Czajka Properties Limited

Fairmount Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 17 August 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Fairmount Nursing Home in November 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

Fairmount Nursing Home provides nursing and personal care for older people, including some people with dementia-related conditions. At the time of our inspection there were 32 people living at the home.

The service had a registered manager. 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.

We found that there were established systems for protecting people from abuse and avoidable harm. The service responded appropriately to any safeguarding concerns. Measures were in place to prevent risks associated with people's care. Care was provided in a safe, clean environment.

New staff were checked and vetted before they started working at the home. There was enough experienced staff to provide people with safe and consistent care. Staff were appropriately trained and supported in their personal development.

People were suitably assisted in meeting their health care needs and taking their prescribed medicines. A balanced diet was offered to ensure good nutrition and where necessary, specialist advice was obtained. Support with eating and drinking was provided and people told us they enjoyed the food.

People and their families were consulted about and able to direct the way their care was given. The service upheld people's rights under mental capacity law when they were unable to make important care decisions. Feedback was sought and any complaints received were properly investigated and resolved.

People and their relatives were happy with the care and spoke highly of the staff. We observed staff were caring in their approach and respectful of people's privacy and dignity. The service gave people the information they needed and supported them to express their views.

Care was planned according to people's individual needs and preferences and adapted in response to any changes. A range of activities and good leisure facilities were made available to help people meet their social needs.

The home had a registered manager who was supportive and provided leadership to the staff team. They promoted transparent communication and were committed to improving the service. The quality of the service was checked to make sure standards were being maintained, though we have made a

recommendation to reintroduce audits of the management of medicines.

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.

Systems were in place to minimise risks to personal safety and safeguard people from being harmed or abused.

Sufficient staff were employed and staffing levels were kept under review to ensure they safely met people's needs.

People received their prescribed medicines at the times they required them.

Is the service effective?

Good

The service was effective.

Staff were provided with suitable training and support to enable them to care for people effectively.

The implications of mental capacity law were understood and the service ensured that people's rights were upheld.

People were appropriately supported in meeting their health care and nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring and had developed good relationships with people living at the home and their families.

People were given support to make daily choices and express their views about their care.

People were treated with respect and their privacy and dignity were promoted.

Is the service responsive?

Good

The service was responsive.

Care planning was tailored to people's needs and the ways they preferred their support to be given.

People were given opportunities to engage in social activities and be involved in their community.

Complaints about the service were taken seriously and acted upon.

Is the service well-led?

Requires Improvement

The service was well led.

A registered manager was in post who provided leadership and support to the staff team.

The home had an open culture and worked inclusively with people and their families.

There were systems to assess and monitor the quality of the service, though more robust oversight of medicines recording was needed.

Fairmount 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 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 17 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, the provider completed 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 the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted other stakeholders including commissioners and received no information of concern about the service.

During the inspection we talked with three people, four relatives/visitors and two visiting professionals. We spoke with the registered manager, the human resources manager, an area manager, the catering manager, the deputy manager and four nursing and care staff. We observed how staff interacted with and supported people, including during a mealtime. We reviewed six people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

The people we talked with described feeling safe at the home and no-one expressed any concerns about the way they were treated. A relative told us, "My [family member] is kept very safe here and has appropriate aids for their safety."

The service made information available to people about their rights to be protected from abuse. A communal noticeboard was dedicated to safeguarding issues, which people, their visitors, and staff could readily refer to. Details displayed included the safeguarding policy, staff responsibilities and an 'easy read' local authority safeguarding guide. The home's guide to the service was being updated and it was planned that this would also include safeguarding information.

Systems were in place for safeguarding people against the risk of abuse and for responding to any alleged abuse. Staff were trained in and had access to safeguarding and whistleblowing (exposing poor practice) procedures. Those staff we spoke with understood their responsibilities for reporting any concerns or suspicions of abuse. Two safeguarding concerns had been raised over the past year, both of which were reported to the relevant authorities, appropriately investigated and acted upon. This was confirmed to us by the local safeguarding authority.

