Woodland Healthcare Limited

Garden House

Inspection report

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Date of inspection visit:
22 September 2016
27 September 2016

Date of publication:
01 November 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 22 and 27 September 2016 and the first day was unannounced. The service was last inspected on 8 August 2013 when it met the requirements that were inspected. On the first day of inspection there were 22 people living at the service.

Garden House is registered to provide accommodation and personal care for up to 30 people. It is situated in the seaside town of Torquay. Garden House does not provide nursing care. Where needed this is provided by the community nursing service.

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

Prior to the inspection the registered manager had completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR contained very little information and told us there were no plans for future improvement. The registered manager assured us that in future the PIR would include more useful information.

People received individualised personal care and support delivered in the way identified in their care plans. People's care plans contained information staff needed to be able to care for the individual. Care plans were reviewed regularly and updated as people's needs and wishes changed. However, information on the main care plans was not always updated following the review. The registered manager was taking action to address this.

Care plans did not contain individual activity plans to ensure people had meaningful activities to promote their wellbeing. Information about the person's life, the work they had done, and their interests was limited so could not be used to develop individual ways of stimulating and occupying people. This meant there were limited opportunities for social interaction between staff and people living at the service. However, there were some regular activities for people to participate in. These included visiting musical entertainers and 'pet therapy'.

Not everyone living at Garden House was able to tell us about their experiences. Therefore we spent some time in the main lounge and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We saw good interactions between staff and people living at the service. However, the interactions were often limited to offering personal care. The registered manager had plans to improve the level of stimulation and interaction available for people.

People's needs were met as there were sufficient staff on duty. During the inspection we saw people's needs were met in a timely way and call bells were answered quickly. However, care staff told us around supper time could be very busy as they had to serve supper as well as help people eat. The registered manager told us they were looking to change rotas so that care staff did not have to serve supper.

People's needs were met by kind and caring staff. Not everyone was able to tell us about their relationships with staff. However, we saw that people were relaxed and happy in staffs' presence. One visitor told us "I know they (staff) care for [relative]" and "I can't have [relative] home, but this is the next best thing". People's privacy and dignity was respected and all personal care was provided in private.

People's privacy was generally respected. People were discreetly assisted to their own bedrooms for any personal care. Staff knocked on people's bedroom doors and waited before they entered. When they discussed people's care needs with us they did so in a respectful and compassionate way. However, during a staff handover held in the lounge, we heard staff discussing people's needs. We discussed this with the registered manager who told us the handover was usually held in the office and would remind staff about confidentiality.

People's dignity was not always upheld. We saw large stocks of incontinence products stacked in people's bedrooms. This meant that anyone entering the bedrooms would know the person had continence difficulties. The registered manager agreed to look at alternative storage arrangements and had discussed these with the maintenance person before the inspection had finished.

Risks to people's health and welfare were well managed. Risks in relation to nutrition, falls, pressure area care and moving and transferring were assessed and plans put in place to minimise the risks. For example, pressure relieving equipment was used when needed. People's medicines were stored and managed safely. People were supported to maintain a healthy balanced diet. People were supported to maintain good health and had received regular visits from healthcare professionals. Healthcare professionals told us they had never had any concerns about the care provided by the service.

Relatives could be involved in planning and reviewing care if they wished. Visitors told us that they could visit at any time and were always made welcome. They also said that staff always kept them informed of any changes in their relative's welfare.

Staff knew how to protect people from the risks of abuse. They had received training and knew who to contact if they had any suspicions people were at risk of abuse. Robust recruitment procedures were in place. These helped minimise the risks of employing anyone who was unsuitable to work with vulnerable people.

People's human rights were upheld because staff displayed a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

Staff confirmed they received sufficient training to ensure they provided people with effective care and support. There was a comprehensive staff training programme in place and a system that indicated when updates were needed. Training included caring for people living with dementia, first aid and moving and transferring.

The registered manager was very open and approachable. People were confident that if they raised concerns they would be dealt with. Staff spoke positively about the registered manager. One told us "[Registered manager] is brilliant, you can talk to her about anything".

