Runwood Homes Limited

Brewster House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Brewster House is registered to provide accommodation with personal care for up to 70 older people, including care and support for people living with dementia. There were 57 people living in the service when we inspected on 23 November 2016, plus an additional four staying for short-term re-ablement. This was an unannounced inspection.

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

Overall people were provided with their medicines when they needed them and in a safe manner. However additional work was needed in relation to the secure storage of medicines and ensuring people received their medicines when they lacked the mental capacity to decide for themselves that it was in their best interests to take them.

People received person centred care from staff who generally had a good knowledge and understanding of each person, about their life and what mattered to them. Additional training in specific health conditions would further strengthen staff's understanding of people's support needs.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support. Referrals for specialist advice had not always happened promptly which meant a delay in people receiving the support they needed.

There were sufficient numbers of staff to meet people's needs and recruitment processes checked the suitability of staff to work in the service.

There was a positive, open and inclusive culture in the service. The ethos of care was person-centred and valued each person as an individual. People were consistently treated with kindness, dignity, respect and understanding. People were empowered to have choice, independence and control in their daily lives.

People presented as relaxed and at ease in their surroundings and told us that they felt safe. Staff knew how to minimise risks and provide people with safe care. Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. People knew how to raise concerns and were confident that any concerns would be listened and responded to appropriately.

Care plans reflected the care and support that each person required and preferred to meet their assessed needs, promote their health and wellbeing and enhance their quality of life.

Staff understood the importance of gaining people's consent to the support they were providing. The

management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

There was a person centred, open and inclusive culture in the service. The service had a quality assurance system in place which was used to identify shortfalls and to drive continuous improvement. The management team were open and responsive to issues we raised and immediately began work on making changes as a result.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Overall people were provided with their medicines when they needed them and in a safe manner. Additional work was needed in relation to the safe storage of medicines and ensuring people received medicines as prescribed.

Procedures were in place to safeguard people from the potential risk of abuse.

There were systems in place to minimise risks to people and to keep them safe.

There were enough staff to meet people's needs. Recruitment checks were completed to make sure people were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff generally had the necessary knowledge and skills to be competent in their role. However, additional training in specific health conditions would further strengthen staff's understanding of people's support needs.

People had access to appropriate services which ensured they received ongoing healthcare support. Referrals for specialist input were not always made promptly.

Staff understood the importance of gaining people's consent to the support they were providing.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people. People's independence, privacy and

dignity was promoted and respected.

Staff had a good knowledge and understanding of people which meant their individual needs and preferences were fully met.

People were supported to have choice, independence and control in their lives. They were listened to and supported to express their views and make decisions, which staff acted on.

Is the service responsive?

Good

The service was responsive.

Care plans reflected the care and support that each person required and preferred to meet their assessed needs, promote their health and wellbeing and enhance their quality of life.

Staff were aware of the importance of physical and mental stimulation, social contact and companionship and supported people to access a range of meaningful activities.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

The service provided a positive, open culture. People were asked for their views about the service and their comments were listened to and acted upon.

The service had a robust quality assurance system and identified shortfalls were addressed promptly. As a result the quality of the service was continually improving. This helped to ensure that people received a high quality service.

Brewster 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 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 unannounced inspection took place on 23 November 2016 and was carried out by two inspectors, one of which was a pharmacy inspector, a specialist advisor who had knowledge and experience in dementia care, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the registered manager, two deputy managers, a director representing the provider, the dementia services manager and five other members of staff.

We spoke with seven people who used the service and four relatives. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed nine people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Records showed people were receiving their medicines as prescribed. There were internal audits in place to enable staff to monitor and account for medicines. , We fed back a to the management team record-keeping discrepancy in relation to a person's anticoagulant medicine suggesting they had received an incorrect dose which placed their health and welfare at risk of harm. The management team agreed that this was not acceptable and told us they would investigate the issue further.