The registered manager had a good understanding of the 'duty of candour' regulation and a specific policy had been developed. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. There was recorded evidence that this had been discussed at meetings with people and their relatives, and with the staff team, to raise their awareness.

We reviewed the safekeeping of people's personal finances. The service had established where people had appointed representatives who had legal status in relation to their finances, such as relatives with power of attorney. Clear records were kept of all monies held on behalf of, or spent for, people in the service. Receipts were obtained and held, where applicable, and double signatures were recorded for all transactions. Monthly audits were carried out to assure people their money was being handled safely.

Potential areas of risk were identified as part of people's initial and ongoing assessments. Where risk factors were highlighted, clear plans were devised which guided staff on how to safely support the person. For example, there were measures to minimise risks associated with moving and handling and falls, including the number of staff required to provide support, handling techniques and the use of equipment. The risk assessments were reviewed and updated to reflect any changes in people's needs and ensure their personal safety was protected.

Accidents and incidents that happened in the service were reported and recorded in detail. Information included descriptions of the accident/incident, completed body maps of any injuries, treatment, and thorough follow ups of reviewing risk factors and updating care plans. The reports were then subject to analysis by the registered manager and senior managers to make sure all necessary actions had been taken

and to prevent reoccurrence.

People were cared for in a comfortable and hygienic environment. We observed the home was clean, suitably equipped to deliver people's care and there were no obvious safety hazards. The service's maintenance person undertook a range of regular safety checks and audits and recorded their findings. These included various checks of aids and equipment, water temperatures, and conditions in each person's bedroom. Health and safety committee meetings were held which were attended by staff of different grades. The minutes showed comprehensive discussion about maintenance and servicing arrangements, infection control, housekeeping, laundry, kitchen and care issues, and updates to policies and safety alerts. Any actions required to ensure safety were clearly stated, along with the person responsible and a timescale for completion.

The service had been inspected by the fire brigade in recent months and the registered manager told us all necessary improvements to fire safety systems had since been implemented. We were shown more regular drills and fire instructions for staff were conducted and a number of practical measures within the home had been completed to reduce the risk of fire.

Our check of recruitment records indicated all necessary pre-employment checks were undertaken before new staff started working at the home. Applicants' suitability was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. Employment application forms and health questionnaires were fully completed, proof of identification was obtained, and interviews were documented. In most instances, references had been sought from suitable sources. We noted a reference from the last employer had not been taken up for one staff member and this was rectified during our visit to ensure recruitment was fully robust.

Staffing numbers were calculated according to the home's occupancy and people's dependency levels. At the time of the inspection these were one nurse and six care staff, including seniors, during the day, one nurse and four care staff in the evenings and one nurse and two care staff at night. The registered manager, who was a qualified nurse, was supernumerary to the roster. Separate ancillary staff were employed for housekeeping, catering and laundry duties.

Staff sickness and holidays were mainly covered by existing staff members and occasional use was made of agency staff, where necessary. The registered manager told us she always tried to get agency staff who were known to the service for continuity. The home also had a bank nurse and a bank care worker available to cover staff absences. The registered manager and deputy manager operated an on-call system that enabled staff to get advice or support and to escalate any emergency circumstances to senior management. Staff had access to documentation that gave them vital information in case of emergencies. This included contingency plans in the event of power failures and maintaining people's safety should the home need to be evacuated.

Some staff we talked with commented on the impact of recent increases in the home's occupancy and the complexity of people's care needs. A relative also told us they had noticed changes, with staff taking longer to attend to their family member and a higher number of agency staff present in the home. The registered manager acknowledged these comments and informed us dependency and staffing levels were already in the process of being further reviewed. Following the inspection, they confirmed the provision of additional nursing hours to accommodate people's needs and revised shift patterns for improving how staff were deployed and supported.

Suitable arrangements were made for the ordering and storage of medicines which ensured there were enough stocks of people's medicines and that they were held securely. Checks of stocks of medicines and storage temperatures were undertaken and there was some evidence of the clinical room being audited.

