OakRay Care Ltd

Broadhurst Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 6 and 9 October 2015 and was unannounced.

Broadhurst is a residential care home for people requiring personal care. A maximum of 25 people can be accommodated and at the time of our inspection there were 22 people living in the home some of whom had physical disabilities or a diagnosis of dementia. Care is provided over three floors, and there are several communal dining and lounge areas and an enclosed garden.

At the time of our inspection the manager had applied to be registered with CQC and their application was being processed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

People said they felt safe in the home and with staff. Staff were knowledgeable about the signs of abuse and how to report their concerns. There were sufficient staff to meet people's needs and support was provided by the manager when staff were on leave.

Staff respected people's privacy and dignity. People were asked for their consent before care was delivered; however, care records for people who lacked capacity to make some decisions did not contain information on how the assessment had been made. We have made a recommendation to the provider about this.

Staff received regular training and supervision, although staff had not been trained to care for specific needs of some people, such as those with a learning disability. We have made a recommendation to the provider about this.

There were sufficient staff to meet people's needs safely and checks were carried out on staff suitability before they started working in the home. Risks to people's health and wellbeing were assessed and staff knew about these and how to reduce them. Food was plentiful and varied and people said they enjoyed the homemade meals and desserts.

People received their medicines in a safe, unhurried manner. The home was clean and staff followed procedures to prevent and control the risk and spread of infection.

People said staff were caring and compassionate. Staff knew people's preferences and respected these. They went out of their way to support people to attend trips and a large variety of individual and group activities were arranged. Innovative ways to encourage people to socialise were used and had been successful in preventing people from becoming socially isolated.

The manager was supportive and involved staff and people living in the home in decisions about improvements to the home. People's feedback was acted on and wherever possible their requests were provided.

Complaints were taken seriously and responded to in a timely manner. Audits of care records and processes in the home were completed, and any issues found were addressed. The quality of care was monitored by the manager, who worked alongside staff regularly. Staff were honest and open and were given feedback about their performance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were aware of signs of abuse and what action to take in response to concerns. People said they felt safe in the home and with staff.

There were sufficient staff to care for people's needs safely. Checks were made on staff to establish their suitability to work in the provision of care.

Medicines were managed safely. The home was clean and staff followed infection control procedures.

Good

Is the service effective?
The service was not always effective.

Staff received regular support and training but this did not cover the specific needs of all people living in the home.

Staff were aware of the need to gain people's consent to care and respected this; however where people had been assessed as lacking capacity there was no record of how the assessment had been reached.

People were given a variety of meal choices and were supported to ensure they ate and drank sufficient amounts. People's health was monitored and staff responded when people required medical attention.

Requires improvement

Is the service caring?
The service was caring.

People felt listened to and respected. They said staff were compassionate and kind.

Staff took care to respect people's privacy and dignity. They consulted people about their care and responded positively to their needs.

Good

Is the service responsive?
The service was responsive.

People's individual preferences were recorded, known by staff and respected.

Staff were innovative when providing activities for people and took extra steps to encourage people who were at risk of social isolation.

People were confident that complaints would be taken seriously. When a complaint was received this was dealt with in a timely and comprehensive manner.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The manager promoted an open and accessible culture in the home; people and staff had free access to the manager.

Staff were honest and open, they contributed to the improvement of the standard of care in the home.

Staff carried out audits in order to maintain and improve the quality of care records and staff practice.

Broadhurst Residential Care 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 inspection took place on 6 and 9 October 2015, was unannounced and was carried out by two inspectors. Before the inspection we reviewed the information we held about the home, including notifications about important events which the home is required to send us by law and our previous inspection report.

We spoke with nine people living in the home and two relatives. We received feedback from four health and social care professionals who visited the home. We also spoke with five care staff, the cook, a cleaner, the activities co-ordinator, the manager and a member of staff from the provider's other care home who was carrying out quality audits in the home. We observed how care was delivered in communal areas and reviewed eight care plans and associated records of care. We also reviewed the provider's policies and procedures, accidents and incidents record, medicines administration and four staff recruitment files.

Good

Is the service safe?

Our findings

People said they felt safe and that care staff provided support in a safe manner. They said, "They get me up and put me to bed; if I ring the bell they are very quick to come", "I don't have to worry about anything", and, "I've no concerns about my safety". Relatives said, "[My relative] uses the hoist; the staff are very patient, they use it very well", and, "They are genuinely good at what they do".

