Prime Life Limited

Braunstone Firlands Nursing Home

Inspection report

Gooding Avenue
Leicester
LE3 1JS
Tel: 0116 255 8809
Website:

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 27 October 2015 and was unannounced.

Braunstone Firlands is registered to provide nursing and residential care and support for 24 older people with dementia and mental health needs. At the time of our inspection there were 18 people using the service.

At the last inspection of the 22 and 23 July 2014 we asked the provider to take action. We asked them to make improvements in the storage of people's medicines and improvements in the training of staff. We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to be compliant by August 2014. We found that the provider had taken the appropriate action.

Braunstone Firlands had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Staff were able to explain how they kept people safe from abuse, and knew what external assistance there was to follow up and report suspected abuse. Staff were knowledgeable about their responsibilities and were trained to look after people and protect them from harm and abuse. Staff were aware of whistleblowing. That ensured people were safe from abuse in the home.

Staff were recruited in accordance with the provider's recruitment procedures that ensured staff were qualified and suitable to work at the home. We observed there to be sufficient staff available to meet people's basic personal care needs and worked in a co-ordinated manner.

Medicines were ordered, stored and administered safely and staff were trained to provide the medicines people required.

Staff received an appropriate induction and ongoing training for their job role. Staff had access to people's care records and were knowledgeable about people's needs that were important to them, which meant the care offered by staff met people's assessed needs.

Staff communicated people's dietary needs appropriately, which protected them from the risk of losing weight. People's care and support needs had been assessed and people were involved in the development of their plan of care. People were provided with a choice of meals that met their dietary needs. The catering staff were provided with up to date information about people's dietary needs.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Relatives we spoke with were also complimentary about the staff and the care offered to their relatives.

We observed staff speak to, and assist people in a kind, caring and compassionate way. We saw that people's dignity and privacy was respected which promoted their wellbeing.

Staff had a good understanding of people's care needs, though some documents within the care plan document contained repeated terms and incorrect names.

Where appropriate people were involved in the review of their care plan, and when appropriate were happy for their relatives to be involved. We observed staff offered people everyday choices and respected their decisions.

People were able to maintain contact with family and friends as visitors were welcome without undue restrictions.

There were insufficient staff numbers to provide a continual level of care and attention, however we saw little of planned and meaningful activities provided for people to engage their time.

Staff told us they had access to information about people's care and support needs and what was important to people. Care staff were supported and trained to ensure their knowledge, skills and practice in the delivery of care was kept up to date. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew it would be acted on.

The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals.

Staff sought appropriate medical advice and support from health care professionals. Care plans included the changes to peoples care and treatment, and people attended routine health checks.

We received positive feedback from the Local Authority staff and visiting professional with regard to the care offered to people and professionalism of nursing staff.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. Nursing and care staff understood their roles and responsibilities and knew how to access support. Staff had access to people's care plans and received regular updates about people's care needs.

Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs.

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 not consistently safe.

People felt safe at the service.

Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported.

People were not supported by sufficient numbers of staff to ensure their safety at all times.

Medicines were stored and administered safely.

Requires improvement

Is the service effective?
The service was effective.

Staff were trained and supported to enable them to care for people safely and to an appropriate standard.

Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005.

People received appropriate food choices that provided a well-balanced diet and met their nutritional needs.

Good

Is the service caring?
The service was caring.

Staff were caring and kind and treated people as unique individuals.

People were encouraged to make choices and were involved in decisions about their care.

Staff gave people reassurance when they needed it.

Good

Is the service responsive?
The service was not consistently responsive.

People received personalised care that met their needs.

Staff did not provide meaningful activities for the people using the service.

People told us they would have no hesitation in raising concerns if they had any.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

Requires improvement

Summary of findings

The home had an open and friendly culture and people told us the registered manager was approachable and helpful.

People using the service and relatives had opportunities to share their views on the service.

People were not supported by sufficient numbers of staff to ensure their safety at all times.

The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this.