The deputy manager reported the home received a good service from the supplying pharmacy, including prompt delivery of medicines prescribed outside of the usual monthly cycle. We spoke with the pharmacist who said they would be completing bi-annual audits of the home's medicines management. They told us, "The level of communication from the service is good. They will contact us if they have any queries or issues. The deputy manager is the main contact, handles everything and feeds back to us regularly."

Qualified nurses only were involved in the handling of medicines. They were appropriately trained and had an annual assessment to check their knowledge and competency. Sufficient information was provided about each person's individual medicines regime. This included profiles and details within care plans of people's requirements, protocols for medicines given on an 'as required' basis, details of any allergies, and photographs for identification purposes. None of the people living at the home currently received their medicines covertly, disguised in food or drink.

Directions for medicines were specified in the medicines administration records (MARs). The majority of MARs had been appropriately completed to confirm people had received their medicines at the times they required them. The management acknowledged there were some gaps in the MARs where staff had omitted to sign confirming administration, or entered codes explaining why medicines were not given. Checks of the supplies showed that the medicines had been administered to people as prescribed in these instances. We have recommended that audits be reintroduced to keep regular oversight of medicines recording. The administration of controlled drugs (medicines liable to misuse) was seen to be suitably recorded.

Good

Is the service effective?

Our findings

We spoke with a senior worker, who was the home's training officer, about the training and support offered to staff. They told us new staff had received an induction to prepare them for their roles before they started working with people. This involved three to four days training at the provider's training centre followed by a number of shifts at the home when they worked in addition to the staffing levels. During this time new employees shadowed experienced staff members, were shown around the home and introduced to people. We were informed new staff were expected to complete the 'Care Certificate'. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. Thereafter, staff received a combination of classroom-based and e-learning training.

The staff we talked with confirmed they had received an induction when they had commenced their employment. Staff were complimentary about the training they received, both as part of their induction and their continuous employment. Many staff spoke highly of the training courses offered at the provider's training centre. One staff member told us they had been offered additional training and that the service was supporting them through university qualifications.

A training matrix was maintained that gave an overview of courses completed by the staff team. This showed the majority of staff were up to date with mandatory training such as safeguarding and moving and handling. The training officer told us they were responsible for reviewing the matrix on a regular basis to establish and arrange the training which staff required. We saw evidence to confirm this and staff told us they received training in other topics relating to the needs of the people they cared for.

Most of the staff we spoke with told us they received regular supervision. The provider's policy for supporting staff included a commitment to providing a minimum of four supervisions each year and an annual appraisal. We reviewed a selection of staff files and found the frequency of supervisions and appraisals was not in line with this policy. We were informed the records did not accurately reflect the extent of sessions that had taken place. The registered manager told us this was an area they were addressing and subsequently provided us with updated schedules which were held electronically. These demonstrated staff had received individual supervision, the due dates for the next session, and that the majority of appraisals had been carried out.

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 found the service generally worked within the principles of the MCA. People's care records captured details of their preferred communication methods and details of any support they required to assist them in

communicating. The records contained advice for staff about ways of supporting people to make decisions and maintain their independence. For example, in one record staff were advised to face and speak clearly, and to give the person extra time to think before asking them to make choices.

The service used an assessment tool to help establish people's ability to make decisions about their care and treatment and any assistance or support they needed. The tool covered areas such as the person's physical and mental health as well as information about their personality and any preferences they had. We noted these assessments had not been carried out for each person and that there were inconsistencies in consent to care and treatment forms being signed. In one instance, a family member had signed to give consent although the person had capacity to do so.
We highlighted these issues to the registered manager who told us they were in the process of reviewing consent records for all people living at the home.

Some staff we talked with had received training in mental capacity law and understood the implications for their practice. One staff member told us they were aware people were not always able to make their own decisions and of the need to protect them and consult family members. Another recognised the need for assessing people's capacity and said they could refer to other organisations for advice if they had concerns.

We saw that formal processes had been followed to uphold people's rights. Where a person was assessed as lacking the capacity to make a particular decision, a decision had been made on their behalf, in their best interests. Relevant people were involved in this decision-making and it was clearly documented. A number of people living at the home had DoLS authorised to ensure they received the care and treatment they needed.

Systems were in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People's needs were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition.