Staff were aware of the signs of abuse and how they should respond if they suspected a person was being abused. They knew who to contact and how to report concerns about a person's wellbeing, saying, "report it straight away", and, "you cannot delay". Staff had all been trained in the safeguarding of adults and a safeguarding policy was in place which covered preventing, identifying and reacting to suspected abuse. Records showed staff had reported concerns to the management team, These had been acted on immediately and notified to the appropriate local authority safeguarding team.

Risks to people's health and wellbeing were assessed and action recorded to reduce risks. Where a person behaved in a way that that put themselves and others at risk this was documented with the appropriate action staff should take to diffuse situations and protect people. This included actions which staff knew about and which we observed worked well with one person. The risk of skin pressure injury to each person was assessed and measures, such as pressure relieving equipment, were in place to reduce the risk. Other risks such as malnutrition, falls and confusion were all recorded for each person, with the level of risk measured as low, medium or high. Staff were aware of each person's risk assessment and knew how to support them in the safest way possible.

We observed staff supporting people to move and it was evident they were aware of the risks when using moving and handling equipment such as a stand-aid, hoist or wheel chair. Staff said to people, "hold on tight", "Okay, you can sit down now", and, "mind your elbows; keep them in when we go through the doorway". A risk assessment for the environment identified risks associated with the areas such as the laundry and the kitchen and how the risks should be managed.

Each person had a personal emergency evacuation plan (PEEP) prepared which showed the support they would need if they needed to leave the building in the event of an emergency, such as a fire. Fire drills were carried out regularly and the time taken to evacuate the building was recorded. A weekly inspection of the means of escape and emergency lighting was carried out and door release devices were checked monthly.

People's received their medicines safely. The provider had an up to date medicines policy, which provided detailed guidance for staff. Only senior care staff, who had received the appropriate training and had their competency assessed, were able to administer medicines to people living at the home.

People's medicine administration records (MAR) had been completed correctly by staff administering their medicines and were audited on a regular basis. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given. There was also a body map available to assist staff in understanding where topical creams should be applied.

An effective system was in place to manage the ordering of medicines. There was a process in place for the ordering of repeat prescriptions and disposal of unwanted medicines. When medicines required cold storage, a refrigerator was available and the temperature was checked and recorded daily to ensure medicines were stored according to the manufacturer's instructions.

Staff administering medicines to people were supportive and unhurried, allowing people to take their medicines in their own time. Some medicines were not given to people at the time indicated in the manufacturer's guidance. On the second day of our inspection the manager had taken action to ensure people received their medicine at the correct time. Staff were aware of the change and had implemented this.

The home was clean although carpets in some parts of the home had an unpleasant odour. The manager explained that new, more cleanable flooring was being sought by the provider to remedy this. The provider had an infection control policy, which detailed the relevant issues and guidance for staff. The manager was the infection control lead for the home. The manager had not completed an

Good

Is the service safe?

annual statement of infection control and prevention. We raised this with the manager who said this was something that they had not got round to yet and would be working on soon.

There were detailed daily cleaning schedules and checklists to confirm when the cleaning had been completed. The communal areas of the home, the kitchen, the bathrooms and people's bedrooms were clean and appropriately maintained. Regular infection control audits were carried out by the manager and where issues or concerns were identified remedial action was taken the same day. For example, during one audit, a light unit was found to be dirty. The unit was cleaned by the maintenance team and checked by the manager as completed.

Personal protective equipment (PPE), such as gloves, aprons and alcohol hand wash were available for staff to use throughout the home. While observing care we saw staff using their PPE when it was necessary.

There were sufficient staff to meet people's needs safely. The manager said that usually they would have four care staff in the mornings, three in the afternoon and two wakeful staff at night. On the day of our inspection there were three care staff on duty in the morning and three in the afternoon. They were supported by the manager who explained that due to staff leave they were one care staff member short. However, staff said that three staff were usually adequate to ensure people's needs were met but that having the fourth made things easier and they could provide one to one support to people if this was required. The manager, deputy manager and senior care staff were available on-call during the night.