There were systems in place to assess, monitor, and improve the quality and safety of care. A series of audits were undertaken by the registered manager. Monthly audits were undertaken including medicines, care plans and accidents and incidents. We saw that where issues had been identified action was taken to rectify the matters. For example, the care plan audit of August 2016 had identified there were some gaps in some information. We saw that this was being addressed by the registered manager. As well as the regular monthly audit when medicines were received, a 'spot check' was undertaken at random intervals. These checks counted the quantities of medicines in stock and checked that Medicine Administration Records (MAR) charts were completed correctly.

We have made recommendations relating to staffing levels and the completion of forms relating to the Mental Capacity Act 2005.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risks associated with unsafe medicine administration because medicines were managed safely.

People were protected from the risks of abuse, because safe recruitment procedures were in place.

Good assessments ensured any risks to people's health and welfare were minimised.

People's needs were met as there were sufficient staff on duty. However, we have recommended staffing levels are kept under review.

Is the service effective?

Good

The service was effective.

People received care from staff that were trained and knowledgeable in how to support them.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

People were supported to maintain good health.

People's human rights were upheld because staff displayed a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). However, some forms relating to the MCA needed to be completed correctly.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was not always respected although all personal care was provided in private.

People's needs were met by kind and caring staff.

People and their relatives were supported to be involved in making decisions about their care.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Opportunities for social interaction were limited.

People's personal care needs were identified in care plans that were reviewed regularly. However, the information was not always transferred to their main care plan.

People received care and support that was responsive to their needs.

Visitors were confident that if they raised concerns these would be dealt with by the registered manager.

Is the service well-led?

Good

The service was well led.

The management was open and approachable.

There were effective quality assurance systems in place to monitor care and plan ongoing improvements.

Records were well maintained and stored securely.

Garden House

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 was 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 22 and 27 September 2016. The first day was unannounced.

One Adult Social Care inspector carried out the inspection.

Before the inspection we gathered and reviewed information we hold about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider.

Not everyone living at Garden House was able to tell us about their experiences. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

During the inspection we met or spoke with all 22 people using the service. We spoke with six care and ancillary staff and the registered manager. We also spoke with two health care professionals and two visitors. Following the inspection we spoke with a healthcare professional and received an email from the local authority's quality support team.

As part of the inspection of the environment we walked around the service with the registered manager and completed the King's Fund tool. This is a tool that looks at how suitable the environment is for people living with dementia.

We looked at a number of records including three people's care records, the provider's quality assurance system, accident and incident reports, three staff files, records relating to medicine administration, complaints and staffing rotas.

Good

Is the service safe?

Our findings

There were 22 people living at Garden House on the first day of inspection and 21 on the second day. Everyone was living with some level of dementia and eight people needed the help of two staff for moving and personal care. People were not able to tell us if they thought there were enough staff to meet their needs. However, the relatives we spoke with told us they felt there were enough staff available whenever they visited. During the inspection we saw people's needs were met in a timely way and people did not have to wait for long periods of time for their needs to be met.

On each day of inspection there were four care staff on duty in the mornings. The registered manager and a number of ancillary staff such as kitchen and cleaning staff were also on duty.
During the afternoon and evening there were three care staff on duty and overnight two care staff were awake. Rotas showed this was the usual number of staff on duty. Staffing levels were determined by using a specific tool. The tool looked at the dependency levels and numbers of people living at the service. It also took into account the layout of the building, which was over three floors, and a set number of hours each week for staff training. The dependency tool showed that the service was already allocated 10 hours each week that was extra to the basic requirement needed to keep people safe. However, the registered manager had identified that more staff were sometimes needed at supper time. This was because care staff also had to serve supper as the cook left before this time. The registered manager was looking to provide more staff during supper time. Staff told us they thought there were enough staff on duty generally, but that supper time could sometimes could be rushed.

We recommend that afternoon and evening staffing levels are kept under review.

