Lifestyle Care Management Ltd

Brook House Care Centre

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?	Good

Summary of findings

Overall summary

This inspection took place on 29, 30 and 31 March 2016 and was unannounced. Brook House Care Centre opened in 2002. The home was registered with a new provider, Lifestyle Care Management Ltd also known as Orchard Care Homes, in November 2015. This was our first inspection of the registered provider at this location. The inspection was also undertaken to check on concerns we had received about the service in relation to safety.

Brook House Care Centre is registered with CQC to provide accommodation and nursing care for up to 74 adults, including adults with disabilities and people with dementia. At the time of this inspection the home was providing nursing care and support to 58 people.

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

People using the service said they felt safe and staff treated them well. Appropriate recruitment checks took place before staff started work. There were enough staff on duty and deployed throughout the home to meet people's care and support needs. Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported from abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

Staff had completed an induction when they started work and they were up to date with the provider's mandatory training. The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans. People had access to a GP and other health care professionals when they needed them.

Staff spoke to and treated people in a respectful and dignified manner and people's privacy was respected. People using the service and their relatives, where appropriate, had been consulted about their care and support needs. Care plans and risk assessments provided guidance for staff on how to support people with

their needs. There was a range of appropriate activities available for people to enjoy. People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

People using the service, their relatives and visiting professionals told us there had been many improvements made since the manager started working at the home. Staff said they enjoyed working at the home and received good support from the manager. The provider took into account the views of people using the service and their relatives about the quality of care provided through relatives and residents meetings and surveys. The manager used the feedback from the meetings and surveys to make improvements. The manager carried out unannounced visits to the home to make sure people where receiving appropriate care and support.

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.

There were appropriate safeguarding adults procedures in place and staff had a clear understanding of these procedures.

There were enough staff to meet people's needs. Appropriate recruitment checks took place before staff started work.

Appropriate procedures were in place to support people where risks to the health and welfare had been identified.

Medicines were managed safely and records showed that people were receiving their medicines as prescribed by health care professionals.

Is the service effective?

Good

The service was effective.

Staff had completed an induction when they started work and received training relevant to the needs of people using the service.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

People were protected against the risks of inadequate nutrition and dehydration. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans.

People had access to a GP and other health care professionals when they needed them.

Is the service caring?

Good

The service was caring.

Staff spoke to and treated people in a respectful and dignified

manner. People's privacy was respected.

People using the service and their relatives were provided with appropriate information about the home before they moved in.

People using the service and their relatives, where appropriate, had been consulted about their care and support needs.

There were arrangements in place to meet people's end of life care needs.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

People were provided with a range of appropriate social activities.

People using the service and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Good

The service was well-led.

The home had a registered manager in post. People using the service, their relatives and visiting professionals told us there had been improvements made at the home since the manager arrived.

There were appropriate arrangements in place for monitoring the quality of the service that people received.

The provider took into account the views of people using the service and their relatives about the quality of care provided at the home through relatives and residents meetings and surveys.

The manager carried out unannounced visits to the home to make sure people where receiving appropriate care and support.

Staff said they enjoyed working at the home and they received good support from the manager. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

Brook House Care Centre

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. The inspection was also undertaken to check on concerns we had received in relation to safety.

This unannounced inspection was carried out on 29, 30 and 31 March 2016. The inspection team on the first day 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 type of service. One inspector returned to the home on the second day. A team of three inspectors and a specialist nurse advisor visited the home on the third day to speak with the registered manager and examine records related to the running of the home.

Before the inspection we looked at the information we held about the home including notifications they had sent us. A notification is information about important events which the service is required by law to send us. We spent time observing the care and support being delivered. We spoke with seven people using the service, four relatives, a visitor, five health and social care professionals, twelve members of staff, the chef, the homes clinical lead nurse, the registered manager and the operations manager. We also received feedback from a tissue viability nurse and the local authorities care home support team on their views about the home. We looked at records, including the care records of ten people using the service, seven staff members' recruitment records, staff training records and records relating to the management of the service.

Not everyone at the service was able to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Our findings

People told us they felt safe and that staff treated them well. One person said, "I feel safe here". A relative said, "I think my husband is safe here. There is more staff now." A relative told us they were happy with the care their husband received. They said, "He's safe. The regular staff are very nice. New staff have started so hopefully they will use less agency staff now."

