Minster Care Management Limited

Broadgate Care 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

Overall summary

We carried out an unannounced inspection of the service on 11October 2015.

Broadgate Care Home provides accommodation and personal care and nursing care for up to 40 older people including people living with dementia and physical needs. Accommodation is provided over two floors. 30 people were living at the service at the time of the inspection.

Broadgate Care Home is required to have 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. At the time of the inspection a registered manager was in post.

At our last inspection on 5 and 6 November 2014 we found the provider was in breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service. The provider did not have an effective system in place to regularly assess and monitor the quality of the service provided. Following this inspection we received an action plan in

Summary of findings

which the provider told us about the actions they would take to meet the relevant legal requirement. During this inspection we found that the provider had met this breach in regulation.

The provider now had checks in place that monitored the quality and safety of the service. This included enabling people and their relatives and representatives and staff to give feedback about their experience of the service.

People received a safe service because risks were assessed and managed appropriately. Staff were aware of the safeguarding procedures in place to protect people and had received appropriate training. There were safe management and administration of medicine processes. Safe recruitment practices meant as far as possible only people suitable to work for the service were employed.

Accidents and incidents were recorded and appropriate action was taken to reduce further risks. Risks plans were in place for people's needs that were regularly monitored and reviewed. Additionally, the environment and equipment had safety checks in place.

There were sufficient staff available to meet people's needs. People's dependency needs were reviewed on a regular basis and staffing levels amended to meet people's changing needs.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This is legislation that protects people who are unable to make specific decisions about their care and treatment. It ensures best interest decisions are made correctly and a person's liberty and freedom is not unlawfully restricted. People's rights were protected because staff were aware of their responsibilities and had adhered to this legislation.

People were supported to receive sufficient amounts to eat and drink. People received a choice of food and drink and menus provided people with a nutritional diet. People received appropriate support to eat and drink and independence was promoted.

Relatives and people that used the service said that staff were knowledgeable about their needs. People's healthcare needs had been assessed and were regularly monitored. People were supported to access healthcare services to maintain their health.

Staff were appropriately supported. This consisted of formal and informal meetings to discuss and review their learning and development needs. Staff additionally received an induction and ongoing training.

People and relatives we spoke with were positive about the care and approach of staff. They were caring, compassionate and knowledgeable about people's needs. People's preferences, routines and what was important to them had been assessed and were known by staff.

The provider supported people and their relatives or representatives to be actively involved in the development and review of the care and support they received. This included regular discussions with people and formal meetings.

People told us they knew how to make a complaint and information was available for people with this information. Confidentiality was maintained and there were no restrictions on visitors.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

Good

There were systems in place that ensured staff knew what action to take if they had concerns of a safeguarding nature.

Risks to people and the environment had been assessed and planned for. These were monitored and reviewed regularly. People received their medicines safely.

The provider operated safe recruitment practices to ensure suitable staff were employed to work at the service. There were sufficient staff available to meet people's needs safely.

Is the service effective?
The service was effective

Good

The Mental capacity Act 2005 and Deprivation of Liberty Safeguards were understood by staff. People's human rights were protected because mental capacity assessments and best interest decisions had been appropriately completed.

People were supported to access external healthcare professionals when needed. The provider ensured people maintained a healthy and nutritious diet.

Staff received an induction and ongoing supervision and training to enable them to effectively meet people's individual needs.

Is the service caring?
The service was caring

Good

People were supported by staff that were caring and compassionate. Staff were given the information they needed to understand and support the people who used the service.

The provider had ensured people that used the service and their representatives had helpful and important information available to them such as independent advocacy and support services.

There were no restrictions on friends and relatives visiting people. Staff asked people about their preferences and respected people's choices.

People were supported to remain independent.

Is the service responsive?
The service was responsive

Good

People's care was individual to their needs and staff supported people to engage in social activities.

People were supported to contribute to their assessment and involved in reviews about the care and treatment they received.

People knew how to make a complaint and had information readily available to them. A complaints procedure was in place and complaints were responded to appropriately.

Summary of findings

Is the service well-led?

Good

The service was well-led

The provider had systems and processes that monitored the quality and safety of the service.