Improvements were needed to ensure medicines were stored safely. Medicines were being stored at correct temperatures that were being monitored daily. However, a large window to the storage room remained open and doors to cabinets in which medicines were stored were not properly closed and locked. Medicines were not secure and could be accessed by unauthorised persons including vulnerable people using the service. We observed part of the morning medicine round and found that the door to the medicine trolley was left open when the trolley was unattended placing people living at the service at risk of access to medicines and accidental harm.

We noted some people refused their medicines, but there were no later attempts to give them.. Where people had limited mental capacity to make decisions about their own care or treatment, staff had consulted with their GPs who advised their medicines should be given to them crushed in food or drink (covertly). Appropriate mental capacity assessments had been carried out. However, for some people this action had not been put in place to help ensure they received their medication.

Supporting information was available to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on how people had their medicines given to them. Additional charts were in place to record the application of prescribed skin patches to ensure their safe use. Each person had a medicine profile with information about medicines that were prescribed for them, however, some profiles were inaccurate as they did not always record changes to prescribed medicines.

When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines. However, more detail was required for medicines prescribed in this way that were used to treat people's psychological behaviour to ensure they were used appropriately and consistently.

We discussed our concerns relating to the management of people's medicines with the management team. They immediately took action to address the issues we had raised.

People presented as relaxed and at ease in their surroundings and with the staff. A person told us, "How I feel safe is that I only have to press a button and someone comes – at home I'd be completely lost". Another person commented, "The door's locked at night, I feel secure". "It's the feeling of the place, it makes me feel safe". A third person said, "I'm fine and feel safe here. Staff attend to me when I need them without delay. I have my call bell beside me and they come to me when I press it".

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received up to date safeguarding training and were aware of the provider's safeguarding adults procedures. They were aware of their responsibilities to ensure that people were protected from abuse. Details of how to report concerns were displayed in the office and the staff room and staff members we spoke with demonstrated that they were aware of the procedures they should follow if they were concerned that people may be at risk.

Care records included detailed risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks specific to each individual according to their support needs. For example, risks associated with pressure ulcers, falls, malnutrition and moving and handling. A person told us, "I have been living here for the past one year and my risk of falls is well managed compared to where I came from." Risk assessments had been updated to reflect changes in people's needs. Such as the introduction of a bed rail for a person which had been risk assessed along with the appropriate assessment of capacity and physical need. This meant that staff had up to date guidance in order to protect people and others from the risk of harm.

The service were proactive in promoting fall prevention. Falls within the service were monitored, potential causes explored and action taken to minimise the risk of occurrence in the future. For example, people had been referred to their GP so that a medicines review could be carried out to establish if their medicines were making them more prone to falling. One person had also been referred to a Parkinson's nurse so that further professional advice could be obtained.

Risks to people injuring themselves or others were limited because equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. There was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

People were protected by robust procedures for the recruitment of care workers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks help employers make safer recruitment decisions and help prevent unsuitable care workers from working with people.

People mostly felt that there were sufficient numbers of staff to care and support them according to their needs. A person told us, "Sometimes they [staff] are a bit stretched, but only occasionally". "They're always available, they do come and have a chat". Another person said, "Sometimes you see more staff than others, it all depends – they're busy and you feel you've got to wait, and that's it". A relative commented, "There are always loads of them [staff] here." Another relative told us how lack of staff had been an issue in the past but, "Nowadays yes [there are enough staff], it doesn't seem to be an issue. [Relative] is not left alone." The service used a dependency tool to assess peoples care needs each month and calculate how many staff were required. This showed that the service were continually reviewing whether they had sufficient staff to meet the current needs of the people living there.

Requires Improvement

Is the service effective?