The home had a policy for safeguarding adults from abuse and a copy of the "London Multi Agencies Procedures on Safeguarding Adults from Abuse". The manager was the safeguarding lead for the home. Staff demonstrated a clear understanding of the types of abuse that could occur. They told us the signs they would look for, what they would do if they thought someone was at risk of abuse, and who they would report any safeguarding concerns to. The manager said they and the staff team had received training on safeguarding adults from abuse. Training records we saw confirmed this. Staff told us they were aware of the organisation's whistle-blowing procedure and they would use it if they needed to. At the time of this inspection there were two safeguarding concerns being investigated by the local authority. We cannot report on these at the time of this inspection. The CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

We observed a good staff presence and staff were attentive to people's needs. Some people using the service and their relatives told us there was always enough staff on duty to meet their care and support needs. They told us that a lot of agency staff had previously worked at the home however they noticed an increase in permanent staffing levels and they were aware that the home had employed a number of new staff. One person said, "The staffing here has improved, I think they are paying them more money." A relative said, "There is enough permanent staff around now, but there wasn't at one point last year. Things have really improved. It's much better now. They don't use as many agency staff so the residents know who is looking after them." A member of staff told us, "Things are much better now that we have more staff. We have more time to talk to the residents and do all the things we need to do." The manager said staffing levels were arranged according to the dependency needs of people using the service. They told us they had increased staffing levels in order to meet people's needs and to reduce the homes reliance on agency staff. The provider had employed 32 new staff following a recruitment drive in January. At the time of this inspection seven of these staff had started working at the home. The manager said they were awaiting recruitment checks to be completed before the remaining staff would begin work.

Appropriate recruitment checks took place before staff started work. We looked at the recruitment records of seven members of staff and found completed application forms that included their full employment

history and explanations for any breaks in employment, two employment references, health declarations, proof of identification and evidence that criminal record checks had been carried out. We saw that checks were carried out to make sure nurses were registered with the Nursing and Midwifery Council (NMC). The manager told us that the organisation monitored each nurse's NMC registration to make sure they were able to practice as nurses. The manager monitored the on-going suitability of staff and took action in line with their policy in relation to concerns about staff suitability.

Action had been taken to support people where risks to them had been identified. Assessments had been carried out to assess the levels of risk to people in areas such as falls, moving and handling, nutritional needs, and skin integrity. For example, where people had been assessed at risk of falling we saw training and guidance had been provided to staff on the prevention of falls. We saw their care plans recorded the support they needed from staff to ensure safe moving and handling. Where people had had a fall we saw these were documented and their risk assessments and care plans updated. Where people had pressure sores we saw advice had been received from a tissue viability nurse and healing of these wounds had been monitored. We also saw that fluid and dietary intake charts were in use where required and these were kept in folders in people's rooms to aid effective recording.

The manager told us the provider planned to refurbish the home. At the time of our inspection a part of one unit in the home was cordoned off for the safety of people using the service and was being redecorated. There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely. Staff said they knew what to do in the event of a fire and told us that regular fire drills were carried out. Staff training records confirmed that all staff had completed training on fire safety. We saw that where required call bells had been placed within peoples reach. We observed that staff responded quickly when call bells were activated.

People told us they received their medicines when they were supposed to and when they needed them. One person said, "The staff let me know what medicines I need to take. I get my medicines on time." Another person said, "They are looking after me. I get my tablets when I need them."

Medicines were administered safely. We spoke to a nurse about how medicines were managed and observed a medication round. They told us that only trained staff administered medicines to people using the service. We saw medicines competency assessments had been completed by these staff before they could administer medicines. We observed the nurse administer medicines to people safely in a caring and unrushed manner. We looked at the medicines folders for two units at the home. These were clearly set out and easy to follow. They included individual medication administration records (MAR) for people using the service, their photographs, details of their GP, information about their health conditions and any allergies. Special instructions were recorded for individuals indicating their preferred method of receiving their medicines. For example one person liked to have their medicines with a glass of warm water. We observed the nurse following these instructions. All medicines were reviewed regularly to ensure they met any changes in people's health needs. As required medicines (PRN) were recorded on MAR's and signed for by staff when administered. There was individual guidance in place for staff on when to offer people PRN medicines. We observed the nurse asking people if they needed their PRN medicines for example, checking if they were in any pain.