People, relatives and staff were encouraged to contribute to decisions to improve and develop the service.

Staff understood the values and aims of the service. The provider was aware of their regulatory responsibilities.

Broadgate Care 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 11 October 2015 and was unannounced.

Before the inspection, 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. We reviewed information the provider had sent us including statutory notifications. These are made for serious incidents which the provider must inform us about. We also contacted the local authority, the local clinical commissioning group, the GP, Healthwatch, a tissue viability nurse, a physiotherapist and a dementia community nurse for their feedback.

The inspection team consisted of one inspector, a specialist advisor who was a registered 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.

During the inspection we spoke with three people that used the service and six relatives for their feedback. We also spoke with the registered manager, a regional manager, the clinical lead, two nurses, the cook and four care staff. We looked at all or parts of the care records of six people along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. We 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.

Good

Is the service safe?

Our findings

People told us they felt safe and confident that if they had concerns about their safety they could raise these with the registered manager. One relative told us, "We are very pleased with the home and have no concerns about our relative's safety or the care that's provided." Another relative said, "I'm happy and pleased with the running of the home it's safe. I have never seen the staff abuse or shout at anyone but respond with gentleness when a resident can be challenging."

The provider had procedures in place to inform staff of how to protect people from abuse and avoidable harm. Staff demonstrated they understood their role and responsibility in protecting people from abuse. They were able to identify the signs and symptoms of abuse and the action to be taken if they had a concern. They said they had received training on how to protect people and that there was a safeguarding policy and procedure available. One staff told us, "We protect people to remain safe. I have no concerns about people's safety." Another staff told us how some people required additional support to maintain their safety. They said, "We are very rigorous about the support provided."

Many people were living with dementia and required support from staff to keep them safe. We observed staff were attentive and responsive to people's needs. Staff clearly knew people's individual needs and how to support them. This demonstrated people could be assured that staff were aware of their individual needs and how to maintain their safety.

Records confirmed staff had received appropriate training and the safeguarding policy and procedure was available and clear for staff to follow. Safeguarding referrals had been made when appropriate. This showed us staff had access to information about how to raise concerns and procedures were followed.

Risks to people and the environment were assessed and management plans were put in place where risks were identified. These informed staff of how to reduce and manage risks. People told us that they were confident risks were managed well. A reoccurring comment relatives made was the importance of a safe environment. They said that the security was good and that this was important for the safety of their family members.

Staff told us how they had information available to them which provided guidance of the action required to manage and reduce known risks. They also gave good examples of how they ensured day to day risks were reduced. This included checking equipment was safe and fit for purpose.

From the sample of care records we looked at, we found risk assessments and plans had been completed to manage risks such as the development of pressure ulcers, nutritional needs, falls and moving and handling. When people were unable to use the call bell a risk assessment had also been completed and people were checked regularly.

The provider had a system in place that recorded and monitored all accidents and incidents. Where accidents and incidents occurred action was taken to reduce further risks. The registered manager gave an example of the action taken to reduce the risk of people falling. This included the use of assisted technology to alert staff of when a person had moved. We also saw referrals to healthcare professionals had been made such as to the falls prevention service. A healthcare professional told us that the service worked well in the action taken with regard to falls and this was managed well.

Personal emergency evacuation plans were in place in people's care records. This information was used to inform staff of people's support needs in the event of an emergency evacuation of the building. Some of these gave a good level of detail whilst others were brief and did not properly reflect the person's support needs. The registered manager told us they were in the process of reviewing these documents.

We saw equipment was in place to meet people's needs. Hoists were available to move people who could not mobilise with assistance and people had their own individual hoist slings. We observed staff supported people safely and appropriately with their mobility needs. However, pressure relieving mattresses were not always set correctly according to the person's weigh, which reduced their effectiveness. We discussed this with the registered manager who agreed to take action to make improvements.

There was sufficient staff deployed appropriately to meet people's individual needs and keep them safe. We received positive comments from people about the staffing levels provided. One relative said, "All the time I have visited there

Good

Is the service safe?

are plenty of staff around to help and support the residents." Another relative said, "There are plenty of staff to support my relative and they frequently come and make sure things are okay."