Our findings

Improvements were needed in staff training because their skills and knowledge varied and training did not reflect all the assessed needs of people using the service. Staff had received training in key areas such as moving and handling, medication, first aid, infection control, health and safety, mental capacity act and safeguarding. Staff were also trained and supported to be able to meet the specific needs of people living with dementia. However, staff had not received training in order to give them the knowledge they needed to support people with other health conditions such as Parkinson's, diabetes and epilepsy. One person told us, "I don't think they know a lot about Parkinson's disease". Another person explained how communicating their needs to staff could be difficult at times because of a difference in language and culture. They told us, "Sometimes I think to myself 'do they know what they're doing.' It's the way they go about things, medication and other things, because of the language sometimes it's a bit of a job to sort them out. Sometimes it takes a long time for things to sink in. They [staff] get there in the end. I think some of them could do with more training."

However, other people told us how staff were knowledgeable and able to support them with their specific needs. One person commented, "Any of them [staff] would come and do what I need, when I had trouble with my catheter they were ever so good, coming up and down to check me." Another person explained how staff took the time to find out about an issue of they didn't know the answer straight away. They said, "If you don't know something they'll (staff) go and ask and let you know – they usually remember and do something about it, they seem organised".

Staff told us that they felt supported in their role and had regular one to one supervision where they could talk through any issues, seek advice and receive feedback about their work practice.

The provider employed a dementia services manager who provided regular training and support to staff in 11 of their services. This included observational supervision of staff and guidance to assist them to have empathy and understanding when caring for people living with dementia. All staff had received a prompt card to remind them of the top ten tips for effective and compassionate communication. These tips included getting down to people's eye level, speaking slowly and clearly and allowing people time to respond. We saw staff putting this into practice, for example, one member of staff knelt down next to a person to explain that it would be lunch time soon, offered them reassurance and checked that the person understood what they had said. This demonstrated that there was a support system in place for staff that developed their knowledge and skilled and motivated them to provide a quality service.

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 registered manager told us that relevant applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. They told us about examples of this and the actions that they had taken to make sure that people's choices were listened to and respected. They understood when applications should be made and the requirements relating to MCA and DoLS.

Staff mostly sought people's consent and acted in accordance with their wishes. One person explained their preferences for moving around, "They (staff) transfer me from my bed to my wheelchair – if they're not sure I tell them about holding onto me and lifting my legs – they talk to me too". "I would rather use my wheelchair to go to the toilet than a hoist." Another person told us, "I'm well satisfied. They know when I like to get up, they say 'are you ready to get up?" However One person was happy with the care they were receiving but commented, "I don't like to be rushed, I like to get up at six, they do that, they wash me and dress me". They [staff] don't ask you, they just tell you what they're going to do." This demonstrated that additional work was needed to ensure staff understood the importance of giving people the opportunity to be able to make decisions for themselves.

Care plans identified people's capacity to make decisions. Where people did not have the capacity to consent to care and treatment, people's representatives, health and social care professionals and staff had been involved in making decisions in the best interests of the person and this was recorded in their care plans.

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Records showed that guidance and support had been sought from relevant professionals to ensure that all people's dietary needs were being met. We observed that people were encouraged to drink plenty of fluids throughout the day. A person told us, "We always have drinks available." Another person said, "There's always fluid available, night and day." This demonstrated that staff were aware of the importance of assisting people to stay hydrated in order to maintain good health.

Lunch time was a positive experience for those using the dining rooms, there was a vibrant and happy atmosphere as people and staff chatted together. Staff supported people who needed assistance in an appropriate way and interacted with them in a personable and caring manner. We observed one member of staff holding a person's hand between offering them food in order to reassure them. People were mostly complimentary about the food on offer. One person said, "The food is not too bad at all, plenty of choice, good quality. I have plenty of what I want, and I can ask somebody if I'm hungry". Another person said of the food, "It's very bland". However a third person commented that the food was, "Quite good, there's always two choices of the main meal, two choices of the sweet and all kinds of sandwiches at tea time, and it's all freshly cooked, warm and tasty."

Some people preferred to eat their meals in their bedroom and staff supported people with this. We observed a member of staff enter a person's room to ask them what they would like for lunch. They asked them in a clear and understanding manner, and when the person said they just wanted soup the member of staff knew what they liked and asked them if that is what they preferred. Families and other visitors were also welcome to eat meals with people. A person told us, "My (relative) ate with me today in my room". Meals and snacks were available at all times of the day. A member of kitchen staff said, "There's always

bread for toast, milk shakes, yoghurts and cereal if anyone wants anything at night time and I make soup up before I go for staff to give people at night. There's a fridge, microwave and toaster in all of the lounges".

