Sundridge Developments Limited

Edenvale Nursing Home

Inspection report

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Date of inspection visit:
04 April 2018
05 April 2018

Date of publication:
16 May 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 04 and 05 April 2018. The inspection was unannounced.

Edenvale Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Edenvale Nursing Home provides accommodation and personal care for up to 35 older people some of whom may be living with dementia. There were 29 people living at the home at the time of this inspection. Accommodation at the home is provided over three floors. There are large gardens and patio area's which provide a safe and secure private leisure area for people living at the home.

There was a registered manager in place. 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 and associated Regulations about how the service is run.

Relevant recruitment checks were conducted before staff started working at Edenvale Nursing Home to make sure they were of good character and had the necessary skills. However, there were unexplained gaps in staff employment histories.

Staff sought consent from people before providing care or support. The ability of people to make decisions was assessed in line with legal requirements to ensure their liberty was not restricted unlawfully. Decisions were taken in the best interests of people. However, we had not been informed where people had a Deprivation of Liberty safeguarding authorisation in place.

People and their families expressed the view staffing levels needed to be improved especially at weekends. The registered manager and provider were actively recruiting to fill a staff vacancy for a cleaner at the weekend.

People told us they liked the food. People received varied meals including a choice of fresh food and drinks. People were supported and encouraged to make choices and had access to a range of activities.

People felt safe living at Edenvale Nursing Home and risks to people were minimized through risk assessments. There were plans in place for foreseeable emergencies.

Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. People were supported to take their medicines safely from suitably trained staff. Staff were aware of people's likes and dislikes and went out of their way to provide people with what they wanted.

Staff received support and one to one sessions or supervision to discuss areas of development. They completed a range of training and felt it supported them in their job role. New staff completed an induction programme before being permitted to work unsupervised.

People were cared for with kindness, compassion and sensitivity. Care plans provided comprehensive information about how people wished to receive care and support. This helped ensure people received personalised care in a way that met their individual needs.

The registered manager maintained a high level of communication with people through a range of surveys and meetings. 'Residents meetings' and surveys allowed people and their families to provide feedback, which was used to improve the service. People felt listened to and a complaints procedure was in place.

There were appropriate management arrangements in place. Regular audits of the service were carried out to assess and monitor the quality of the service.

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 had deteriorated to requires improvement.

Improvements were needed to ensure recruitment practices were safe.

People and their relatives expressed the view staffing levels were not always safe at weekends and felt more management presence was required at weekends.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Edenvale Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 04 and 05 April 2018 and was unannounced. The inspection team consisted of two inspectors 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 kind of service.

Before this inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. We also checked other information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people who used the service and eleven relatives. We also spoke with the registered manager; director of operations, temporary manager, deputy manager, two registered nurses, chef, activity coordinator, and three care staff. We looked at a range of records which included the care records for five people, medicines records and recruitment records for four care staff. We looked at a range of records in relation to the management of the service, such as health and safety, minutes of staff meetings and quality assurance records.

We last inspected the home in June 2016 where no concerns were found. The home was rated as good in all domains.

Requires Improvement

Is the service safe?

Our findings

Most of the people and their relatives told us they felt safe. One person said, "They check that the windows are closed at night. That's important, being on the ground floor and they check us every hour". A relative told us, "Yes, she's safe. There's a good level of staff who know her." Another relative said, "It's very good, there's always lots of staff. They give [person's name] lots of attention. [Person's name] loves the staff and they interact with her well". However we spoke to a relative who told us, "Not always. They don't seem to feel he's wobbly on his feet. I feel they don't notice. He fell last week in the corridor. We choose to come here, but also we feel we need to be here. On days when I'm not here and no one in the family can cover for me, it's a big worry". We spoke with the registered manager about these concerns and they told us they would look into them.

Recruitment processes were followed that meant staff were checked for suitability before being employed by the service. Staff records included an application form, two written references and a check with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, there were a couple of unexplained gaps in staff employment histories and a missing employment reference from one file. We spoke with the registered manager about this who took immediate action to obtain and document the information. They also advised that a full audit would be completed of all staff files and additional measures put in place to prevent any reoccurrences.

We received mixed views about staffing from people and their relatives and about how much time staff had to support people. Most people felt there were enough staff in general but felt at weekends they were short staffed. One person told us, "I think there's enough [staff]". Another person said, "No, not at weekends. Sometimes at the weekends they only have three. It's alright in the week. I don't know how often the senior staff should be here, but you never see them at weekends". A relative told us, "There's not the same level of care at weekends. The bed linen is not as it should be. It wasn't clean on Saturday, but when we came on the Wednesday it was fine. Apart from that, no complaints".