Staff told us they felt adequate staff were rostered on duty to meet people's individual needs. They said that staff sickness could cause some difficulties but on the whole staff sickness had improved recently. The registered manager and regional manager told us that agency staff, and bank staff employed by the provider was used to cover staff shortages. Additionally they said that they were recruiting more staff to the bank to better provide consistency and continuity when staff shortages occurred.

People's dependency needs were assessed and regularly reviewed. The registered manager said that this was used to determine staffing levels. This told us that the provider ensured staff were deployed appropriately dependant on the needs of people who used the service. Safe recruitment procedures were followed. Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people.

People received their medicines safely and as prescribed by their GP. One relative told us, "There was an agreed change in medication which I think has contributed to the improvement of my relative's health and well-being." Another relative said, "My relative has medication daily and it's given in a safe way by the nurses."

We found the management of medicines, including storage, monitoring, ordering and disposal followed good practice guidance. We reviewed 10 people's medicines administration records (MARs) and found there was a photograph of the person to aid identification, a record of any allergies and information about how the person liked to take their medicines. We found PRN protocols were in place for most of the medicines. These are medicines that are given when needed, for example for pain, illness or anxiety. This meant that staff had clear guidance to follow to ensure these medicines were being given safely. We identified some concerns with the frequency of PRN used for a person. We discussed this with the clinical lead who agreed for this person's needs to be reviewed.

A medicines policy was in place and staff training and competency assessments for medicines administration and management had been completed annually. Weekly medicines audits had been completed and the clinical lead told us they also carried out spot checks of medicines administration in addition to this.

Good

Is the service effective?

Our findings

People were supported by staff that had received appropriate training and support to do their jobs and meet people's needs. People told us that they found staff were knowledgeable and competent in meeting their needs. One relative told us, "I feel the staff are well trained to do their jobs." Another relative said, "The family feel that the staff are good at their job and know the residents quite well; we understand that there is regular training for all staff members."

Care and nursing staff told us they had received an induction and said that the quality of the training and support was good. One care staff told us, "The training is good and if you identify a particular training need the manager will organise it." Additionally, nursing staff told us they had access to ongoing professional development and gave examples of recent health related training they had received which they described as, "high quality." The registered manager told us and records confirmed, training and support meetings to review staff's training and development needs was planned throughout the year. Training was accessed by various sources including in house, and external such as the local authority and the local clinical commissioning group. This told us that the provider was supportive to staff and that staff were kept up to date with best practice guidance.

The provider had an induction programme for new staff that included the Skills for Care Certificate. This is a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life. This meant that staff received a detailed induction programme that promoted good practice and was supportive.

Staff were knowledgeable about people's care and treatment needs. For example they told us of the action they would take when a person had an epileptic seizure. Additionally, we found staff had a good understanding of the needs of people living with dementia and how best to support these needs.

People's needs had been assessed and a range of support plans had been developed to inform staff of the care and support the person required. We looked at the care people were receiving and this generally corresponded with their support plans. We noted there were support plans for the management of people's health conditions and these contained a good level of detail.

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.

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.

Staff showed a good understanding of the principles of this legislation and gave examples of how people's human rights were protected. One staff said, "We protect people's rights by looking at least restrictive practice and ensure decisions are made in the person's best interest and involve people known to the person."

Staff had received training on MCA and DoLS and they had access to a policy and procedure that provided them with the information they needed to know. From the sample of care files we looked at we saw what action the provider had taken that protected people's human rights. For example, if a person had lasting power of attorney this was known. This gives another person legal authorisation to act on their behalf about decisions relating to their care and welfare and or their finances. Where people lacked mental capacity to make specific decisions about their care and support, appropriate assessments and best interest decisions had been made and recorded. This showed how the decision was made, who was involved and that least restrictive practice had been considered.

People told us that staff involved them in discussions and decisions about how they wanted to receive their care. This included being asked their consent before care and support was provided. One relative said, "I'm involved in all care planning reviews and feel the staff take on board what

Good

Is the service effective?

I was saying. If there are any concerns about my relative staff will call me at home and we discuss the situation." Another relative said, "When my relative says something the staff listen and support my relative."