People were protected from avoidable harm and abuse. Staff had received training in keeping people safe and knew about different types of abuse. They knew how to recognise abuse, and told us what they would do if they thought someone was being abused within the service. Not all staff knew who to report any concerns to outside of the service. However, they said they knew they would be able to find the information if they needed it. We discussed this with the registered manager who agreed to put the contact details for the local safeguarding team on the staff noticeboard. Staff told us they were confident the registered manager would deal with any concerns they raised. We observed how people who could not tell us if they felt safe reacted towards staff. Throughout the day we saw them interact with staff in a relaxed manner, smiling and laughing. People held staff's hands when talking to them, showing us they felt safe in their company.

There were robust recruitment systems in place. This protected people from the risks associated with employing staff who may be unsuitable to work in care. Staff were thoroughly checked to ensure they were suitable to work at the service. These checks included obtaining a full employment history, seeking references from previous employers and checking with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with vulnerable people.

Arrangements for identifying and managing risks were in place to keep people safe and protect them from harm. Risks to people's safety and wellbeing were assessed. For example, risks in relation to nutrition, falls, pressure area care and moving and transferring were assessed and plans put in place to minimise the risks. For example, pressure relieving equipment was used when needed. Where one person had been identified as being at risk from poor nutrition, the advice of a dietician had been sought.

Procedures were in place to protect people in the event of an emergency. Staff had been trained in first aid and there were first aid boxes easily accessible around the home. Personal emergency evacuation plans were in place for people. However, the plans contained limited information on how to safely evacuate people from the building should the need arise, such as a fire. The registered manager agreed to update the plans to ensure more detail was recorded.

Any accidents or incidents that occurred were recorded and reviewed to see how they happened and whether any actions were necessary to reduce the risk of reoccurrences. The registered manager reported all falls to the local 'falls register' team. All reports were looked at by the team who would provide information and support to manage people's care safely, if any concerns were identified.

Suitable equipment was in place to meet people's needs. For example, hoists, wheelchairs and lifts were available which helped people move around the service independently. Maintenance contracts were in place for the equipment, which was clean and had recently been serviced.

The premises and equipment were maintained to ensure people were kept safe. Records showed that equipment used within the service was regularly serviced to ensure it remained safe to use. For example, hoists, pressure relieving equipment, gas and electrical installations were checked in line with the associated regulations.

People were supported to receive their medicines safely and on time. Medicines were stored securely in locked cupboards in a locked room and only staff who had received training administered medicines. Medicine Administration Record (MAR) charts indicated people received their medicines on time as prescribed by their GP. There were arrangements in place to ensure people received medicines that were required to be taken outside of the usual medicine rounds. Audits of medicines were undertaken when medicines were received in to the service each month. Records were kept of any medicines returned to the pharmacy.

During the inspection we observed staff offering people their medicines, explaining to them what their medicines were for and ensuring they had a drink available to take their medicines with. Where people had been prescribed medicine to be taken when required (PRN) for pain relief, they were asked at specified times if this was required. Each person's medicine records included full details of the medicines they were taking, what the medicine was for and any side effects staff should look out for. This ensured staff were aware of what medicines they were administering.

Good

Is the service effective?

Our findings

People living at Garden House had needs relating to living with dementia, mobility and general health. People received effective care and support from staff with the skills and knowledge to meet their needs. There was a comprehensive staff training programme in place and a matrix indicated when updates were needed. Staff had received training in a range of subjects including medicine administration, first aid and moving and transferring to help meet people's needs. They had also received more specific training such as caring for people living with dementia.

There was an effective system in place to ensure staff were putting their learning into action and remained competent to do their job. Staff records showed they received regular supervision and yearly appraisals. Staff received individual supervision sessions when they were able to discuss all aspects of their role and professional development. During supervision, staff had the opportunity to sit down in a one to one session with the registered manager to talk about their job role and discuss any issues. In order to assess competency, senior staff observed the care practice of staff when they were meeting people's needs. The registered manager told us they often worked alongside care staff in order to ensure staff remained competent to do their job.

The registered manager told us new staff undertook a detailed induction programme. Newly appointed staff were either continuing with training qualifications they had started before joining the service or were following the Skills for Care, care certificate framework. The care certificate is an identified set of standards used by the care industry to ensure staff provide compassionate, safe and high quality care and support.

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.