Staff rotas were planned in advance and reflected the target staffing ratio we observed during the inspection and the same amount of staff at the weekend. However, the registered manager was in the process of recruiting an extra cleaner to assist at weekends. During the inspection we saw that staff were not rushed and responded promptly and compassionately to people's requests for support. Staffing levels were determined by the number of people using the service and their needs.

We spoke with the registered manager about the concerns raised about staffing levels. They told us, "We have done well with recruitment and have been able to reduce agency staff. I will come in on nights and weekends if needed to stop agency staff which has helped with better team work." They also told us that, whilst some people did not feel there were sufficient staff at the weekend, care staffing levels at this time remained the same as on weekdays. They told us management would often carry out announced and unannounced visits at weekends.

People were kept safe as staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. The staff members we spoke with had undertaken adult safeguarding training. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member said, "I would report anything like abuse to the manager. If they didn't act, I would let the CQC know".

People benefited from staff that understood and were confident about using the whistleblowing procedure. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. One staff member told us, "I would speak to [registered manager's name] and make her aware and if not dealt with go to her manager or whistleblowing line".

People were supported to receive their medicines safely. We looked at the Medicines Administration Records (MAR) for all people living at the home. We noted there were no gaps in these records. All MARs contained a front sheet with a recent photograph for identification purposes, along with relevant information, such as the person suffered from allergies or preferred to take their medicines in a particular way.

There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. Where people had been prescribed medicines to be given 'when required' (PRN) protocols were in place for all medicines taken this way; they outlined how, when and why they should be taken and included maximum doses over a 24 hour period. We noted where a person could be given varying numbers of tablets, for example one or two painkillers, that this was clearly recorded on MARs.

Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

People had individual risk assessments that identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Staff showed that they understood people's risks and we saw that risk assessments were monitored and reviewed every month. These included environmental risks and any risks due to health and the support needs of the person. Risk assessments were also available for moving and handling, use of equipment, medicines, bedrails, skin integrity, choking, medical conditions and falls.

Risk assessments had been completed for the environment and safety checks were conducted regularly on electrical equipment. A fire risk assessment was in place and weekly checks of the fire alarm, fire doors and emergency lighting were carried out. Records showed staff had received fire safety training. Staff were aware of the action to take in the event of a fire and fire safety equipment was maintained appropriately. The home had a business continuity plan in case of emergencies. This covered a range of eventualities and arrangements were in place in case people had to leave the home in an emergency. There were Personal Emergency Evacuation Plans (PEEP) in care plans which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood.

We observed staff assisting people to move using a variety of hoists and stands. There were enough staff to do this safely; staff were evidently competent in managing this and treated people with dignity and respect whilst undertaking it. For people whose mobility was restricted, or were bedbound, they had access to their call bells. One person told us, "Once. I thought the door was closed and I put out my hand to push it and I

fell. They said I went down like an angel; I just crumpled, without a sound. They got me up with the hoist. They were so kind. They couldn't do enough for me. They let me go to the toilet on my own now after 16 months; they didn't before because of the falls. It means a lot to be able to do that. They really do look after you".

Care plans contained information concerning the occurrence of accidents or incidents, including falls. It was identified where, when and how accidents had occurred. Therefore it was possible to identify any trends concerning areas of the home people were most at risk in and to target preventative measures there. For example, one person had been referred to the Falls Prevention Team following a number of falls. One person told us, "I rang the bell and in minutes they were on the scene. It was really good".

The home was clean and tidy and staff demonstrated a good understanding of infection control procedures. We did not detect any malodours during our visit. The provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves. There were also individual infection control risk assessments in people's care plans. There were ample hand hygiene stations throughout the home. All hand basins contained hot running water, soap and disposable towels. However we found a torn chair in one person's room which posed an infection control risk. We spoke with the registered manager who informed us they would replace the chair.

Good

Is the service effective?

Our findings

People were effectively supported to eat and drink enough to meet their needs. People told us they liked the food. One person said, "It's very nice and there's plenty of it. They come and ask, there's a choice of two things". Another person told us, "It's good, they're very liberal with the portions. I eat well. If I don't like it, they get me something else. This morning I had breakfast at 8.30 but later on I was so hungry, I said to one of them 'Could you ask the chef for a piece of toast ', they brought back two slices of toast and marmalade". A relative told us, "The food is excellent".