People were supported to eat and drink and maintain a balanced diet based on their needs and preferences. People spoke positively about the food choices available. One relative told us, "The food looks appetising and well presented on the plates and there are several options to choose from." Another relative said, "The meals are good with several choices at each meal time. There are drinks and snacks available during the day which is good."

Two out of six staff spoken with raised some concerns about the quality and quantity of food available. The clinical lead said they were aware of some of these concerns and had recently had a meeting with the kitchen staff to discuss this and make improvements. Other staff spoke positively about the choices and availability of food.

We checked the menus and found there was a five week menu rotation and a choice of two main meals at lunchtime and a hot choice or sandwiches were provided at tea time. At breakfast people had a range of hot and cold choices. We were told three people regularly had a full cooked breakfast and saw these people received this. The meals served at lunchtime corresponded with the menu for that day. The cook had a good knowledge of people's dietary needs and requirements such as a soft diet or pureed food and those who required a diabetic diet. Information about people's needs were recorded and kept in the kitchen. The cook also fortified food for some people at nutritional risk by adding butter, cream and cheese where possible. We saw some people with swallowing difficulties required their fluids to be thickened to reduce the risk of choking. Thickener was available to ensure this was provided.

We observed people were offered drinks and snacks during the day. Some people required assistance from staff with their meals. Staff were seen to be attentive and supported people appropriately. Independence was promoted by providing people with specialist eating and drinking utensils.

People were supported to maintain good health and have access to healthcare services. Relatives agreed that people were well supported with their healthcare needs. One relative said, "If there was any concerns about our relative's health they [staff] would send for the doctor then call us."

Healthcare professionals gave positive feedback about how staff met people's healthcare needs. This included timely and appropriate referrals for advice and they were confident any recommendations made were implemented. From care records looked at we found people's health needs had been assessed and people received support to maintain their health and well-being.

Good

Is the service caring?

Our findings

Staff had developed positive caring relationships with people who used the service. People spoke positively about the care and approach of staff. One relative said, "The staff are very kind and considerate." Another relative said, "The staff appear to have knowledge of the residents and they interact well with them." All people we spoke with talked positively about the atmosphere of the home comments included, "There's a warm and gentle atmosphere in the home which I do like, it's calming for everyone."

Feedback from healthcare professionals also stated that staff were kind and caring and managed people's needs well.

We spoke with a member of staff that had come in on their day off to support a person to attend a health appointment. They told us that they did this because they cared, they said, "I love caring for people, I like to give my best." The registered manager told us, "Some staff go the extra mile."

Staff showed an understanding of people's needs, including their preferences and personal histories. A relative told us, "I tell them [staff] of my relative's history so they can support my relative with past knowledge." Some people were living with dementia and had periods where they became confused or agitated. Staff responded quickly to calm and reassure people if they showed signs of distress.

Staff had a calm and reassuring presence and we saw many examples of how staff sat with people, held their hand and provided comfort. One person told us, "The staff are nice and caring. Sometimes when they aren't busy they will sit down and talk to me to make sure that I'm okay and did I need anything."

We observed staff used people's preferred names and checked with people regularly and spoke with them in a kind and considerate manner. A relative told us, "They [staff] always call my relative by their proper name." We found that the staff were organised and had a positive approach which created a relaxed and calm atmosphere.

People were involved as fully in decisions about their care and treatment as possible. A relative told us, "Staff often talk to me about my relative's care and they do listen to what I say to them." Another relative said, "I know my relative's needs are met by the carers who are really good at what they do."

We observed staff supported people at their own pace. Staff were not rushed and spent time engaged with people in conversation, giving explanation and choice before care and support was provided. For example, we saw people were offered choices of where they wished to sit to eat their meals and staff respected people's decisions. A choice of drinks were offered and the cook was observed to ask people a short time before lunch what they would like to eat. Visual pictures of food choices were used to support people to make informed choices. We noted this was good practice for people with short term memory needs.

The registered manager told us how people who used the service and their relative were invited to attend review meetings to discuss the care and treatment they received. We saw care records contained letters which had been sent out to relatives to invite them to a care plan review meeting at six monthly intervals. From the sample of care records we reviewed we saw examples where people and their relatives had been involved in these meetings. Information about independent advocacy support was available. This meant should people have required additional support or advice and representation the provider had made this information available to them.