We checked the balances of medicines stored in the medicine cabinet for four people using the service against the MAR and found these records were up to date and accurate. Daily medicines fridge and clinical room temperature monitoring was in place and recordings were within the appropriate range. Regular audits of medicines were completed to monitor and reduce the likelihood of any risk. Each audit had an

associated action plan and one was seen on the units clinical room notice board so staff were reminded of actions required such as "All medicine boxes and bottles must be dated when opened." These processes helped protect people from the risks associated with inappropriate use and management of medicines.

Medicines were stored securely in locked trolleys and controlled drugs stored in a cabinet in the locked clinical room. There were safe systems for storing, administering and monitoring of controlled drugs and arrangements were in place for their use. We saw a controlled drugs record book. This had been signed by two nurses each time a controlled medicine had been administered to people using the service. Daily checks of controlled drugs were in place and were documented in the controlled drugs record book. Nurses counted the drugs at handover times twice a day. The home had a safe system for the disposal of medicines. We saw records of medicines destroyed had been signed and dated by staff.

Good

Our findings

One person using the service told us, "The staff know me very well and what my needs are." Another person said, "The staff are consistent with the care they give me." A relative said, "The staff are meeting my husband's needs, they know what they are doing here. There are some new staff and they are going through training at the moment."

Staff said they had completed an induction, in line with the care certificate, when they started work and they were up to date with the provider's mandatory training. One member of staff told us they were shadowed by experienced staff as part of their induction before they were permitted to work alone. We looked at staff training records which confirmed that staff had completed an induction when they started work. This included training the provider considered mandatory and training relevant to the needs of people using the service. Mandatory training included safeguarding adults, health and safety, moving and handling, infection control, first aid awareness, fire safety and food hygiene. One member of staff told us the manager had supported them to access specialised training and had been flexible with their shifts which enabled them to attend the training classes each week. Another staff member told us they had been supported to gain additional training in pressure ulcer management and they were now the champion for the home.

Where nurses had recently been employed we saw the provider had obtained evidence of their previous training and experience. For example one nurse had previously worked at a nursing home and had training on catheterisation, emergency first aid, dementia care, medicines and moving and handling. We saw this nurse had completed an induction and had been monitored by senior nurses and the clinical lead nurse. The manager showed us a training program for April and May 2016 for new nursing staff. This training included topics such as, pressure sore prevention, safe use of insulin, diabetes management, tissue viability, oxygen therapy, dysphagia, palliative care and falls prevention.

A health professional told us they had visited the home every week since August 2015. They provided staff with pressure ulcer prevention training in September 2015 and had scheduled further training for April 2016. A member of the local authorities care home support team (CHST) told us that since the current manager started working at the home they had been a very keen and diligent user of their services. The training provided by the CHST included medicines, falls prevention, pressure ulcer prevention, nutrition, and first aid and training had been very well attended and the staff had been interactive and keen.

Staff told us they received regular supervision, an annual appraisal of their work performance and said they were well supported by the manager. One member of staff said, "I get supervision every two months and had

an annual appraisal last year. I like working at the home. I like the residents and the staff. There is good teamwork here, we all support each other." Records seen confirmed that staff were receiving regular formal supervision and, where required, an annual appraisal of their work performance.

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 manager demonstrated a good understanding of the MCA and DoLS. They said that most people using the service had capacity to make some decisions about their own care and treatment. We saw that capacity assessments were completed for specific decisions and retained in people's care files. Where the manager had concerns regarding a person's ability to make specific decisions they had worked with them, their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA. We saw that a number of applications had been made to the local authority to deprive people of their liberty. Where these had been authorised we saw that the appropriate documents were in place and kept under review and the conditions of the authorisations were being followed by staff.

We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care files we looked at. The DNAR is a legal order which tells a medical team not to perform Cardio-pulmonary Resuscitation on a patient. However this does not affect other medical treatments. These had been fully completed, involving people using the service, and their relatives, where appropriate, and signed by their GP.