Some people living at Garden House were living with dementia and this could affect their ability to make decisions about their care and treatment. Staff had received training in the MCA and people were supported by staff who had an understanding of the principles of the legislation. This ensured people who did not have the mental capacity to make decisions for themselves had their legal rights protected. People were able to make some day to day decisions for themselves, but may not have the capacity to make more complex decisions about their health and welfare. Throughout the inspection we heard staff offering people choices. People were asked what they wanted to do and what they wanted to eat or drink. Staff told us they always assumed people were able to make decisions for themselves and knew an assessment would be needed if they thought the person did not have capacity to do so. They were also aware that if a person had been assessed as not having the capacity to make specific decisions then meetings should be held to discuss what would be in the person's best interests.

Records showed that although people's capacity had been assessed, the assessments were not related to a

specific decision as required within the MCA. For example, on one person's assessment the decision to be made was a statement of the conclusion that had already been reached. That is, that an application to deprive the person of their liberty should be made. We also saw some 'best interest' decisions had been taken on behalf of people who had been assessed as lacking capacity. These decisions had been made by the registered manager only. Best interest decisions should involve the views of as many relevant people as possible, including relatives and health and social care professionals.

We recommend that the service seeks guidance to refresh their understanding of the MCA and carry out assessments and decision making in line with the MCA Code of Practice.

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 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 registered manager had made applications to the local authority to deprive 21 people of their liberty. This was in order to keep them safe by the use of a locked front door. Due to the large number of applications being processed by the local authority only six authorisations had been granted at the time of the inspection. While the applications were being processed the service was keeping people safe using the least restrictive possible measures.

People were supported to receive a healthy balanced diet with plenty to drink. Staff frequently offered people tea, coffee or cold drinks. Meals were presented nicely and equipment such as plate guards were used to help people eat independently. The cook had a list of people's dietary preferences and menus were adjusted to take account of these. The cook told us they prepared several low sugar meals and also a vegetarian meal. Where people did not want the main meal there was a range of alternatives on offer such as baked potatoes and omelettes. Those people who were able told us they enjoyed their food and one person said their lunch had been "beautiful". We saw people eating their lunch and everyone appeared to be enjoying it, there was very little left on their plates.

Following the inspection we spoke with a dietician who had visited the service to assess one person's nutritional needs. They told us the service had acted swiftly to refer the person to them as the person had lost a significant amount of weight in a short time. The dietician told us they felt staff were knowledgeable about the person's needs and had no concerns over the person's welfare.

People were supported to maintain good health and had access to healthcare services where required. Records showed people had seen their GPs and other health and social care professionals as needed. We spoke with two visiting healthcare professionals who told us that the staff were very good at contacting them when required. They said staff took advice and followed it through efficiently. They told us they had never had any concerns about the care provided by the service.

The service was clean and tidy and pleasantly decorated with no unpleasant smells. We spent some time walking about the home completing the King's Fund tool with the registered manager. The King's Fund tool looks at how suitable the environment is for people living with dementia. We found that some of the suggestions of the tool were in place. For example, there was a variety of seating available including settees as well as single chairs. There was a dedicated quiet area situated just off the hallway.

However, there were still many improvements needed. For example, there was no independent access to outside areas and there was limited signage to help people find their way around the service. The registered manager had recently met with a representative of the provider and had drawn up a plan to make the

environment more suitable for people living with dementia. The registered manager spoke passionately about their plans to improve the environment. They had plans to name corridors with street signs, to paint toilet and bathrooms doors to make them stand out from other doors and to make people's bedroom doors look like the front door of a house.

Good

Is the service caring?

Our findings

Staff at Garden House treated people with respect and kindness. Staff were seen supporting people in an easy, unrushed and pleasant manner. We heard staff listening and communicating well with people, giving them their full attention and talking in a pleasant manner.
When addressing people staff used people's preferred names and appropriate language. We saw that people responded well to staff, speaking, smiling and laughing with them. There was much fun, laughter, appropriate banter and hugs between staff and the people they supported.

Not everyone was able to tell us about their relationships with staff. However, we saw that people were relaxed and happy in staffs' presence. Staff carried out their duties in a caring and enthusiastic way. Staff were observed to be kind and patient, supporting people in an easy, unrushed and pleasant manner. They walked with people at their pace and knelt down to be on people's level when chatting to them. Staff were mindful of people's needs. They offered plenty of fluids and snacks and discreetly asked if people needed help with personal care.