Staff were subject to checks to see if they were suitable to work in the care industry. References as to staff conduct in previous employment were provided, and a check with the Disclosure and Barring Service (DBS) was carried out before staff were permitted to provide support to people living in the home. The DBS helps employers make safer decisions when recruiting staff to work in the provision of care.

Requires improvement

Is the service effective?

Our findings

People said their needs were met by confident and skilled staff. They said, "[Care staff] know what they are doing, I'm sure", and, "They help me get up and put me back to bed; everything's lovely". Relatives said, "They have their training, and they handle things admirably", and, "[My relative's] needs are always met". Health professionals said, "It's good care", "[Care staff] know their limitations; they call us in good time and work well with us", and, "They are skilled; it's very positive care".

Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Staff were able to explain the principle of capacity and how it applied to people living in the home. A visiting health professional said, "They support people to make simple decisions and make 'best interests' decisions where appropriate".

The care records for three people living at the home contained information which identified that they were living with a cognitive impairment and lacked capacity to make certain decisions. However, only one of these contained a written capacity assessment in relation to restrictive practice. For example, two of the three people had a best interest decision recorded in their care plan to allow staff to use bedrails to restrict their movement and keep them safe. These decisions recorded that the person did not have capacity; however, there was no record of how that assessment was reached. The Mental Capacity Act 2005 Code of Practice states 'An assessment of a person's capacity to consent or agree to the provision of service will be part of the care planning process for health and social care needs, and should be recorded in the relevant documentation.

We recommend that the provider seek advice and guidance on adopting the latest best practice guidance in respect of mental capacity assessments for people living with a cognitive impairment.

Staff knew that gaining people's consent to care was important and we observed them frequently asking people for this. For example, they said, "Is it OK if we move you to the dining room now, or would you like lunch here?" and, "Would you still like your hair done?" Staff recognised people's right to refuse care and this was respected. Where this would impact on their health and wellbeing this was documented and advice was sought from relevant health professionals.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely. The manager had applied for a DoLS authorisation for seven people, as they were subject to constant supervision at the home. Staff understood how the DoLS applied to people in the home and the need to support them and keep them safe in the least restrictive way.

New staff completed an induction and were assigned a 'buddy' member of staff, who would work with them and support them whilst they were new to the home. Induction training covered areas such as moving and handling, food hygiene, and fire awareness. Most training for staff was comprehensive and up to date. A record was kept of what each member of staff had completed and what training was due. Staff said training was effective and helped to increase their understanding. One staff member said, "Dementia training really helped me understand; you feel like you know [the person with dementia] more now". Staff said they completed a mix of online and practical training and were aware of upcoming training courses. Several staff were completing a vocational care qualification and were supported to do so by the manager. Some specific needs that people had had not been addressed by training, such as the needs for people with a learning disability. The manager said they would be arranging this training as soon as possible.

We recommend that the provider seek advice and guidance on adopting the latest best practice in respect of ensuring staff are trained to meet the specific needs of people with a learning disability in the best way.

Staff were supported with regular supervision meetings. Staff training needs were discussed and staff said the meetings were helpful. Goals were set for staff

Is the service effective?

development, and these were followed up and reviewed regularly. If concerns were raised about the care provided by staff this was addressed with supervision meetings. Likewise if staff had concerns about their workload or shift pattern, these were discussed and staff were able to make adjustments to their rota to enable them to continue working at the home. The manager said they had recently started to take senior staff with them to assess people's needs. They said they did this, "so [senior staff] know what's involved; they need to be part of the assessment; it's part of their development".

People were given a choice of nutritious food and drink and staff were vigilant in making sure people had enough to eat. People spoke positively about the meals, saying, "I had delicious fish and chips today, followed by jam roly-poly and custard", and, "The food is lovely; plenty to eat and lots of choice". All meals were homemade and a variety of options were made available. The cook said, "If [people] don't like the choices they can have anything they like". This was evident when one person declined the choice of beef stew and dumplings or salmon and broccoli tart. They were offered another meal which they enjoyed. A relative said, "If there is something [my relative] doesn't like [the cook] bends over backwards to get what she wants". Homemade puddings were on offer and these were made with a sugar substitute so that people with diabetes were able to enjoy them too. People enjoyed their food and there was very little wastage. The cook and care staff were aware of people who had difficulties eating or swallowing and meals were provided in a way that was safe and palatable for them. Care staff supported people to eat and drink where this was necessary, and some people had adapted cutlery and crockery which helped them to maintain their independence when eating. Where a person was losing weight this was monitored and action taken to try and increase their calorific intake. The dining room was cheerfully decorated and a pleasant atmosphere was promoted by smiling staff who were on hand to provide support and encouragement to people.