Braunstone Firlands 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 27 October 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist nurse adviser. A specialist nurse adviser is a qualified nurse who has experience of working with this service user group. This nurse specialist was a qualified mental health worker, and worked in a number of areas with older people.

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. The provider had returned the PIR.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information received sent to us from people who used the service or the relatives of people who used the service and health and social care professionals.

We contacted commissioners for health and social care, responsible for funding some of the people that lived at the home and asked them for their views about the service.

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.

During the inspection visit we spoke with the three people who used the service, one relative, the area manager, the registered manager, the nurse on duty and three care workers. We also spoke with the visiting Alzheimer's Society Representative and a visiting Community Psychiatric Nurse.

We looked in detail at the care and support provided for six people including their care records. We also looked at three staff recruitment records, and repair and maintenance records for the building.

Requires improvement

Is the service safe?

Our findings

At our inspection of 22 and 23 July 2014 we found that there were unsafe arrangements in place for the storage and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that improvements had been made. We found that there were adequate supplies of meal supplements in stock, and medicines were stored in a room and that the temperature of the room was regularly monitored. These records showed that the temperature was within the appropriate limits for the purpose of storing medicines safely.

The registered manager sent us a copy of the medication policy and procedure and local arrangements for medication temperature monitoring following our visit. This was well detailed but required to be updated to reflect the correct range of cold storage temperatures. We contacted the registered manager about this issue and they will have the policy amended and the entries clarified.

We saw that the nurse on duty wore a red tabard whilst giving out medicines. This was an issue at the last inspection where the nurse was continually interrupted. The nurse told us that this was introduced following that inspection, and now ensures people do not disturb nurses when they are administering medicines.

We looked at the records for 14 people who received medicines. These had people's photographs in place, and were completed appropriately, with signatures and countersignatures, where these were required. Information about identified allergies, and people's preference on how their medicine was offered was also included. Some people were prescribed 'PRN' (as required) medicines sometimes called protocols, and these guide staff to the circumstances and regularity when these medicines should be given. These protocols were in place, and provided accurate information for staff. Medication audits were in place and completed regularly which meant the provider could be confident that people had received their medicines as prescribed.

At our inspection of 22 and 23 July 2014 we found that the registered person had not ensured that adequate arrangements were in place to protect people from unsafe or unsuitable premises.

The provider sent us an action plan outlining how they would make improvements.

We found improvements had been made as doors to toilet areas had been repaired. We found there had been an extensive decoration programme undertaken, which had made the home warmer and homelier in appearance. That meant the provider had taken our comments on board and improved the safety of the building for people living there.

There were systems in place for the maintenance of the building and its equipment. We looked at the maintenance book and records that confirmed this and where shorfalls were identified and repairs and improvements were recorded.

We spoke with people and asked them if they felt safe at the home. One person told us, "I spend a lot of time in my room, I am am happy and safe here." They told us that if they thought someone was not being treated well that they would speak with the registered manager or one of the staff. This had the potential for people's safety concerns not to be listened to. We spoke with the registered manager who told us they would discuss the contacting of external agencies at the next resident meeting, which would be in addition to the posters placed around the home. Many of the others we spent time with were unable to pass comment on their safety. We did spend time observing people in the communal areas of the home. Staff attended promptly to people's needs, which included responding to people whose behaviour challenged due to their support needs.

However there were times when we saw one and sometimes two people displayed behaviour that challenged in the lounge area. This required the attention of both staff, and meant they were unavailable to attend to other people's needs at that time, or engage in meaningful activities.

We saw comments had also been recorded in the minutes of resident and relative meetings such as, "They need more staff – they run round like hurricanes", and, "Staff are always rushing round."

Requires improvement

Is the service safe?

We did not see any group or individual activities being undertaken, staff were fully engaged in delivering care and support to people.

One member of staff said, “In theory two staff up here is enough but it’s not when some-one has challenging behaviour.”

We saw one staff member attempted to go on a work break but was unable to go due to a person who was at risk of falls repeatedly trying to get out of his chair.