Where specific needs or risks were identified, care plans were implemented with guidance on meeting the person's dietary requirements and, where applicable, any support needed with eating and drinking. For instance, one person's care plan showed they received their food, fluids and medicines through a percutaneous endoscopic gastrostomy (P.E.G) feeding tube. Advice from nutrition and diabetic services was built into the plan, giving staff guidance on the support required and outlining the person's daily intake targets. When reviews of the plan indicated concerns, for example when the person had lost weight, further advice had been sought from relevant healthcare professionals. Daily records of the person's intake were monitored, though the nursing staff agreed to amend the records to clarify the daily targets and whether they had been met.

People had been asked about their dietary needs and preferences when they moved into the home. This information was regularly updated and held in the kitchen for the catering staff to refer to. A four week menu was in place, with copies displayed around the home and included in the welcome pack provided to people. Diabetic options were always available and we were informed a variety of other diets could be catered for. We saw choices of meals were offered and the catering staff told us alternatives could be readily prepared if people did not want what was on the menu. Drinks and snacks were served between meals and jugs of water were provided in lounges to encourage good hydration.

Relatives told us they felt the care provided was effective and they were kept updated about any issues affecting their family member's health. Their comments included, "[Family member] has some pressure

damage and they've explained this to me", and, "If [family member] has a bruise or anything they will inform us exactly how it happened." Another relative said their family member's health had improved since coming to live at the home and commented, "They saved her life." They added that their family member had put on weight and they felt they were being well cared for.

Medical history information was obtained along with details of health care professionals involved in the person's care and health care needs were assessed. People living at the home accessed a full range of health care services. The registered manager told us health needs were monitored through monthly reviews by GPs and a Nurse Practitioner to identify changes or any additional support required. Care records showed all visits from, or contact with external professionals was documented, including details of any treatment and advice provided.

A visiting health care professional told us, "Communication is very good and they're very good at taking advice." The service was working towards achieving the Gold Standards Framework, an initiative that aims to improve the quality, co-ordination and outcomes of care for people at the end of their lives. Where not already established, people and their families were being consulted about their wishes in relation to end of life care and treatment.

Good

Is the service caring?

Our findings

During our visit we found there was a warm, inclusive atmosphere in the home. We saw staff were polite and friendly in their interactions and showed a patient and caring approach towards people and their visitors. Where people were unable to tell us about their care, we observed they appeared relaxed in the company of staff and responded positively when they engaged with them. Frailer people who were nursed in bed looked comfortable and well cared for and staff were attentive to their needs.

People and their relatives told us they felt the care provided was of a good standard and spoke highly of the staff. People's comments included, "They (staff) are all lovely to me and I get all the help I want", and, "This is our home and they look after us very well." A visiting healthcare professional commented, "The home is very nice and staff are very pleasant. Residents seem very well cared for and happy."

A relative told us, "The care is good. My [family member] has been consistently cared for and at times the care has been outstanding. Most staff have a caring attitude and even former staff have visited [family member]. I especially like the more mature and experienced staff." This relative also recalled an "absolutely amazing" special birthday party which had been held at the home for the person and how other relatives and friends who attended had remarked on the friendly nature of the staff.

A visitor, whose friend had recently moved into the home, told us, "All is going well and [name] is happy here. Some of the staff are superb, really caring and go the extra mile." Other comments from visitors included, "All the staff are good. They all speak and are pleasant", "The service and the care are absolutely fantastic", and, "Staff individually are very good."

We saw routines were flexible and people were free to choose where and how they spent their time. Some people were able to tell us they were offered choices in daily living such as when to get up and go to bed, where they dined, and they were given choices of meals and drinks. Information was displayed giving people details about what was happening in the home, including the staff on duty and the day's menu, as well as forthcoming events. An informative welcome pack was also provided to each person that explained what they could expect from using the service. Confidential information, including people's care records was seen to be held securely.

Family and friends were able to visit when they wished. A relative confirmed this, telling us, "There are no restrictions on visiting times." The needs of relatives were also sensitively taken into consideration. For instance, a relative was being supported to stay overnight in the home and take meals and drinks, whilst their family member was being cared for at the end of their life. This relative told us, "They're taking care of me, too."