People told us that staff respected their dignity and privacy and their independence was promoted. A relative told us, "All the staff treat our relative with care, dignity and love." Another relative said, "The staff are kind and considerate treating my relative with dignity and respect. If the staff need to carry out a personal task they ask me to leave the room to protect my relative's privacy."

Staff told us how they considered people's privacy and dignity when providing care and support. This included respecting and being sensitive when providing personal care. Knocking on people's door before entering. One staff said, "I treat people as I would want to be cared for and what I would expect for my family." We spoke with a member of staff that was a dignity champion. They told us that this meant they ensured people's dignity was respected at all times. They did this be setting good standards for themselves and staff to follow.

Good

Is the service caring?

We observed people being moved using a hoist, we saw how staff explained what they were doing and ensured people were covered appropriately during the move to protect their dignity. People were supported to maintain their independence. Some people had walking frames that supported them to be independently mobile.

From the sample of care records we looked at we found examples of 'end of life care directions'. These provided information to staff on people's wishes at the end of their life and to clarify action to be taken in the event of a sudden deterioration in their condition

The importance of confidentiality was understood and respected by staff. Confidential information was stored safety.

Good

Is the service responsive?

Our findings

People received care and treatment that was personalised and responsive to their individual needs. One person told us, "Staff help me with my personal care and they make sure I don't fall over." Relatives told us how they had been involved in the assessment, the development and ongoing reviews of support plans for their family member. This told us that people's needs had been assessed and were regularly reviewed to ensure staff had up to date information about people.

Staff gave examples that showed they were aware of and supported people with their chosen routines and preferences. One staff said, "We use the care plans and life history books to help us get to know what's important to people in how they wished to be cared for." Another staff told us, "You have to get to know the person and gain their trust and understand what's important to them and listen to what they say."

Relatives gave positive comments about how their family members were supported with their preferences and needs. A relative said, "Our relative goes to bed and gets up at their choice. They are always in nice clean clothes and the personal hygiene is good too." Another relative told us how their family member's health had improved due the service being responsive to their needs. Additionally, another relative said that whilst there family member was cared for in bed a referral to the physiotherapist had been made to, "Help my relative get mobile again."

People's individual needs and preferences in relation to their religious and spiritual needs had been considered and met. For example, the local churches provided spiritual care for people that requested this support. On the day of our inspection a visiting religious group visited and people were supported to participate in prayers and hymns. We noted that people who were cared for on the first floor were not given the opportunity to join in.

From the sample of care records we looked at, people's needs had been assessed before they moved into the service and support plans developed that included people's routines and preferences. Most care records contained a booklet entitled "My life story" which had been completed to provide details about their previous life and interests. Support plans contained information about people's individual wishes and preferences. This told us that staff had information available to them to enable them to support people with their individual needs as they wished.

Relatives told us that activities were provided for people to participate in. One relative said. "There are some activities that occupy my relative." Another relative commented on the daily activities that were provided. They said, "The activity coordinator spends some time with my relative so that's nice."

On the day of our inspection we noted that the music that was played in the downstairs lounge was of earlier years that people were able to reminisce about. People appeared relaxed and to enjoy listening to this music. Also in the downstairs lounge a range of activities were provided that focused on reminiscence provided by an external agency. People were encouraged to engage with this even if they only participated for a short period of time. However, upstairs we noted that whilst staff stayed with people in the lounge and checked their well-being and provided drinks, there was little meaningful activity. The service had an activity coordinator who told us of the activities they provided, this included external entertainers visiting the service. They said, "I provide some group activities but will sit and talk with people even if it's for a short time."

People received opportunities to share their experience about the service and raise any issues or concerns. People that we spoke with were all complimentary about the service they received. One person told us, "If I had got any worries I would talk to the carers who would help me." A relative said, "If I had concerns I would speak to the manager who is quite approachable." Relatives told us that they had attended 'resident meetings' and had received questionnaires from the provider requesting feedback about the service. One relative told us, "I have in the past attended resident and relatives meetings which I found useful and got feedback."

Staff told us that if someone raised a complaint or concern with them they would try and address it, document it and report it to the registered manager. We saw there was information available for people and visitors about how to complain. The registered manager told us that they had not received any complaints since our last inspection.