There were appropriate actions to risks, for example in one person’s care plan it stated that they could be physically and verbally aggressive towards staff when assisting with personal care. The care plan advised staff to speak in a calm and reassuring manner and to offer a cup of tea, also ABC charts to be completed. ABC charts are used by medical professionals to monitor peoples behaviour, where alternative therapies and techniques can be planned to alleviate challenging behaviour. We saw that staff did those things when the person became agitated. In another person’s care plan it said staff should walk away for a short while if the person became agitated. We saw that staff did this as well, though remained close by in order to ensure the person remained safe.

A visiting health professional told us, “The care plans are good and I feel my patient is secure and safe here.”

Staff were trained in safeguarding (protecting people who use care services from abuse) and knew what to do if they were concerned about the welfare of any of the people who used the service. All the staff we spoke with understood their responsibilities with regard to safeguarding. They knew the different types of abuse and how to identify them. They also knew who to report any concerns about abuse to, and who to approach outside the service if that was required, which would support and protect people. Staff was aware of the term whistle blowing, and who to report concerns to.

One staff member said, “I have had training in safeguarding, and I know about whistle blowing, and what to do.” Another member of staff had also had safeguarding training and knew about whistle blowing.

People’s safety was supported by the provider’s recruitment practices. We looked at recruitment records for staff. We found that the relevant checks had been completed before staff worked unsupervised at the service.

People’s care records included risk assessments. These were regularly reviewed and covered areas of activities related to people’s health, safety, care and welfare. The advice and guidance in risk assessments were being followed. People we spoke with were aware of potential risks to themselves due to their mental health and lifestyle choices and told us they spoke with staff and health care professionals and were fully involved in decisions about their care showing people’s choices and decisions were supported.

Good

Is the service effective?

Our findings

At our inspection of 22 and 23 July 2014 we found that there was a lack of a specialised pureed diet. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements.

We spoke to people about the food, one person said, "The food is always nice", another person said, "Tea and breakfast are nice but lunch could be better, it's not hot enough, we usually get a choice of two options at lunch."

We spoke to the registered manager about the lunch time meal provision. The meal comes ready prepared from a central kitchen, and this home is last on the current round. The main meal started to be served after 1.00pm. The registered manager said she would speak with the central kitchen and see if the distribution could be changed and Braunstone Firlands meals delivered earlier.

Menu preference questionnaires were in care plans and included people's likes and dislikes. That ensured the staff were aware of people's food preferences. Food recording charts were in place for most people's even when they don't have a weight loss or any special dietary requirements. People were asked if they would like to eat in the dining room, lounge or their bedrooms. Support was given and additional staff came to offer support so that every-one ate at the same time. At breakfast people were asked if they would like more but at lunch this did not appear to be an option. We spoke with the registered manager about this who agreed to take this up with the staff group.

The home has two dining rooms. During our inspection we saw lunch being served in both of these. People had a choice of juice or water to drink while they were waiting for their food to arrive. The registered manager served the meals from a hot trolley, they said this was a good use of their time as she was able to see all the people in the home. We observed two carers, each supporting a person to eat. They were attentive, focused on the individual, assisted at a pace that appeared to suit the person and they spoke in a warm and reassuring manner throughout.

We spoke with the catering staff who told us about the range of diets catered for which included pureed, fortified, and diabetic. The staff said new items were added to the menu if people said they wanted them.

We looked at records for four people who needed particular support with their nutrition and hydration. All care files included nutrition assessments and associated eating and drinking care plans. Monthly weights were recorded as part of the Malnutrition Universal Screening Tool (MUST), and results were routinely recorded. We saw there were routine assessments of choking risks and referrals to Speech and Language Therapists (SALT) and Dieticians in response to assessed difficulties. There was evidence in care plans of the use of dietary supplements, fortified meals and the consistency of food altered to ensure people were provided with an appropriate diet.

Records showed that people had access to a range of health care professionals including GPs, a specialist dementia team, SALT staff, district nurses, chiropodists, opticians, and dentists. If staff were concerned about people's health they referred them to the appropriate health care services and accompanied them to appointments. That meant that people were supported to maintain a healthy lifestyle.