Staff were alert to changes in people's health and contacted health professionals where this was appropriate. A relative said, "They support [my relative] to go to hospital appointments; they are well organised like that". A GP made a weekly round at the home, discussed the health of all the people living in the home and visited those who were unwell. They said, "I'm here weekly; staff are aware when people's needs increase and they get in touch appropriately". Another health professional said they had worked with care staff well in order to support a person who would have otherwise required admission to hospital. They added, "The staff are willing to listen to advice and are doing more to ensure that is passed on to all staff". Records showed staff contacted district nurses and other professionals such as chiropodist, dentist and optician when people needed these services.

Good

Is the service caring?

Our findings

People said they had no concerns with staff and that care provided to them was delivered in a kind and considerate manner. They said, “They are all caring; we have a laugh”, “It’s all good natured; they let me have a go at them”, and, “I like it here; the people are nice; the girls are nice”. Relatives said, “I cannot speak highly enough of the staff”, “They are very caring girls with a sense of humour”, and, “They are always very patient”.

Staff provided care in a compassionate manner, and with regard to people’s individual circumstances. When supporting people to mobilise, they communicated with people throughout, explaining what was happening whilst ensuring they moved at the person’s pace. One staff member reassured a person who had said, “Don’t leave me!” by responding calmly, “I’m not leaving you; I’m here; I’ll stay in the lounge with you”. When a person became agitated for an extended length of time, the manager and other staff were kind and patient, providing reassurance to the person and seeking to make them comfortable. Staff promoted a happy and jovial atmosphere and people responded to this positively. When a person started to sing whilst walking through the hallway, several staff joined in with them which the person showed they enjoyed by singing louder and laughing. Staff had engaged in fundraising activity in order to purchase activity equipment for the home and we saw this in use at our inspection.

Staff were attentive to people’s needs, including small things that helped people feel more comfortable. When a person appeared to be searching for something, a member of staff said, “Are you looking for your glasses? They are over here [person’s name]” and then helped the person locate them. Relatives expressed their appreciation for the way staff provided care saying staff were, “patient and understanding”, and, “professional with much humanity”. Often, they said, staff went “the extra mile”. A visiting health professional said, “I’ve seen [staff] sitting reading to people; giving them 1:1 support”.

People were involved in discussions about their care. One person said, “I’m often asked if there is something I want to change”. A relative said, “[My relative] has a keyworker; we can talk to her about anything”. People said they were given choices and made decisions about their care. This included being asked what they would like to wear, where they wanted to eat their meals and what they would like to do each day. People said staff listened to them and respected their opinions.

Staff took care to protect people’s privacy and dignity. They knocked on people’s doors, and waited for an answer before entering. Staff spoke respectfully and discreetly to people about their needs. Each person was assisted to use the toilet when they required this, and staff said, “People have their own times; we go by them”, and, “We ask if they want you to wait outside until they are ready”. Staff said they shut curtains, and covered people with a towel when providing personal care, saying, “I wouldn’t want to be getting dressed with the curtains open”. When a singing activity started in a room, staff discreetly asked a person if they would like some quiet in the smaller lounge, as they knew the person did not appreciate loud activities. The person expressed gratitude for this. Visitors were free to visit any time and were greeted warmly by staff and the manager.

Good

Is the service responsive?

Our findings

People's needs were assessed with them, and with their family members if appropriate. One person said, "I don't have to worry about anything; they sort it all out for me". Relatives said, "They see to [my relative's] every need", and, "It's individualised care; if [my relative] doesn't want to get up that's OK. No-one forces her to do anything".

Where they were able, people had signed their care plan, and reviews were conducted with them regularly. They had a 'This is me' document which was prepared for when the person was receiving care in an unfamiliar setting, such as in hospital. It contained essential information about the person, their care needs and their preferences. Staff knew people's preferences but still gave people choices in case they changed their mind. One staff member said, "I show a few outfits and ask what they would like to wear. 'Do you want your hair up or down?' that kind of thing".