People were asked where they wanted to sit in the dining room and they were assisted to sit at the table of their choice. Staff were attentive to people, and were encouraged to eat. Some people needed assistance to eat whilst others needed help to cut their food and were asked about the assistance they required. For example, they were asked if they wanted gravy. Staff were pleasant and chatted with residents. However, we observed one staff member assist one person to eat. They did this in a hurried manner, bringing a spoonful of food up to their mouth while they were still eating, on several occasions. Another person seated next to the staff member was provided with a meal. The staff member then proceeded to assist both people to eat. Then after a while, a visitor who was visiting their relative who was seated at the table took over assisting the person to eat. Although the visitor knew the person they appeared confused about who they were and asked her if they were a family member. We spoke with the registered manager who informed us they were disappointed about this and had not observed this before.

We recommend the registered manager and provider continues to monitor people's experiences at mealtimes to promote an enhanced meal time experience for people living with dementia.

The staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves. The care plans we looked at reflected this. We saw a variety of referrals and assessments had taken place, including those involving dieticians and speech therapists.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Supervisions provided an opportunity to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Staff told us they felt supported and that they could talk to senior staff at any time. However, formal supervisions had fallen behind schedule. One staff member told us, "Supervision's meant to be more often, not had mine for a while it's due soon". Another staff member said, "We get supervision regularly and that's really good. We get to have our say". We spoke with the registered manager and provider who were aware supervisions had fallen behind schedule and extra administration support had been provided to allow staff time to carry out regular supervisions and a schedule of regular supervisions had been arranged with staff.

New staff to Edenvale Nursing Home completed an induction programme. Arrangements were in place for staff who were new to care to complete The Care Certificate. The Care Certificate is awarded to staff that

complete a learning programme designed to enable them to provide safe and compassionate support to people. One staff member told us, "I completed the Care Certificate over two weeks in the training room. Also had lots of refreshers training since". Another staff member said, "Just changed trainers and training is now longer and more in depth. Trainer really enthusiastic and gives you a chance to ask questions". Other comments included, "Training recently been every week. Just got a system come up, all up to date".

Nursing staff received both peer and managerial support during the revalidation process. Revalidation must be undertaken periodically by all registered nurses in order to remain on their professional register. This involves demonstrating the nurse's practice and training is up to date and relevant to the work they do. A registered nurse told us, "It's much better than it was. There were some staff members last year who were undertaking (nursing) procedures without training, but that has improved now".

A training and development plan was in place. The operations director told us they had increased training as it had been out of date and were now offering staff the opportunity to complete a national qualification in care. They had also been working with the registered manager to put a development plan in place for supervisions, which included additional administration support to provide management to be more clinical to support staff with supervisions. As a result plans and contracts were in place with staff and dates set for supervisions and training. The service had also supported staff to become moving and handling champion's which were starting in March and by the end of April all moving and handling training would be complete with an on going support for all staff.

Staff had received training in the Mental Capacity Act 2005 (MCA). 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. Staff showed an understanding of the MCA. Before providing care, they sought verbal consent from people and gave them time to respond.

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 authorisation 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. Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment. Staff were aware of the support required by people who were subject to DoLS to keep them safe and protect their rights.

People's mental capacity had been assessed where this was appropriate and had been incorporated into their care plans. This gave clear information for staff on how to ensure they received consent from people before supporting them. For example, each care plan identified whether a person was able to participate in the decisions about an aspect of their care and how staff should support them with this. Where people were unable to provide this consent, staff had completed decision specific best interests' assessment involving relatives and representatives of the person as appropriate.

Care records showed one person needed to receive their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person is refusing treatment due to their mental health condition. Staff had ensured families and health care professionals had been fully involved in a best interests' decision making process about the administration of these medicines. This was in line with the Mental Capacity Act 2005 to ensure the safety and welfare of the person. However, covert medication

was only used on the occasions where people refused their medicines. All attempts were made not to give medicines covertly unless absolutely necessary.

People were supported to access healthcare services when needed. One relative told us, "He gets very good care. He was in hospital and if he'd been in there longer, we would have lost him. He's got dementia and in hospital no one had time to talk to them. Back here, the staff have been marvellous and have given him the care he needs. He was in bed and needed nursing care. He wasn't eating, but they slowly built it up". Records showed people were seen regularly by doctors, specialist nurses and physiotherapists. Care plans were in place for to give staff clear guidance on the care needs of people who lived with specific health conditions; for example, we saw one person lived with Parkinson's disease and the added risks to their mobility and falls and how their condition can affect differently each day was identified in their care plans.