People generally had access to health care services and received ongoing health care support where required. One person commented, "[GP] has come in when there's been a couple of things [GP] wanted to discuss, [GP] hasn't changed my medication." There was frequent contact with the district nursing team and staff kept a record of the reasons people had been referred and the outcome of each visit. Staff followed the guidance of the professional advice given. For example, one person told us how they had had some pain due to their catheter, "They've [staff] gone out of their way to get the district nurse quickly. They [staff] wash the site and keep it clean. I don't think I've ever had an infection with it."

Referrals to the speech and language therapy (SALT) team had not always been made promptly. A person who had previously been under the care of the SALT team had been assessed as being at risk of choking however a new referral had not been made. We discussed this with the management team who made a referral immediately and made arrangements for the SALT team to visit the person the following day.

Good

Is the service caring?

Our findings

The atmosphere within the service was relaxed and welcoming. A relative described the service as, "Superb." They added, "I was unbelievably dubious before [relative] came in. The minute [relative] got here, [they] loved it. I couldn't be happier that [relative] is happy." Another relative told us, "The [staff] make you feel welcome, they are friendly and support the relatives too."

People were positive and complimentary about the care they received. A person said, "They [staff] are always very good to me". We observed staff demonstrating empathy, understanding and warmth in their interactions with people. For example, we saw how during an activity a member of staff was attentive to all those present including one person who was unable to participate directly. When this person became anxious the member of staff sat with them, asked what was wrong. They explained things clearly to the person and provided reassurance in a meaningful way.

Staff had a good knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. One person told us, "I think they understand my needs. The staff have been keeping my spirits up. They say 'Morning [name of person], how are you this morning?' The staff are quite friendly and caring, and they do try to do their best for you." Another person said, "Yes I think they do understand me, I think they understand me better than I always understand them. I think on the whole most of them are very friendly." Staff were aware of what was important to people. A relative told us, "[Person] can't have a shower or a bath [due to bandaged legs. It's lovely because [staff] washed everything." They added, "They're [staff] good at matching up [person's] clothing, [person] likes to look nice." This demonstrated that the ethos of care was person-centred and valued each person as an individual.

Care plans documented people's likes and dislikes and preferences about how they wanted to be supported and cared for. For example, one person's care plan gave details about the type of toiletries they likes to use and how they liked to get ready in the morning.

People were involved in discussing their care and support needs. A person told us, "One of the [staff] comes to talk about my care plan, asks all of the different questions, they explain it to me. At first they involved my [relative] but usually they just ask me. They have asked questions about my past, things like that." People also had access to advocacy services which meant that they were supported to make their voice heard.

Where appropriate relatives were also involved in discussing peoples care and were kept informed. One relative said, "They [staff] tell us how [relative's] been, how [they've] been in the night. If they have any concerns. We have input into [relative's] care." However another relative told us that there had at times been a delay in them being updated. They said, "A couple of times [person's] had a fall and my [sibling] has not got to know until later in the day". One relative told us how they'd previously not been happy with the quality of the care records but that they had seen a big improvement. They said, "I've asked and gone through all the records. Previously they were not consistent. Now I don't ask [to look at records.] I don't need to." They explained that they had seen the improvement in care and support provided to their relative and no longer felt the need to check their records.