Those people that could tell us their views and their visitors said staff were kind and caring. All the interactions we saw between people and staff were positive. One visitor told us "I know they (staff) care for [relative]" and "I can't have [relative] home, but this is the next best thing". The atmosphere within the service was relaxed and very friendly.

We saw many 'thank you' notes from families, expressing their gratitude to staff. For example, one note said 'We would just like to say a massive thank you for all the care and love you gave [relative] during his time with you at Garden House'. Another relative had written 'it was always a pleasure coming into the home, the lovely welcome and seeing [relative] well cared for and the kindness shown'.

We asked the registered manager for examples of when staff had gone 'above and beyond' when caring for people. They told us one staff member gave their own time to watch football on TV with one person and had also taken them out to the pub. One staff member cooked special food for one person as they were from the same cultural background. Staff also took an active part in caring for one person's pet. Taking the pet to the grooming parlour and the vets. Staff also escorted the person and their pet for walks. Staff told us they really enjoyed helping to care for the pet.

People's preferences were obtained and recorded during their pre-admission assessment. Staff demonstrated they knew the people they supported and were able to tell us about people's preferences. For example, staff told us what people liked to eat, what they liked to do and when they liked to get up and go to bed. Everyone had their own bedroom. Some people had personalised their bedrooms with items they had brought from home. Many rooms had photographs of family and friends and ornaments that had a special meaning.

People's privacy was generally respected. People were discreetly assisted to their own bedrooms for any personal care. Staff knocked on people's bedroom doors and waited before they entered. When they

discussed people's care needs with us they did so in a respectful and compassionate way. However, during a staff handover held in the lounge, we heard staff discussing people's needs in front of other people. We discussed this with the registered manager who told us the handover was usually held in the office and would remind staff about confidentiality.

People's dignity was not always upheld. We saw large stocks of incontinence products stacked in people's bedrooms. This meant that anyone entering the bedrooms would know the person had continence difficulties. The registered manager agreed to look at alternative storage arrangements and had discussed these with the maintenance person before the inspection had finished.

A 'respect' audit had been carried out by the provider's representative on 21 September 2016. The audit looked at the interaction between staff and people living at the home and if staff were discreet when caring for people. The audit found staff were respectful towards the people they cared for.

Not everyone was able to be involved in planning their care. We saw that where people or their relatives wished to take part in planning care they could be. Relatives told us that they could visit at any time and were always made welcome. They also said that staff always kept them informed of any changes in their relative's welfare.

Staff helped people to celebrate special occasions. Staff told us people always had a special cake for their birthday and a party for any 'special' birthdays.

Requires Improvement

Is the service responsive?

Our findings

People received individualised personal care and support from staff who knew them well. People's needs were assessed before and while living at Garden House. Care plans contained good descriptions of people's needs and how they liked their care to be delivered. One person's care plan gave staff instructions on how to manage the person's behaviour when they became anxious. Another person's care plan instructed staff on how to help the person with their specific personal care needs.

However, care plans did not always contain the most up to date information available. Care plans were reviewed regularly and the review document contained up to date information. This information was not transferred to the actual care plans. For example, one person's care plan stated they lived at the service with their spouse, but staff told us the person's spouse had passed away some time ago. The review contained that information in the month following the spouse's death, but had not been mentioned in the following months. This meant staff did not have the most up to date information with which to care for the person.

Care plans contained limited information on people's social history. However, staff knew some details of people's past lives that helped them interact with people. For example, staff knew one person had been very keen on dancing. The person walked freely around the home and whenever staff saw them they began to dance. The person smiled broadly and did a few dance steps themselves.

While there were some opportunities for social interaction and activities these were limited. There were no individual activity plans to ensure people had meaningful activities to promote their wellbeing. Information about the person's life, the work they had done, and their interests was limited and of little value in developing individual ways of stimulating and occupying people. However, staff told us they had time to spend with people on an individual basis and we saw that staff spent social time with people in their rooms. There was a programme of group activities. For example, during our inspection people enjoyed a visit from an outside entertainer. We saw such entertainment took place weekly along with hand and nail treatments. There were also regular visits from a 'pet therapist' who brought a selection of animals into the service for people to look at and hold.