The provider was in the process of updating the home making the environment appropriate for the care of people living there. There was a programme of redecoration in place and being completed at the time of the inspection. New carpets flooring and curtains were planned for later in the month, after the painting had finished. The provider had arranged for an external dementia audit of the environment to improve the quality of the environment. New signage and accessories had been suggested which the provider told us they were planning to implement soon.

Good

Is the service caring?

Our findings

People and their relatives told us they got on well with staff and staff treated them with kindness and compassion. One person told us, "Oh, more than kind. They are very nice girls and they work jolly hard." Another person said, "It's like being friends. They've become good friends." Other comments included, "Ever so, even the youngsters. They give me a kiss, a peck on the cheek. I think it's so nice". As well as, "It's lovely. The staff are lovely and nothing is too much bother. If my friend comes, I can ask for a drink and I get it. Nothing is too much bother". A relative told us, "They're [staff] friendly and helpful." Another relative said, "I always feel comfortable coming in. Usually you see a member of staff who knows you. Some of the staff have been here for years".

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. It was evident staff saw people as individuals. One staff member told us, "I think it's very homely here". We asked staff if they thought the home was a caring place. One staff member told us, "I think so, definitely. I wouldn't stay if it wasn't".

We observed care and support given to people throughout the day. We found the care to be safe and appropriate, with adequate numbers of staff present. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. Staff were responsive to people's needs and addressed them promptly and courteously. It was evident all staff knew all people really well; for example, staff knew people's food preferences without referring to documentation. Those at risk were monitored closely but discreetly where necessary; for example, those presenting with choking risks.

People experienced care from staff who understood the importance of respecting people's privacy and dignity, particularly when supporting them with personal care. One relative told us, "There's a nice atmosphere. You can tell it's OK by the way staff talk to them. They are all treated with respect". Staff told us that privacy and dignity was adhered to and we observed care was offered discretely in order to maintain personal dignity. People's privacy was protected by ensuring all aspects of personal care was provided in their own rooms. One staff member told us, "If I enter a room I knock on the door and wait for them to answer. If they need personal care I take them back to their room to complete". Another staff member said, "Knock on the door introduce yourself make sure door closed and talk through what you are doing and maintain dignity".

We looked at people's care plans regarding their end of life care. No-one at the home was currently in receipt of end of life care. The care plans we looked at contained information concerning where the person would prefer to end their life and who should be present. We also noted cultural and spiritual beliefs were taken into account. For example, one person was a Jehovah's Witness and did not want the use of blood or blood products at any point.

Confidential information, such as care records, were kept securely and only accessed by staff authorised to view it. When staff discussed people's care and treatment they were discreet and ensured people's care and

treatment could not be overheard.

Good

Is the service responsive?

Our findings

We received mixed views about activities arranged in the home. One person told us, "I do my walk along there twice a day. I knit, one of the nurses brought in some wool, and I do crosswords and read my bible. This afternoon they'll bring in some magazines. I'm never bored. My church comes in sometimes". Another person said, "I'm just up here in my room. I have the chance to go down into the lounge if there's something special going on. I don't always feel like it". A relative told us, "They had parties and singing. She joins in with the singing and has a dance. [Person's name] doesn't have the ability to do crafts, she'll sit at the table and do bits and pieces". Another relative said, "There's day-to-day stimulation, but it's getting the consistency. There's mental stimulation, but there could be physical training, like chair exercises or throwing around a balloon. It does depend of the ability of people, but three or four of the ladies definitely need more stimulation." A third relative told us, "I don't know if there's enough activities. I visit another home where people are doing things and there's signs up about what's going on in the lift and the living room, but here there's no signs. I think it's nice for people to have music and to sing".

The activities coordinator was on holiday on the first day of the inspection and no activities were provided. We spoke with the activity coordinator on the second day of our inspection and we observed people arranging a flower display. Records showed that activities included, quizzes, outside entertainers, reminisce, bingo, cooking, music, and one to one session with people. A weekly programme of events were organised and details of upcoming activities placed in people rooms so people would be aware of what activities they could participate in. They told us they were in the process of completing; 'This is me' life histories with people to make activities more person centred and were completing a national training qualification in activities.

People experienced care that was personalised and care plans contained detailed daily routines specific to each person. Care plans provided information about how people wished to receive care and support. Assessments were undertaken to identify people's individual support needs and their care plans were developed, outlining how these needs were to be met. Care plans were comprehensive and detailed, including physical health needs and people's mental health needs. For example, one person could exhibit distressed and sometimes challenging behaviours. Staff had recorded incidents related to this in behavioural charts in order to identify potential triggers. A care plan was produced which informed staff in which verbal and non-verbal ways distressed behaviour manifested itself. There was also a plan of action, outlining tried and tested methods to calm the person, including Bible readings and the use of music.