People's health care needs were identified and care plans were detailed and assisted staff in meeting peoples' health care needs. We saw the appropriate input and information from health care professionals where necessary. There was evidence of routine care plan and health care plan reviews were thoroughly and routinely completed where required.

One staff said, "training is very good, it's all hands on. When we did moving and handling we had a go in the hoist so that we can understand why people get agitated when they are being transferred". Another member of staff said, "the training is very good, we get very involved, we get good training in challenging behaviour."

We spoke with the registered manager about the training, and she told us they were in the process of reviewing and improving staff training. They had introduced a new three-day staff induction to help ensure staff had the basic skills they needed when they first began working in the home. This replaced the previous 'e-learning'

Good

Is the service effective?

(computer-based learning) induction. The registered manager said this was an improvement as it included competence checks which helped to ensure staff could put what they'd learnt into practice.

We spoke with staff who confirmed that they had undertaken induction training appropriate for their job role and on-going training followed. We confirmed the training staff had undertaken with the matrix which showed staff had also completed training in first aid, health and safety and moving and handling people safely. Where people's training was not up to date, this was clearly recorded on the training matrix. The registered manager had a plan for staff attend updated training by February 2016.

Staff felt communication and support amongst the staff team was good. The daily handover meetings provided staff with information about people's health and wellbeing. Staff felt supported through the regular staff meetings, supervisions and appraisals. Staff found meetings were informative and were used to review their practices.

Throughout our inspection we saw staff offered people choices and sought consent before they offered assistance. We saw staff used moving and handling equipment and transported people appropriately by wheelchair. We saw that staff chatted with people, and so kept them informed as to what they could expect

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The files we viewed showed evidence of MCA assessments. There was evidence of applications for Urgent and Standard Authorisations in respect of DoLS procedures. The DoLS applications showed evidence of considering peoples' particular needs. For example there were applications to respond to needs such as, the use of bedrails, providing personal care and leaving the care home.

Staff were knowledgeable about how they supported people to make daily choices and decisions on a regular basis. They told us that sometimes people have fluctuating capacity due to their mood or anxieties, in which case they would give the person some time before repeating the question. This showed staff understood the need to gain people's consent and agreement which involved them making informed day to day decisions.

We spoke with a visiting professional adviser representative, who told us that they reviewed people's documentation and care plans in respect of DoLS applications. They told us that the care home staff were responsive to suggestions for improvements that she had made i.e. she reported recommending changes on previous visits and these had been appropriately responded to and amended when she checked them upon revisiting.

Good

Is the service caring?

Our findings

At our inspection of 22 and 23 July 2014 we found that the registered person had not ensured that adequate arrangements were in place to protect people's dignity and respect. We found toilet doors did not close effectively and there was a lack of dignity around personal care.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements.

We observed the staff treated people with dignity and respect throughout our visit. The staff we spoke with were able to describe how they preserved people's privacy and dignity, and we saw people were supported appropriately with personal care. We heard one member of staff call one of the people who lived at the home as by the term they preffered. They later confirmed this was the term they preffered to be addressed by. We also saw where people were provided with personal care and doors were closed whilst this was undertaken, and we observed staff knock and await a response before entering peoples' rooms.

People that we spoke with said, "The carers are fantastic but they don't have a lot of time as they have too much paperwork", another person said, "The staff are really nice." One member of staff said, "I love it here, it's so rewarding". The staff we spoke with knew peoples' individual needs.

We observed a carer sit with a person who was getting agitated. The staff member was talking about the person's family in a gentle voice and holding their hand, this calmed them down. We saw where another two people who lived at the home who began a heated discussion. We saw staff intervened, attempting to distract them by talking to them and speaking to both in a calm manner. One member of staff assisted one person downstairs in order to diffuse the situation. We looked at the peoples' care plans and saw these deflection techniques were a part of the plan to diffuse situations that otherwise could have promoted behaviour that challenged.