People were provided with sufficient amounts of nutritional foods and drink to meet their needs. People's care plans included assessments of their dietary needs and preferences. These assessments indicated their dietary requirements, food likes and dislikes, food allergies and their care and support needs. Care plans included information relating to people's dietary needs for staff to refer to. For example, one person's care plan stated, "Does not recognise the use of a knife and fork and will need prompting and assistance with meals." Nutrition and diet risk assessments were in place. We saw referrals had been made to the dietician and GP following weight loss. We found speech and language therapist's advice had been sought for people with swallowing difficulties. A health professional who supported people requiring enteral feeding said, "The staff make appropriate referrals to our team. Food and fluid charts are in place and people's weight is monitored."

We observed how people were being supported and cared for at lunchtime. A daily pictorial menu was displayed on a notice board in the dining room in each unit for people to make their choices from. One person using the service told us, "The chef is great. I am a vegetarian; he really does try hard to make nice meals for me." Another person told us, "The food is okay. We get lots to drink. You can ask for what you want to eat." Some people required support with eating and some ate independently. The atmosphere in the dining room was relaxed and not rushed and there were enough staff to assist people when required. Some people ate their meals in their rooms in accordance with their preferences. We saw that they received hot meals and drinks in a timely manner. We saw that people were also provided with drinks and snacks throughout the day and these were available in the lounges on each unit.

We found there was clear and frequent communication between each unit and the kitchen regarding people's dietary preferences and requirements. We spoke with the chef. They showed us documents which alerted kitchen staff to people's dietary risks, personal preferences and cultural and medical needs. The chef said they accommodated people's personal preferences by offering range of choices each meal time. For example, they cooked separate meals if people requested one which is not on the day's menu. We noted that the provider had awarded the home a certificate as a "Centre of Culinary Excellence 2015". We also noted that the kitchen was exceptionally clean and well-kept and had been awarded a five star food hygiene rating from the Food Standards Agency.

People were supported to maintain good health and had access to health care support. Where there were concerns people were referred to appropriate health professionals. A GP told us they visited the home twice a week or when required to attend to people's needs. They told us the home was trying hard to meet people's needs. They met with the manager on a regular basis to discuss how they could improve how they worked together. They had noticed significant improvements since October 2015. They said the clinical lead nurse was very good and she was raising the standards of care and that the staff were very willing and flexible and carried out their recommendations. A tissue viability nurse told us they found the wound management and care of wounds was good. Staff followed peoples care plans and actively sought advice from them when they needed it.

Good

Our findings

People and their relatives told us staff were kind and caring. One person said they were unsettled when they moved to the home but staff looked after them well and made sure they got their medicines. Another person said, "The care I get is as good as it could be. Some of the staff here are amazing, they are doing their best for me. The chef for example, if he gets any spare time he drops by for a game of chess." A visitor told us they had lived at the home before moving out into their own accommodation. They said they had been very well looked after and they regularly visited the friends they had made whilst they lived there.

People using the service told us they had been consulted about their care and support needs. One person told us they were involved in planning for their care, for example, they chose the clothes they wanted to wear and could request when they wanted their hair cut or a manicure done. Another person said, "I talk to the staff about my needs. They have just recruited a new physiotherapist and I met them last week, so that's going to be helpful for me."

It was evident throughout the course of the inspection that staff knew people well and understood their needs. We witnessed many examples of good care giving and saw that people were treated with understanding, compassion and dignity. We saw them actively listening to people and encouraging them to communicate their needs. We saw notices hung on bedroom doors advising others to call back later as staff were providing personal care to people. Staff said they also ensured people's privacy by drawing curtains and shutting doors. Staff tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could. They addressed people by their preferred names, explained what they were doing and sought permission to carry out personal care tasks. They told us they offered people choices, for example, with the clothes they wanted to wear or the food they wanted to eat. One person using the service said staff showed them respect and always explained what they were doing for them. A relative told us, "The staff are courteous and respect me and my husband."