The registered manager told us they aimed to support people and their families to express their views about their care and the service in general. Records and comments from relatives confirmed this. Pre-admission assessments provided information about the person's mental health and whether they needed support in making decisions about their care and treatment. Wherever possible, people living at the home and/or their

representatives were consulted about and involved in reviews of care. Advocacy services were able to be accessed if a person did not have family or friends to represent their views. Surveys and resident and relative meetings were also used to communicate news and seek feedback about the service.

The home had designated staff with lead roles for championing the rights of people with dementia-related conditions and treating people with dignity. A staff member told us they recognised the importance of developing relationships with people and of making sure people felt comfortable with them when providing their care. Staff were aware of the need to maintain people's privacy and dignity and gave examples of covering people and ensuring doors were closed when providing personal care.

During our visit we saw good practice, such as staff knocking on bedroom doors before entering. At lunchtime, support was provided in a dignified way, with staff sitting alongside those people who needed assistance with eating and drinking. Staff discreetly cut up food where needed, served accompaniments and encouraged people to help themselves to vegetables from tureens. There were nice touches, including people being offered advocaat-based drinks and beer. Those people we talked with told us the food was very good. We observed the mealtime was not rushed and was a pleasant and sociable experience.

Good

Is the service responsive?

Our findings

Relatives told us the staff were good at keeping them informed about their family member's ongoing care and welfare. One visitor said the home had their contact details and they were always called about any change in the person's condition, no matter how small. Other comments included, "We're consulted about changes", and, "They invite us in for regular reviews." A visiting healthcare professional told us, "They're responsive and contact me if there are any problems."

The registered manager informed us the provider was looking at introducing a new call system in the service. This had been trialled at another of the provider's care homes and enabled staff response times to people summoning assistance to be monitored.

Care records showed assessments were completed before people moved into the home to ensure their needs could be met. Further assessments were then carried out on admission and these were routinely updated to reflect people's current needs. Information gathered was used to formulate personalised care plans for all identified needs. The care plans provided guidance to staff on the level of care the person required, their daily routines, and the ways they preferred to be supported. The gender of staff that people wanted to give support with personal care, the times people liked to get up, and food likes and dislikes were stated.

There was evidence that care was reviewed and care plans were evaluated on a regular basis to check they remained appropriate in meeting people's needs. The care plans were also updated when there were changes in a person's needs, ensuring staff had detailed instructions on how best to provide their support.

People were allocated a named nurse or care worker with responsibilities towards their care. We saw that care had been planned in a person-centred way, using details from information that was obtained about the person's life history and preferences. Some relatives told they had been asked to contribute this information to enable staff to understand the person's background and interests.

Relatives commented positively about the individual care and attention they felt the staff provided to their family members. For instance, one relative told us about how staff had adapted the way they cared for and communicated with their family member as their physical and mental health declined. This had included staff using information about the person's background to good effect and their family member being given foot massages by a care worker which aided their comfort. Another relative told us some staff communicated with their family member in the language of the country of their origin.

A range of activities were planned and provided for people living in the home to help meet their social needs. The programme included pet therapy, arts and crafts sessions, and exercise classes. The home employed an activities co-ordinator who also arranged one-to-one sessions, trips and entertainment for people to participate in. People and their visitors were able to make use of the facilities at the Fairmount Park Clubhouse, situated within the complex. These included fitness and leisure facilities, bar, restaurant, and regular organised social events.

A visitor said people were given opportunities to go out locally accompanied by staff. They told us about a recent garden party, that seasonal events were held, and explained staff encouraged people to get involved, though respected their wishes if they chose not to. We were also informed there had been a Summer fayre this year that had raised funds and was well supported by families and people from the local community.