People wherever possible were encouraged by staff to make decisions about their care, support and daily routines. A person told us, "They're reasonably flexible, according to the staff that are on. They usually give me a choice [of when to get up.]" Another person explained how they were able to have a bath when they wished with support from staff, "They take us for a bath, always once a week I like to have it but it's quite strenuous for me. They're very good with me." People were supported to be independent where possible. For example, one relative told us, "[Person] is mobile with their frame, it's ideal here because [person] can walk down to the lounge and dining room [using the lift.]" This demonstrated that staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

People's privacy and dignity was mostly promoted and respected. One person told us, "Sometimes they knock, sometimes they just bowl in" However they added, "They cover me up when they're washing me, it is dignified." Another person said, "[Staff] have tried their best, there are a lot of [staff] here from the far east, and sometimes you have to explain things two or three times. They cover me up when they're washing me, I'm happy with that." A third person said, "They [staff] treat me as a person, they knock and call out if it's ajar [the door.]" This showed that staff recognised the importance of privacy and dignity as core values in the service and worked together with people to promote them.

Good

Is the service responsive?

Our findings

People and their families told us they received personalised care which was responsive to their needs and their views were listened to and acted on. A person expressed how they were happy with the support they received and commented, "I couldn't have coped on my own, they've helped me to get back to being able to be myself again."

Staff were knowledgeable about people and communicated with each other to pass on any changes in people's individual needs. A person explained that staff knew about their needs because, "I know that several of the staff that attend to me have read that [care plan.]" This helped staff to have a good understanding regarding the specific needs of people.

Care plans were person centred and reflected the care and support that each person required and preferred to meet their assessed needs. All aspects of people's physical, emotional and social needs were considered. Details were included relating to people's specific health conditions. For example, diabetes, Parkinson's, catheterization and use of a stoma bag. Although it was clear what people's specific needs were, some of the care plans relating to them lacked detail. For example, one person's diabetic care plan stated, "[Person] needs to eat a suitable diet for someone who is diet controlled diabetic." This needed additional detail to ensure staff understood the specific support the person needed with their diet and their preferences in relation to this.

People were involved in the planning of their care. Care plan's indicated that people and their relatives where appropriate had contributed to the documents relating to their current support needs and future wishes. For example, one person told us that they had a urine infection and had been advised to drink plenty of water. They were also aware of their other medical conditions and what was being done to treat these. This showed that the person was involved in their treatment plans and was kept well informed. The care plan for one person included a future decision plan which included details about their wishes in regard to their care in the future should they be unable to verbalise this. The plan was detailed and included input from the person and their family. This demonstrated that people were empowered to contribute to the assessment and planning of their own care and support needs.

People told us that staff responded fairly quickly to call bells and always within five minutes. One person told us, "It varies, sometimes it's very quick, occasionally you have to wait, you have to be patient – they've got other people to see to as well of course." Another person commented, "Sometimes they (staff) come and sometimes you have to wait five minutes – it hasn't caused me a problem, yes they always come". When staff were not able to assist people immediately they answered the call bell to explain they would be with them as soon as they were able. This communication with people meant they were reassured that staff would be able to provide them with the assistance they needed.

People told us about how they spent their day. One person told us, "I do quizzes, play games. I do word searches, colouring in books, knit scarves. "They added, "I feel uncomfortable about going out, I look forward to coming back to my room." They were reassured that although they didn't wish to go out, "There

is always a member of staff who would get what I want [from the shops.] There's one of the carer's allotted to you to do that."

An activities co-ordinator was employed by the service. A list of activities for the week was displayed on the main notice board and included exercises, games, arts and crafts, sing alongs, memory lane and current affairs. We saw some of these activities taking place which people were engaging in and enjoying together with staff. There was a regular church service on a Thursday morning and a Christmas lunch advertised in early December stating that family were welcome. One relative was disappointed that, "Nobody took [person] down to karaoke, [person] would have loved that, but I've asked [activities coordinator] to ask [person] next time."

In addition to the planned activities staff interacted with people and on a one to one basis throughout the day according to their individual needs. For example, one person sat in their chair between others nursing their doll on their lap. They appeared calm and relaxed. A group of people enjoyed a game of alphabet bingo led by a member of staff. The member of staff explained, "I ask them what they would like to do. I just get on with it. I try to do what they would do if they were at home." The dementia services manager told us that this was something which was actively encouraged and staff were empowered to engage in activities with people whenever they were able.

