Staff had a good understanding of person centred care and how to deliver it. One staff member said, "It's giving people the care they would want for themselves."

Plans were in place for people to receive appropriate end of life care. Care plans were in place for end of life that reflected people's wishes and preferences at this time. Records showed that discussions took place with people and relatives for any plans or advanced wishes. Staff had received training in end of life care and there was a staff member who took the lead on end of life care. Where people had specific medicines or clinical needs at this stage of their lives, records showed that nurses had received clinical training and supervision in this area.

People's needs were regularly reviewed and where changes in need were identified, these were actioned by staff. Care records contained evidence of a monthly review and responsive reviews took place where people's needs changed. A recent review of one person's care took place after a visit from the dietician in which they were recommended a fortified diet to gain weight. The care plan had been updated and records showed the new diet was implemented the same day.

People had access to a range of activities. A relative told us, "The activities co-ordinator is excellent. He is really good with the residents. He always tries to engage them with lots of things and they seem to respond well to him." There was a timetable in place with activities that covered a range of interests. The activities co-ordinator developed activities based on people's interests and any feedback or requests. Activities involving music, films, quizzes, arts and crafts and storytelling took place regularly. People at the home liked animals and benefitted from visiting organisations that brought animals to the home. An aviary had been built in the garden with cockatiels and budgies that people could watch. We observed a musical activity from a visiting church taking place and it was well attended. People were engaged and nodded along to the music playing and appeared happy and involved.

A number of people were cared for in their rooms and benefitted from one to one activities. People told us that staff spent time with them in their rooms and daily notes recorded that staff had spent time with

people. People had access to televisions and DVDs in their rooms. We observed staff spending time with people in their rooms on a one to one basis during our inspection.

People knew how to raise a complaint and the provider responded appropriately to any concerns raised. A relative said, "I have not complained of anything but if that arose, I would speak to the management and I think they will listen to what I have to say." There was a complaints policy in place and it was in display within the home. People and relatives told us that they were aware of how to complain and felt their issues would be taken seriously by management. The provider kept a record of any complaints and record showed that they were investigated and responded to appropriately by management.

Good

Is the service well-led?

Our findings

People told us that the service was well-led. One person said, "The carers and their superiors are very good. They are polite and kind and they work well together." A relative said, "I feel that this home is well managed. To run such a big place is hard but I think that they are managing well." Another relative told us, "I think that this home is well managed and the residents are well looked after."

There was clear leadership at the service and people spoke highly of the registered manager. The registered manager was on leave at the time of our visit but there was appropriate cover and systems in place that meant people's care was not affected by this. The provider had regional managers supporting the service with clear line management for staff. There were good communication systems for staff in the form of a daily handover, regular meetings of clinical and care staff as well as newsletters. During the inspection we observed staff working well together. A senior care worker oversaw care staff and we noted that tasks were completed by staff when required throughout the day. People told us that they received care promptly when they needed it and records supported this. Staff told us that they felt supported by management and that there was an open door at the manager's office. One staff member said, "Management listen to us and they are very quick to respond if we ask for anything."

Regular meetings took place to involve people, relatives and staff in the running of the service. A full staff meeting took place twice a year and records were kept of these. Records of the most recent staff meeting showed that it had been used to discuss a wide variety of topics including training, safeguarding and communication. Staff had discussed becoming 'champions' in areas such as dignity, dementia and end of life care. These roles showed that the management team were willing to delegate to staff by giving them responsibilities. The lead roles also provided staff with opportunities to develop their knowledge and support their colleagues in their lead area.

Meetings took place for people and relatives and were used to gather feedback and provide a forum for them to make suggestions. The most recent meeting had been used to discuss activities and people had requested a trip to a local bird sanctuary and this had been arranged by staff. Relatives told us that they were kept informed about their loved ones care and that staff provided them with information that they found reassuring. The provider routinely informed relatives following any significant incidents as well as the local authority or CQC where they were required to do so.

People and relatives were regularly asked for their feedback in order to measure the quality of the care that they received. An annual survey was completed by people and relatives. The survey results were compiled and a plan was put in place to respond to any areas in which people were not satisfied. The most recent survey was mostly positive but where minor issues had been raised, the provider had responded to them. For example, a small number of people had responded to say they were not aware of all the activities in the home. In response to this, an additional board was put up in the home displaying activities and staff informed people of activities that were happening each day. We observed staff doing this on the day of inspection.

Regular audits were carried out to assure the quality of the care that people received. The provider had numerous audits in place that covered all aspects of people's care. Audits of areas such as infection control, dignity and documentation took place regularly. Records showed that where improvements were identified, these had been actioned. A recent dignity audit had found that a floor was sticky in one area of the service, this had been addressed by the time of our inspection. The provider carried out a number of clinical audits that provided analysis of clinical needs. These covered areas such as pressure care, infections and nutrition. Records showed there had been very few infections or pressure sores at the home. A recent nutrition audit picked up slight changes to a person's weight that had not been previously identified and the person was referred to their GP in response to this change.

The provider kept accurate and up to date records. All records seen on the day of inspection had been recently reviewed and staff kept detailed daily notes. Where people required charts to monitor areas such as food or fluid intake and repositioning, these were kept accurately by staff. The provider carried out regular audits of care plans as well as staff files and health and safety checks.

The provider had a vision for the service and an ongoing plan to drive improvement. Outcomes of audits and surveys were recorded in a central plan that the provider oversaw and signed off when actions were completed. The plan showed there had been recent changes to how files were kept and new content sheets and dividers had been put in place, to make care records easier to navigate. We noted these were in place when we reviewed people's records. The provider submitted a PIR which detailed what the service did well and any improvements and our findings on the day matched the contents of the PIR.