We spoke with a visiting professional who told us, "The staff appear to be very caring. I have never seen anything that has caused me concern about the home"

We observed staff interactions with people and noted these to be caring and warm. The bedrooms we were given permission to view, were homely and contained personal memorabilia, which provided a familiar environment for people

We saw where people who lived at the service were able to make their own choices. For example one person asked mid-morning if they could take a shower. The care staff took them aside and discussed, whether they would prefer a bath or shower and also enquired what support they would like from the staff. This was done with person's privacy and dignity in mind, away from the main lounge seating area. We saw the person was assisted and enabled to undertake their choice of personal care.

We also saw where staff ascertained people's dietary likes and dislikes. That was evident through the mid-morning drinks trolley and the main meal at lunch time.

Requires improvement

Is the service responsive?

Our findings

We spoke with a visiting relative who told us, "My mother has been here [date mentioned] I am very happy with my mother's care." "They have been very supportive in helping me through the [specialised funding process]. They added, "They keep me informed and I have no complaints about the place."

We looked at a number of care plans which had been recently reviewed and updated. There was evidence of comprehensive, individualised, assessment and care planning within the files. We saw care planning was thorough and individualised. There was evidence of identifying people's past history, likes, dislikes, wishes and aspirations and these were incorporated into the care planning and the guidance given in care delivery.

We saw where independence was encouraged and was stated in the care plan. For example in one person's care plan it stated that they required support with personal care. The plan indicated they were able to wash their upper body themselves, so instructed staff should only assist with lower half in order to maintain independence.

There was evidence of information being collated about peoples' medical and medicine histories with use of a "Hospital Traffic Light" assessment form. That identified key facts about the peoples' individual health histories, which were used when people required medical information, for example an outpatient appointment or in patient admission to hospital. That ensured people had the correct health and medicine information when required.

Care plans showed evidence of being reviewed and use of risk assessments and clear guidance to staff in respect of mitigating the risk. For example, guidance on food intake in response to choking risk, prescribed numbers of staff and use of specific equipment to mitigate moving and handling risk. There was evidence where people's additional health needs had been responded to by staff as they arose. For example referrals to: Gp's, Dietician or nutritionist, the Tissue Viability Nurse, Speech and Language Therapist and Community Psychiatric Nurse.

We reviewed the records of 7 people that required specialist dressings and treatment, for pressure ulcers and skin tears. The nursing response was appropriate in that, skin risk assessments were implemented and regularly reviewed. Pressure relieving equipment was put into use, turning regimes to relieve pressure were implemented and we noted that appropriate positional changes were recorded and body mapping was completed. Wounds were photographed and dated and a wound care plans were developed. We also saw the appropriate involvement and support from a Tissue Viability Nurse was provided. That meant that the nursing staff provided a quality service to people with wound care and nursing needs.

However though care plans were individual to the people's needs, we noted some actions were duplicated. For example in the 'communication' part of care planning, the same terms were in two people's actions even though their needs were different. In the second person's care plan the person's name was incorrect. That meant the actions had been copied from care plan to care plan.

Daily reports were very task orientated and included: physical health, skin care, toileting, mobility/falls, personal hygiene, how many staff were required and how long did care tasks last. There was no area for how the person was that day. We discussed this with the registered and area managers, who agreed to look at the document in question.

There was an activities folder in the lounge. During the month of October the activities recorded were, listening to music, singing and reading the paper. There were a number of occasions when staff had not recorded if staff were offered or had declined the range of activities on offer. On one occasion a person had been a walk outside, and on another staff had spent time with a person and massaged their hands and feet, and another where the person had nail care on one occasion. The registered manager informed us the local authority had assisted in establishing the preferences and abilities of some people in the home with regard to activities. Following the inspection we contacted the local authority who confirmed this. During our visit we completed a number of observations, but did not observe staff undertaking any activities, as they did not have time (see safe for details). There was a shortage of care staff to enable meaningful social activities to be planned and executed.

We spoke with one visiting professional who told us, "The staff are responsive and listen to recommendations. I made some suggestions to the support plans when I visited previously and these were implemented when I subsequently reviewed the plans"

Requires improvement

Is the service responsive?