Good

Is the service well-led?

Our findings

At our last inspection we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were some shortfalls in how the provider assessed, monitored and reviewed the quality and safety of the service. We found at this inspection the required improvements had been made.

The service had quality assurance systems in place that monitored quality and safety. People who used the service, relatives or representatives and staff were involved in the development of the service. Surveys were used as a method to gain people's experience and views about the service. We saw a satisfaction survey action plan dated March 2015 following feedback from relatives and friends of people who used the service. Where action had been identified we saw examples that the provider had responded to this. For example, comments received stated that not all people knew who the named nurse or keyworker was for a person. These are named staff that have additional responsibility in meeting people's needs. We saw that on people's doors this information was displayed. This meant people knew who they could talk to in addition the registered manager. Additionally, some people had raised concerns about support plans not being discussed with people. We saw that review meetings had been implemented to ensure people were involved in discussions.

We also saw a satisfaction survey action plan dated August 2015 following feedback from staff. This enabled the provider to review how staff felt about their work and identify any actions that were required to make improvements. This feedback identified the need to further develop support and team work team for staff. As a result of this team leader roles had been developed. We spoke with a team leader who told us they had recently been appointed and how the staff team had benefited from this new role.

The regional manager also told us that the provider sent out monthly newsletters to inform people about activities and events and this information was available on the website.

Staff told us that there were staff meetings arranged on a regular basis and that they felt the management team valued their contribution. One staff said, "Yes, I feel valued and listed to." The registered manager told us that they had an 'open door' policy and welcomed staff and relatives or representatives to approach them at any time to discuss any issues or concerns. Relatives and staff we spoke with confirmed that the registered manager and the clinical lead were approachable, supportive and responsive.

The provider had systems in place to monitor the quality and safety of the service. This was effective as the risks to people were being assessed, monitored and responded to by both the staff team and management team. These included reviews and audits of people's support plans and risk assessments, staff training, supervision and appraisal and regular competency checks of staff performance. In addition the management team carried out regular audits. These included health and safety audits, incident and accident audits and medication audits. Wherever issues or problems were identified it was clear what action had been taken to resolve issues. This meant that people living at the service could be confident that the quality of service provided was being monitored and responded to.

The service prompted a positive culture that was person centred, inclusive and open. People told us that they knew who the registered manager was and that they were visible and that they found them friendly and approachable. Additionally, people said that communication was good. A relative told us, "When I'm not here the staff call me to tell me what the issue is and we try and resolve it together."

Staff had a clear understanding of the vision and values of the service. One staff said, "We provide personalised care by putting the person at the centre of their care. We involve people in their care and treat people with kindness and dignity." Staff told us they enjoyed working at the service as staff worked well together. One staff said, "The team work is really good." They went on to say they knew everybody did their job properly and they could rely on each other.

People we spoke with including staff described the service as having good management and leadership. One relative told us, "If I had any concerns or needed to complain I would discuss them with the manager who I know would take what I was saying serious and respond in a positive way. I have a nice relationship with him. "Another relative told us how the service had moved their relation with just a few hours' notice from another service that closed quickly.

Good

Is the service well-led?

They described the service as "The home is 'fit for purpose' is clean and tidy and there is a warm feeling about the place." A healthcare professional told us how well the service had responded to managing a sudden move for people from another service.

One staff said, "I feel listened to and supported. I am empowered to do what I feel is necessary." Staff said that if they raised an issue with the registered manager, they were listened to and action was taken. They were confident that they could talk with the regional manager if necessary who visited the service regularly. One staff said, "The regional manager is really good, he takes time to speak to us and the residents and listens to what people have to say." Another staff said, "It is 100% better since the new manager and regional manager had started at the home." They said a lot of changes had been made which had improved the care and service provided. Additionally, staff said that the new clinical lead had also made a good impact and was driving forward improvements.

There was a whistle blowing policy in place and staff said they would feel able to use it if necessary. We were told daily handovers were used to provide feedback to staff on areas for improvement from audits and complaints.

There was a registered manager at Broadgate Care Home. Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that since our last inspection the provider had notified CQC of changes, events or incidents as required.