The registered manager had recognised stimulation and interaction was an area that needed improvement and had highlighted equipment to purchase to enable staff to provide more stimulation for people.

Staff responded to people's needs in a sensitive manner. One person became anxious and was very firmly holding a staff member's hand. The staff member was patient with the person and spoke to them in a calm and reassuring manner. Another staff member came to assist and brought a cup of tea. The person let go of the staff member's hand in order to take the cup of tea. Staff told us that it was important to continually reassure the person that they were safe as otherwise their anxiety would increase.

Staff had received training in caring for people who were living with dementia. One staff member told us the training had given them ways to reassure people and that patience was a great asset. Staff were careful to speak slowly and calmly and gave people time to process any information, good eye contact was also

maintained. This showed us that staff knew how to care for people with dementia.

Not everyone living at Garden House was able to tell us about their experiences. Therefore we spent some time in the main lounge and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We saw good interactions between staff and people living at the service. Staff spoke with one person about their knitting and another about a book they were looking at. However, much of the interaction was task related, for example asking people if they wanted a drink. Staff did not always interact with people when they entered the lounge. For example, on several occasions staff entered the lounge and spoke only with other staff members.

The registered manager took note of, and investigated any concerns raised. We saw that two complaints had been recorded in 2016 both had been investigated and concluded satisfactorily. Visitors told us they felt able to raise any concerns and said they would speak to staff if they needed to. However, they told us they had never had to make a complaint. Those people who were able told us they were happy with everything.

The registered manager told us they had held a meeting for people and their relatives to discuss any concerns. However, only one relative had attended. The registered manager had therefore sought people's views about the service by sending out questionnaires. They had received some replies and would be collating a report when they had received more forms.

Good

Is the service well-led?

Our findings

The service is part of the Woodland Healthcare group. One of the directors of the group regularly visits the service to audit the care being provided and support the registered manager. The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who used the service.

There were systems in place to assess, monitor, and improve the quality and safety of care. A series of audits were undertaken by the registered manager. Monthly audits were undertaken including medicines, care plans and accidents and incidents. We saw that where issues had been identified action was taken to rectify the matters. For example, the care plan audit of August 2016 had identified there were some gaps in some information. We saw that this was being addressed by the registered manager. As well as the regular monthly audit when medicines were received, a 'spot check' was undertaken at random intervals. These checks counted the quantities of medicines in stock and checked that Medicine Administration Records (MAR) charts were completed correctly.

Each month the registered manager completed a 'diary' that was returned to the provider. Information in the diary included any staff training that had taken place, how many staff supervisions had been conducted and if any complaints had been received.

Prior to the inspection the registered manager had completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR contained very little information and told us there were no plans for future improvement. We discussed this with the registered manager who told us this was the first time they had completed such a document and had been unsure of how much information to include. They assured us that in future they would include more useful information.

There was a positive and welcoming atmosphere at the home. Staff told us they thought there was an open and honest culture in the home. One member of staff told us staff feel able to speak up if they were unhappy about something. Staff told us they were happy working at the service. One staff member said "The residents are amazing. I know I will always walk out of here with a smile on my face". They added "It's nice to get out of bed and want to go to work and look forward to the day you have got in front of you".

Staff told us they were encouraged to make suggestions to improve the service. One staff member told us they had suggested obtaining picture cards in order to aid communication with one person. The cards had been obtained and had helped with the person's communication.

Staff spoke positively about the registered manager. One staff member said they felt more supported at Garden House than any other service they had worked at. Another staff member said they had been supported by the registered manager through their personal problems. Another member of staff said "[Registered manager] is brilliant, you can talk to her about anything".

The registered manager told us they kept their knowledge of care management and legislation up to date by using the internet, attending as many training sessions as possible and updating their qualifications. They were aware of their responsibilities under Regulation 20 of the Health and Social Care Act 2008, Duty of Candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

Records relating to the management of the service were well maintained. All records we asked for were kept securely but easily accessible.