Another visiting health professional told us, “When I first visited, I raised a Safeguarding alert due to a visiting relative raising a concern with me. The home was very open about my concerns and I was impressed by their response, and very impressed with the nurse, [named person].” They went on to explain, “They have been managing my patient very sensitively.”

The provider had systems in place to record complaints. Records showed the service had received ten written complaints in the last 12 months. Outcomes had been provided for each, and changes made to the service.

We saw there were regular meetings for the people and their relatives. These had been minuted and were available for people to refer to, however the comments made by people had not been acted on. For example there were a number of comments with regard to poor staffing numbers which had not been addressed or commented on by the registered manager or their supervising manager.

Requires improvement

Is the service well-led?

Our findings

People we spoke with during the inspection were complimentary about the service and staff. They included relatives of people in the home and visiting professionals.

The care planning documentation showed evidence of being person-centred and considered peoples individual rights in respect of their liberty with Deprivation of Liberty Safeguards (DoLS) paperwork being submitted and updated. There was evidence of identifying people's likes, dislikes, wishes and aspirations to enable care delivery to respond to personal needs and wishes.

The service had a registered manager who understood their responsibilities in terms of ensuring that we were notified of events a provider had a legal responsibility to notify us about. The registered manager had a clear understanding of what they wanted to achieve for the service and they were supported by the staff group, the regional director and other head office staff.

We were made aware of a recent Safeguarding issue which involved the care delivered by a trained nurse. The service had responded appropriately to this by, acknowledging the safeguarding issue, taking the appropriate steps to deal with the concerns and identifying an alternative nurse leader.

All staff all had detailed job descriptions in place and had regular supervision meetings which were used to support staff to maintain and improve their performance. There were separate supervision arrangements for the nursing staff as the registered manager was not qualified to undertake these as they were not a qualified nurse. Staff had access to paper copies of the provider's policies and procedures.

The provider's procedures for monitoring and assessing the quality of the service operated at two levels. These procedures were based on 11 'key indicators of performance'. The registered manager carried out a range of scheduled checks and monitoring activity to provide assurance that people received the care and support they needed. The provider had appointed an area manager to oversee the development of the home. They visited and observed the staff group and produced reports on their visits. These regional manager's reports were also reviewed by the provider's operational board. This meant the most senior managers in the provider organisation knew how the service was performing.

The manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. The manager worked alongside staff on the floor to develop her understanding of their roles and see where change was needed.

When we observed the people who lived at the home and their staff support, there were times that both staff on the first floor were engaged with people leaving others unsupervised. We found comments made by relatives at meetings arranged by the registered manager mirrored what we saw on the day.

Staff were aware of their accountability and responsibilities to care and protect people and knew how to access managerial support if required.

Staff had access to people's plans of care and received updates about people's care needs through the daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, suggesting the care processes were being well managed. There was a system to support staff, through regular staff meetings where staff had the opportunity to discuss their roles, training needs and could discuss how the service was changing.

Staff told us that their knowledge, skills and practice was kept up to date. We viewed the staff training matrix, which showed that staff had received or had dates planned for refresher training. That was for their job role and information on conditions that affected people using the service such as dementia awareness and behaviours that challenge.

We saw the system in place for the maintenance of the building and equipment, with an ongoing record of when items had been repaired or replaced. There is a maintenance team who undertakes these repairs. Staff were aware of the procedure for recording and reporting faults and repairs. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

Requires improvement

Is the service well-led?

We discussed the checks and audits the manager and staff conducted in order to ensure people received the appropriate support and care. The registered manager told us they conducted regular audits in order to ensure health and safety in the home was maintained. We saw records of the checks that had been undertaken to ensure the building was safe for people.

These checks included the medicines system, care plans, accidents and incidents and people's weight loss or gain and their nutritional and dietary requirements

There were regular meetings held for the people who used the service and their family or friends where they were also enabled to share their views about the service. These were also used to inform people of changes to the service. That meant people could be involved and influence how the service could be improved.