People were encouraged to maintain relationship with friends and family. One person told us, "They'll take me down in the wheelchair to see a friend along the corridor." A relative commented,
"Staff have said you can come anytime you like, as early and as late." This demonstrated that staff were aware of the importance of physical and mental stimulation, social contact and companionship and focussed on what was most important for individuals.

There was a complaints procedure in place which explained how people could raise a complaint. People felt comfortable speaking with the management team if they had any concerns. A person told us how they were not happy that a member of staff had used the corner of a towel rather than a flannel when assisting them to wash their face. They commented, "I feel that I might have a word with the manager about that flannel business. I'm sure [registered manager] will be diplomatic and handle it well." A relative said, "I feel I can approach anyone [with a problem.]" They added, "I haven't seen anything that would worry me." Records of complaints showed that they had been responded to appropriately and in a timely manner. This showed that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right.

Good

Is the service well-led?

Our findings

There was a person centred, open and inclusive culture in the service. A person told us, "I haven't regretted coming here, it was my choice and if I did it all again I would come here. There's never any smells or problems, everyone else living here seems very pleased."

People and their relatives told us that they felt well supported. A relative commented, "They're [management and staff] always approachable, very friendly". Another relative said, "This place has been superb. It's amazing how they remember all of my relatives [who visit] names." The provider and management team placed importance on sharing information about the service provision with people, their relatives and other visitors. Information was prominently displayed in the reception area including; the providers statement of purpose, residents guide, business continuity plan, latest CQC report and annual quality assurance review. There was also a bereavement information pack to provide guidance and support to families at the appropriate time.

People, relatives, visitors and staff all gave positive feedback about the current management and leadership of the service. One relative said, "[Registered manager] has made a concerted effort to turn things around." They added, "It's definitely improved a lot. I've previously made complaints, [relative] always used to be wet, [their] skin was breaking down. I was constantly complaining. When [registered manager] started I told [them] about my concerns. It does seem to have changed a lot, [relative] is never wet, [they] always look as though [they've] had their personal care attended to."

The management team were a visible presence within the service. One person told us, "[Registered manager] comes to see me, calls in when [they're] passing." Another person also commented, "[Registered manager] comes up and sees us. [They'll] call out and come in."

The positive culture was further promoted through the provider's Charter of Values which stated "Every person matters and will be treated equally, compassionately and with the utmost respect and dignity" Staff practice demonstrated this approach was being adhered to and they were clear on their roles, responsibilities and how they contributed towards the provider's vision and values. Care and support was delivered in a safe and personalised way with dignity, respect and independence promoted.

Staff were encouraged and supported by the management team and were clear on their roles and responsibilities. The positive culture in the service was further promoted amongst the staff team by the Brewster Team Pledge which stated; "We will listen and communicate. We will support each other. We will be assertive. We will have continuity and consistency." Staff had regular supervisions which enabled the management team to set clear expectations about standards and gave staff the opportunity to discuss issues openly and develop in their role.

Staff were confident that they could raise any issues of concern and that these would be dealt with appropriately. Staff told us that they were comfortable approaching the management team and were encouraged to question practice and implement new and improved ways of doing things.

This meant that staff felt valued and were motivated to drive continual improvement within the team.

The provider had quality assurance systems in place which were used to identify shortfalls and to drive continuous improvement. People, their relatives and staff were asked for feedback through surveys and both formal and informal meetings. Action was taken as a result of the feedback received. For example, action taken as a result of a recent activities satisfaction survey was recorded as, "I have two karaoke DVDs on the way so staff can participate." We saw these being used on the day of our inspection. This showed that people were empowered to voice their opinions and could be confident that they would be listened to and appropriate actions would be taken to improve the service.

Where we found shortfalls in relation to medicines management and a delay in making referrals to the speech and language therapy team, The management team were open and transparent and sought feedback to improve the service provided. They took prompt action to remedy these issues and demonstrated how they intended to use our feedback to make further improvements within the service.