People received appropriate end of life care and support. We spoke with a nurse from a palliative care team. They told us the palliative care team provided training and support for staff on end of life care and said staff were raising the homes standards in dealing with end of life (EOL) care. EOL care plans were in place and staff followed the plans and any advice they gave them. They said, "The palliative care team has a good relationship with the home and communication is very good, if the nurses are not sure about something they give us a call and we call into the home. This is one of the better care homes I visit." A GP told us about a recent experience of working with the home. They told us about a person who had passed away and whose first language was not English. A member of staff of the same nationality spent time with the person,

attending even on their days off, to talk with them before they passed away. The GP felt that this was a good example of how the home worked with and cared for people.

People using the service and their relatives were provided with appropriate information about the home in the form of a 'Service user's guide'. This included the complaints procedure and the services they provided and ensured people were aware of the standard of care they should expect. A member of staff told us this was given to people and their relatives when they started using the service.

Good

Our findings

People using the service and their relatives told us the service met their care and support needs. One person told us, "I receive consistent care from staff." A relative told us, "My grandfather has been to many homes around this area for respite, this is the best home compared to others."

At the time of our inspection we saw that information held in people's current care files was being transferred to the new providers care file/planning system. The system was in place for most of the people using the service. We saw that care and health assessments were undertaken to identify people's support needs before they moved into the home. The manager told us that care plans and risk assessments were developed using the assessment information. Care plans included detailed information and guidance to staff about how people's needs should be met. They described people's daily living activities, their communication methods, mobility needs and the support they required with personal and nursing care. The care files also included the person's life history, personal preferences, capacity assessments and, where appropriate, Deprivation of Liberty Safeguards authorisations and associated records. A member of staff told us the new system included better information about people's needs and they were much easier to complete, update, monitor and follow. Another member of staff told us the nurse in charge made sure staff read the care plans, this ensured that staff understood and were up to speed with peoples care and support needs.

Information contained in the care files indicated that people using the service, their relatives and appropriate healthcare professionals had been involved in the care planning process. A relative told us, "I am very involved with the home when it comes to planning for my husband's care. I always go to the review meetings, they always ask for my opinions. I have good communication with the home. They work with me, and do all they can to meet his care needs." A visiting social care professional told us, "I have been coming to the home for eighteen months to review peoples care and support needs. I think the service has improved. If I pick up issues about peoples care needs these are followed up immediately. For example their care plans are amended or referrals are made to appropriate health care professionals." A dietitian told us that staff included any advice they gave in peoples the care plans. They said, "The people I see are well looked after." We saw that peoples care plans and risk assessments were reviewed regularly and reflected any changes in people's needs.

People were provided with a range of appropriate social activities. One person said, "I like the activities, there's plenty of things for me to do if I want to." We saw activities information displayed on notice boards in each unit. Activities included coffee mornings, movie days, reminiscence, bingo, arts and crafts, group

games, puzzles, card games and "boccia" an indoor bowling game. We observed people playing a game of Hengo (bingo) with a visiting worker from a project that introduces chickens to care homes. The home had two activities coordinators. One told us that people really enjoyed it when the chickens had been brought in and about the homes plans to build a henhouse in the garden. The home had a number of pets including guinea pigs and hamsters. We saw a dog with its handler came to visit residents as part of the planned activities. The care coordinator told us about people's reactions when the dog visits and in particular for people who are unable to participate in group activities.

The care coordinator showed us planned events for the coming months. These included an Abba tribute show in April and a Summer Fete. They told us that entertainers such as magicians, ventriloquist's and Punch and Judy shows visited the home. They said that members of a local church supported some people using the service from the home on Sundays to attend a Sunday service. We met a visiting cleric who told us they visited the home each week to visit people, some of whom were nursed in bed. They said, "The staff are very caring."

People using the service and their relatives said they knew about the service's complaints procedure and they would tell staff or the manager if they were unhappy or wanted to make a complaint. They said they were confident they would be listened to and their complaints would be fully investigated and action taken if necessary. We saw copies of the complaints procedure displayed throughout the home. One person using the service said, "I know about the complaints procedure. If I need to make a complaint I would just follow that." A relative said, "I would raise my concerns with the manager if I had any. I am confident they would deal with them appropriately." We saw a complaints file that included a copy of the providers complaints procedure and forms for recording and responding to complaints. Complaints records showed that when concerns had been raised these were investigated and responded to appropriately and where necessary discussions were held with the complainant to resolve their concerns.