The provider had a complaints procedure that was given to people and displayed in the home for reference. This covered the process for making a complaint and gave details of other contacts for support or advice. People and their relatives told us they would feel able to raise any concerns or complaints about the service with the registered manager. We found that clear records were maintained of investigations and the actions taken in response to complaints. Where appropriate, concerns had also been also been referred onto other agencies.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had registered with the Care Quality Commission (CQC) in February 2016. They understood their management responsibilities and registration requirements and had kept the CQC notified of any events which affected the service. The registered manager had recognised at times there had been some delays in notifications being submitted. They had taken action to address this, ensuring the system of delegation was understood and using the CQC provider portal (online system) to speed up the process.

The registered manager told us they had regular contact with the provider and senior managers, including meetings and ensuring they were kept appraised of issues about the running of the home. The registered manager described recent input from a nurse consultant that she had found beneficial in terms of clinical governance at the service. The deputy manager told us they really enjoyed working with the registered manager and spoke of good mutual support. They felt they worked well together in developing the service and had already made a number of improvements. A visiting professional told us, "The home is really well managed" and that the registered manager was always available and willing to discuss things if the nursing staff were busy. This professional said they would recommend the home to others.

Staff spoke highly of the registered manager, telling us they were approachable and took any concerns seriously. A nurse told us the home was a lovely place to work and, although the work was challenging, felt the management team was very supportive. A care worker felt the service was well managed, and said the registered manager was patient, treated people well and dealt with things respectfully. Another care worker commented on the approachability of the registered manager, and said staff were encouraged to be involved in the running of the service. This care worker told us they felt able to go directly to the registered manager if they were unhappy with anything. We were told the registered manager always left their contact details when off duty and came in, if needed. Staff told us staff meetings took place at least every two months and more often if there were issues to discuss.

Visitors were also very positive about the management and leadership in the service. One visitor told us, "[The provider] comes in regularly, talks to people and is approachable." Other comments included, "The manager is very good and has made a huge change for the better. When my [family member] first came here they wanted to meet and get to know the manager, so the manager went in each day to see them and have a chat", and, "The management is very good."

There was a culture of openness and transparency within the service. We were told that families were informed of any incidents affecting people living in the home and that a full explanation was provided. Investigation findings were shared with the appropriate people as was documentation of meetings. Where appropriate, apologies were expressed, along with details of how the service had learned from the events.

There was evidence that lessons had been learned from the analysis of accidents and incidents. Examples included precautionary referrals being made to other professionals such as tissue viability nurses and dieticians as a result of the accident analysis. Records also showed complaints were analysed to identify any

patterns or trends which might highlight the need to make changes to care practices.

We noted the provider and registered manager attended the resident and relatives meetings. Minutes seen demonstrated there were thorough and meaningful discussions around care issues and that open feedback was given about the home's compliance with standards. We also saw from minutes of a previous meeting that the findings from satisfaction surveys had been tabled and discussed. These were predominantly positive, with most people and their relatives rating the overall service as 'excellent' or 'good'.

A range of regular audits were carried out to check the quality of the service. Audits included infection control, environmental issues and care records. However, we noted that no medicines audits had been carried out in recent months. This meant that the recording deficits we had identified, including a period of 17 days where a person's medicine had been administered but no records were made, had not been picked up by the service.

We recommend the provider makes arrangements to reintroduce audits to ensure there is more robust governance of the management of medicines.

The provider had introduced an independent check on quality standards earlier in the year by commissioning an external company to carry out a full audit of the service. The audit was based on CQC fundamental standards of quality and safety for care services. As a result, an action plan had been drawn up that we saw was updated as improvements were completed. A nurse consultant had also conducted a quality audit in June 2016 covering areas including aspects of care, the environment and staff development. The registered manager told us the consultant was due to return to the home in September 2016 to check the identified improvements had been acted on.

The registered manager understood the importance of working in partnership with other agencies and professionals. They attended the local Registered Managers Networking Group and were an Independent Sector Representative on Bradford Safeguarding Adults Boards' Task Training Group and the Improving Practice Group.

The service was a member of various bodies and schemes for improving practice, including the Investors in People scheme, the CQUIN (Commissioning for Quality and Innovation) award; and the Social Care Commitment. The home held a five star rating from the Food Standards Agency. The registered manager told us they were looking to introduce an employee of the month to reward good work and innovation by staff members.