Care plans contained people's personal history. Staff said this helped them to, "get to know people better", as they could talk about their interests and things that the person enjoyed. They added, "You feel like you are caring for a family friend when you know more about them". Where people had expressed an interest in a particular activity such as singing or quizzes, we saw these were arranged. People's preferences, such as for male or female care staff, favourite meals, the way they took their tea and their clothing preference were recorded and respected by staff. Staff said they tried to get to know, "how the person ticks, their sense of humour etc. and go with that". People's level of independence for specific activities was recorded which informed staff to help the person remain as independent as they could whilst remaining safe.

Daily records of care provided showed people were cared for according to their assessed needs. Where a person was at risk of low mood, this was recorded; staff assessed the person's mood and activity and responded accordingly. For example, they provided more 1:1 support if the person was feeling agitated. If a person's needs changed this was communicated to staff via a communications book which staff read at the beginning of each shift, and also posted on the staff notice board to ensure all staff were aware. We observed a shift handover discussion. This was clear and detailed about each individual and their needs. Staff were knowledgeable about each person and asked questions to clarify changes to people's care. People's needs were discussed in a sensitive and personalised way. A visiting health professional said, "The day to day care is good".

People influenced changes and improvements within the home. The manager spoke to people on a daily basis and people came in to the office to see the manager frequently. People had expressed an interest in an 'old fashioned sweet shop' being installed in the quiet lounge and this was underway. Residents' meetings were held periodically and from these it had been decided that the main lounge would be decorated with new furniture and furnishings; people had been asked about their preferences for this. The dining room had been decorated in a 'café style' following feedback from people in the home and suggested improvements to the garden had been completed. People had requested particular outings such as to the garden centre, the seafront and said they wanted a Halloween party. These had all taken place or had been arranged to happen shortly. A 'wish tree' was in place in the dining room. People, and staff, were encouraged to write their wishes on cards and these were tied to the wish tree. If at all possible, the wishes were made to 'come true' and included specific meals, outings and activities which had been arranged.

The activities co-ordinator endeavoured to engage with people who were at risk of social isolation. They said, "I try to spend some time with them, even if it is only two minutes at a time; [one person] eventually agreed to leave their room and come downstairs; now they join in with the activities". Another person still declined to join activities but did regularly come into the dining room for lunchtime socialising. If a person wanted to, they could do the planned activity in the comfort of their own rooms. The activities co-ordinator had arranged for one person to do pizza making in their room as they didn't want to join the group; if a person enjoyed an activity in isolation they were encouraged to join others doing the same activity, such as colouring. Background music was playing in the home and this was people's choice of music. We saw people enjoyed the music and some got up and danced with staff and with the manager. A newsletter was prepared monthly which showed people what events and activities were coming up and highlighted people's birthdays, new staff and contained photographs of recent activities. People knew about these and expressed enthusiasm about them.

Good

Is the service responsive?

The activities co-ordinator was innovative in their attempts to engage people in social activity. They said they had noticed that when activities were arranged in one room the same four people joined in. They moved the table to a different room where more people sat, and they all joined in. They had also changed the layout of the chairs in the lounge for activities and this has resulted in more people joining in, and others more able to watch without joining in if they wished.

People living in the home were encouraged to remain part of the community. Families were invited to join in activities and did so. When the local carnival was passing by people were supported to watch it and engage in the celebrations in whatever way they could. One person had not been out of the home for a long time but was supported to do so on this occasion. People and staff had engaged in fundraising activity for a local charity.

Photographs of outings and celebrations were recorded in a scrap book which was used for reminiscence activities and photographs of people who lived, or had lived, in the home adorned the hallways. Some were people's wedding photos or of them engaging in a sporting activity they enjoyed when they were more able. The activities co-ordinator said it was sometimes, "a challenge to get people involved. But I get to know them well and keep trying". They sought feedback after activities and made changes accordingly to improve the experience for people. People said that the activities staff, "could not do more" for them. A relative said, "[The activities co-ordinator] is always full of ideas and they usually happen", adding that they were, "enthusiastic and capable". A visiting health professional said of the activities in the home, "They are creative, a real variety; they do well with music and entertainment".