Good

Our findings

The home had a registered manager in post. The registered manager started work at the home in May 2015. A relative said, "I think the home is well run. I have noticed in the last few months that things have definitely improved. The manager is very approachable and always puts things right immediately." A member of the local authorities care home support team told us the manager had been a very organised and efficient leader and was working extensively to improve staffing and the home. They were very pleased with the cooperation and effort that the manager had put in.

Staff spoke positively about the leadership provided by the manager. They told us there was an out of hours on call system in operation that ensured that management support and advice was always available to them when they needed it. One member of staff told us, "Everything has improved since the manager started working at the home. I feel well supported by her, even the small things I talk to her about are dealt with. I now feel the home has prospects and things are going to get better." Another member of staff told us, "I get good support from the manager and senior staff. I love working here, so much so I've never had a day off work. We have a good team and we help each other to make sure things are done properly."

Quality monitoring systems were in place. We saw a quality monitoring report from the providers compliance officers visit to the home in February 2016. The report covered the CQC's five key questions of safe, effective, caring, responsive and well led and highlighted areas of good practice and areas where improvements could be made. The manager confirmed, and we saw, that actions had been taken to address these recommendations. We also saw a monthly quality review report completed by the operations manager in March 2016. This also covered the CQC's five key questions and recorded the improvements made at the home and actions to be completed by the next visit in April. The manager showed us completed monthly audits the provider required home managers to carry out. These included audits of care plans, medicines, falls, complaints, incidents and accidents, weight loss and pressure sores. We also saw a report from an unannounced visit carried out at the home by the manager in March 2016. The visit covered staffing issues, call bell answering, the security of the building and the welfare of the residents. Where any issues were identified staff were spoken with and these were recorded in the report. The manager told us they carried out these unannounced checks to make sure people where receiving appropriate care and support.

Regular monthly staff team meetings took place. These meetings were attended by the manager, deputy manager, senior nursing staff, care staff and the chef. Issues discussed at the February meeting included recruitment, induction, training, safeguarding, whistleblowing, moving and handling and people using the service meal time experiences. The manager told us that minutes from the meeting were made available to

staff on all of the units. They also told us that the meetings were not always well attended as they were sometimes arranged at short notice. They had taken steps to improve staff attendance by giving staff a longer notice period. A unit manager told us unit meetings had recently been initiated and they were proud of the systems they had put in place to ensure staff were aware of their roles and caring responsibilities. A member of staff told us, "A lot of things have changed for the better since the manager came here. We didn't used to have team meetings but we do now. We can discuss people using the services needs and discuss how we can work better as a team. Residents are also able to have more activities."

Some staff at the home had been designated champions in specific areas of care and had received enhanced training in these areas. For example, there were champions in fall prevention, men's well-being and pressure ulcer prevention. The falls champion told us, "Being the falls champion has broadened my knowledge and I have a better insight in what we are doing." The pressure ulcer prevention champion told us their role was to raise staff awareness of pressure ulcers and make sure staff knew what needed to be reported and recorded. They said being a champion was an important role and made them feel good.

The provider took into account the views of people using the service and their relatives through relatives and residents meetings and surveys. The manager said they used the feedback from the meetings and surveys to make improvements at the home. We saw the minutes from a resident and relatives meeting held during our inspection. Topics discussed at the meeting included the use of agency staff, staffing levels, staff recruitment and maintenance issues. The minutes recorded issues raised by residents and relatives and actions taken or actions required to make improvements. A relative told us they attended the meetings. They said the manager listened to people's concerns and tried to sort things out. Another relative said they raised a concern with the manager about staff shortages at the last meeting. They noted that staffing levels had improved after the meeting. The manager showed us a summary from a survey sent to health care professionals and visitors to the home. Feedback had been positive for example health care professionals felt staff provided them with sufficient information to deliver their services and visitors said they were made to feel welcome when they visited the home. The manager told us they had carried out a resident's survey in March 2016 and they planned to analyse the feedback from these surveys, draw up a report and an action plan and share the findings with people using the service, their relatives, staff and health care professionals.