Staff told us they reviewed care plans with people monthly. Records confirmed that people received appropriate care and staff responded effectively when their needs changed. People or their relatives had signed care plans demonstrating they had been involved in identifying how their needs would be met.

People's needs were reviewed daily through a daily handover. One staff member told us, "Handovers every morning go over what's happened over night and get handover sheets. Also get told what's happening in the day". This ensured important information were passed between staff throughout the day and night to make sure that important information about people's well-being and care needs were handed over to all the staff

coming on duty.

Residents meetings' were held regularly and people's families were also invited to attend. A relative told us, "They're very good. They address situations as they come up." Another relative said, "The next one is on Saturday. Four regulars attend and there's usually four or five other relatives on top. The families advocate on behalf of the patients, but the patients can attend as well." Minutes showed people were kept informed about any changes and asked their views about aspects of the service such as refurbishment update. The service also sought feedback from people and their relative's members through the use of a quality assurance survey questionnaire which was sent out yearly.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider was in the process of purchasing larger menu and activity boards and clearer signage to ensure information was accessible for all people living at the home.

People knew how to complain or make comments about the service and the complaints procedure was prominently displayed. One person told us, "I would report anything I see because it's not fair on those people who can't speak up." A relative said, "In general it's pretty good. We've got no complaints." The complaints procedure contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. The staff we spoke with were clear about their responsibilities in the management of complaints. Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

People and their relatives felt the home was well run. One person told us, "Everything seems to run very well." Another person said, "Oh yeah. She's [registered manager] very kind. She's very strict with the staff though." A relative told us, "[The manager] is very switched on, she's got her finger on the pulse." Other comments included, "Very well. To be honest I dreaded [person's name] coming into a home, but it's all been good." As well as, "They're very welcoming and good with the residents and with the relatives."

People and their relatives told us they would recommend the home. One person told us, "I already have to my friends. I said, 'You put your name on the list." Another person said, "Yes, definitely." A relative told us, "I would recommend it. I have done. We looked at every single home in the area and this was the most wonderful." Other comments included, "Yes, we have." As well as, "Yes, definitely."

Staff told us they felt supported by management. One staff member told us, "I love it here. I feel very supported in my role very good manager". Another staff member said, "Manager lovely, very understanding and supportive. She's really good. Nurses all supportive as well". However some staff felt the registered manager should be more authoritative in their role. They told us, "Manager is good I wish she would be a bit more tougher about staffing issues. It has calmed down a bit but some staff bring in personal problems into work and moan about each other and sometimes it's not nice to work in". Another staff member said, "I like the manager but they're not tough enough. Some staff take advantage". A third staff member said, "I think things have improved; the manager is really hard working".

Whilst the provider had system in place to identify incidents and provide us with notifications about these, they had failed to notify us about all incidents as required. A notification is information about important events which the service is required to send us by law. The provider had sent us notifications relating to most incident's, including, serious injuries, safeguarding and deaths. However, they did not tell us about an incidents where a person had a Deprivation of Liberty Safeguarding authorisation in place. We spoke with the registered manager who acknowledged that these notifications should have been made and had made arrangements to monitor these notifications in future.

Staff meetings were held with nurses and care staff and minutes showed these had been used to reinforce the values, vision and purpose of the service. Concerns from staff were followed up quickly. Staff were encouraged to read minutes if not able to attend meeting. One staff member told us, "I've been to one staff meeting. It was good about standards at the home and trying to be the best we can be".

The registered manager used a system of audits to monitor and assess the quality of the service provided. These included care plans, medicines, infection control, and health and safety. For example with medicines they looked at the wider aspects of medicines management, such as storage and disposal. Records showed issues raised in these reports were dealt with promptly and effectively.

There were processes in place to enable the manager to monitor accidents, adverse incidents or near misses. This helped ensure that any themes or trends could be identified and investigated further. It also

meant that any potential learning from such incidents could be identified and cascaded to the staff team, resulting in continual improvements in safety.

In addition to the audits, the home was supported by the director of operations who visited the home regularly to support staff and speak to residents. Part of their role and support involved carrying out an informal inspection of the home during their time spent in the home. Where issues or concerns were identified they spoke with the registered manager and told us they often speak to the registered manager about staffing and dependency levels. However they were aware no formal records of their conversations or actions were recorded and are planning to now make this process more formal. They were also available to support staff and monitor the quality of the service provided.

The provider had appropriate polices in place which were supplied by the provider as well as a policy on Duty of Candour to ensure staff acted in an open way when people came to harm.