Care staff came into the home on their day off to take people out who wanted to and people had enjoyed trips to restaurants, bowling and to the local pier. Each person had a 'keyworker' member of staff who was responsible for meeting their needs. They would get to know the person well and discuss their care needs with them. The keyworker for one person who had not being leaving their room for a while said they had tried 1:1 activities with them, including pamper sessions, changing clothes, and reading a card from a friend. They said, "When I read the words [the person] smiles" and they were more likely to have a conversation. The garden was equipped with easy seating and people said they had enjoyed being in the garden during the warmer weather. The manager attended the funeral of a person who had lived in the home and took another person with them who had expressed a desire to pay their respects. The manager took care to reassure the person that they had dressed appropriately and that they would be leaving in plenty of time to get there. The person was supported to go out regularly and when they returned the said, "I've had a lovely day; I've been out. I've really enjoyed myself".

People said they had no complaints about the care they received. They said, "Complaints wouldn't worry me; if I had one I would go to the office", and "I'm sure the staff would listen if I had anything I needed to say". Relatives said, "I've no complaints. If I did I would talk to [the manager]", and, "[My relative] has never complained about anything". A complaints policy was in place with the timescales a person could expect a formal response to their complaint. We reviewed a complaint which had been responded to promptly and in line with the policy. An action plan had been created to deal with the complaint and the outcome of the investigation was to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

People were complimentary about the manager, saying they were, "always out and about; popping in or having a dance with us". People frequently went into the manager's office to talk or just sit with them. Relatives expressed their thanks for the, "personal interest" the manager and staff had showed in their family member. They commented, "I can only speak highly of care staff and the manager", "I'm impressed with this home; I would definitely recommend it", and, "[The manager] gets top marks; [They] really care; are perceptive and in touch with the residents".

The manager's vision was to provide, "a homely atmosphere, with decisions made with people and not for them; person-oriented and not task led". They added that the values of dignity, respect and choice were paramount and that every effort was made to provide people with what they wanted. They encouraged team work amongst the staff group and worked alongside care staff regularly to monitor whether the values were being shown in practice.

Staff said that the manager was supportive, saying, "You can go to [the manager] any time; [they'll] try and sort it out in any possible way". Others said, "If you've got a problem you can speak to [the manager]", and, "We can discuss worries or concerns or the care of a resident. [The manager] always listens and deals with anything I raise".

Staff said an open culture was encouraged in the home. They commented, "I don't worry; if I was doing something wrong [the manager] would have told me". Another said, "When I did something wrong [the manager] came and showed me straight away what I had done. I didn't mind; I haven't done it again".

The manager was aware of their duty of candour responsibilities. Duty of candour is a requirement that providers of care must be open and honest with people receiving care, when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Records showed staff received positive feedback and anything negative was addressed in a timely way The manager thanked staff for going beyond their duties to improve the care provided in the home and a scheme was in place to reward staff for this.

The provider was involved in the home and visited regularly. They made funds available for improvements and were supportive to the manager in their endeavours to improve the care provided in the home. Staff were involved in the development of care delivery. They were asked for ideas for improvement and a recent suggestion regarding the application of creams had been implemented successfully. Staff said, "[The manager] doesn't just take over; she asks us about things first". The manager said, "The care team are open to suggestions; we listen to each other".

Staff meetings covered any issues or changes in the home. A survey of staff was carried out and the results indicated a high level of satisfaction with teamwork, complaints taken seriously, training needs recognised and fair treatment of staff. The manager sought to empower care staff by giving them more responsibilities, or showing them a different aspect of the work, for example allowing care staff to spend a day in the office. People were able to give feedback at any time and a survey of people's views was due to be carried out in November 2015.

The provider endeavoured to share best practice across both the homes they owned. On the first day of our inspection a senior staff member from the sister home was present. They were carrying out audits of care records, food, fluid and other monitoring charts. They noted discrepancies and a notice was posted to staff showing what the results of the audit were and staff signed to confirm they had noted these. Other areas audited were the laundry, which covered the infection control measures such as the availability of PPE, and the treatment of soiled linen and clothing. Records showed action was taken immediately when errors or omissions were found in the monitoring of people's care. All accidents and incidents in the home were recorded in detail as well as the action taken in response. These records were reviewed to establish if there were actions that could be taken to prevent accidents. Following this review, practical action had been taken in the lounge to reduce occurrences of behaviour that put people and staff at risk.