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Ella McCambridge Care Home

Inspection report

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Tel: 01912341881

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 2 August 2017.

At the last inspection in May 2015 the service was not meeting all of the legal requirements with regard to person centred-care. At this inspection we found improvements had been made and the service was no longer in breach with regard to person-centred care. However, we considered more improvements were required with regard to record keeping.

Ella McCambridge Care Home is registered to provide care and support for up to 67 older people, some of whom may have dementia or a dementia related condition. At the time of inspection 60 people were using the service.

A registered manager was 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 2008 and associated Regulations about how the service is run.

People said they were safe and staff were kind and approachable. There were sufficient staff to provide safe and individual care to people. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Care was provided with kindness and people's privacy and dignity were respected. Records were not all in place that reflected the care that staff provided.

The environment was well-maintained and plans were proposed to promote the orientation and independence of people who lived with dementia. We have made a recommendation the environment should be designed according to best practice guidelines for people who live with dementia. Activities and entertainment were available to keep people engaged and stimulated.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. People had access to an advocate if required.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to people's dining experience, environmental design and record keeping.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People received a varied and balanced diet to meet their nutritional needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way.

You can see what action we told the provider to take at the back of the full version of the report.

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.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was clean, safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff were given a good level of training and support to help them care for people effectively.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

People were provided with appropriate support in meeting their health care and nutritional needs.

A programme of refurbishment was taking place around the home. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Is the service caring?

Requires Improvement

The service was caring.

People were made comfortable and were treated with dignity and compassion as they received end of life care.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making. However, systems for people to choose their food and people's dining experience required refining.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. However, records were not all in place that reflected people's current care and support needs.

There were some activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support.

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

The home had a quality assurance programme to check on the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found during the inspection.

Ella McCambridge 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 checked 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 took place on 2 August 2017 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using 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 communicate with us.

During the inspection we spoke with 15 people who lived at Ella McCambridge care home, 11 relatives, the registered manager, the deputy manager, eight support workers including two senior workers, two members of catering staff, the hairdresser and two visiting health care professionals. We observed care and support in communal areas and looked in the kitchen.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for five staff, six people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One person commented, "I feel quite safe here." Another person said, "There's always someone around to look after me." One relative told us, "[Name] is safe here and well cared for." Another relative commented, "When I leave here I know [Name] is alright, it's a weight off my mind." A third relative said, "We don't feel guilty when we leave here, we know [Name] is safe and happy here." Another relative told us, "I feel very comfortable leaving [Name] here when I go home."

There were sufficient staff to support the 60 people living at the home at the time of inspection. Staffing rosters and observations showed on the top floor 29 people, who lived with dementia were supported by five staff including three senior staff. On the ground floor 31 people were supported by four support workers and the deputy manager. A staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. They informed us they had received relevant training. The deputy manager told us people did e learning and local authority safeguarding training.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency. We were informed during the inspection that a fire evacuation slide chair was due to be delivered for the safe transportation of people from the top floor in case of fire.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which

checks if people have any criminal convictions, had been obtained before applicants were offered their job. Application forms included full employment histories.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths. We received confirmation after the inspection that a mobile hoist in one of the bathrooms was being replaced.

Certificates of maintenance for the premises were up to date. However, we noted a fire risk assessment was not up to date. The deputy manager informed us this had been identified and was being addressed. We received conformation immediately after the inspection that a comprehensive fire risk assessment was to be carried out imminently by an external fire specialist company.

Good

Is the service effective?

Our findings

Refurbishment of the home was taking place. Lounges, dining rooms and other communal areas had been redecorated and carpets had been replaced. Bedrooms were decorated and personalised with people's own possessions. One relative told us, "Staff are encouraging [Name] to personalise their room which we plan to do now that we know they are permanent here." The building was bright and spacious. The environment was being designed to ensure it was stimulating and therapeutic for the benefit of people who lived there. There was visual and sensory stimulation to help maintain the involvement and orientation of people with dementia. There were sitting areas in hallways and corridors which were decorated with pictures of interest to stimulate people. We discussed the need for appropriate signage around the building to help maintain people's orientation. For example, lavatories, bedrooms and bathrooms to have pictures and signs for people to identify the room to help maintain their independence.

We recommend the service finds out more about current best practice regarding the design of accommodation for people who live with dementia.

People were supported to maintain their healthcare needs. Relatives praised the effective care provided, particularly in terms of their family members' improved health and well-being since they had come to live at the home. One relative told us, "Since [Name] came here, we could see an improvement in health. [Name] re-gained weight and looked much better." Another relative told us, "[Name] has made improvements since they've come here, we can see a difference in them." Relatives told us they were involved and kept informed of people's progress and well-being. One relative commented, "I am fully included in everything that goes on with [Name]'s care." Another relative said, "Staff keep us well informed and they are very approachable if we need to ask any questions." A third relative told us, "The staff here are very good, they explain everything to us."

People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and occupational therapists. One relative commented, "The staff have been very pro-active in [Name]'s care, they have had equipment recommended and then provided the equipment [Name] needs." Another relative commented, "[Name] needed to go to hospital recently, two staff went and supported [Name]." Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. One relative told us, "The GP who visits here is very good." A visiting professional commented, "I have no problems with the care provided. Communication is very good and staff involve us as soon as they need to." Another professional told us, "Staff will contact us if they have any concerns about anyone's healthcare."

Staff told us communication was effective to keep them up to date with people's changing needs. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person. One staff member told us, "All staff attend the night shift handover and on late shift the senior will handover to nightshift."

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. One staff member told us "I have supervision every eight weeks." Another staff member said, "I feel well-supported in my role." The deputy manager told us annual appraisals took place with staff to evaluate their work performance and to jointly identify any personal development and training needs.

Staff members were able to describe their role and responsibilities. A number of staff members had worked at the home for several years. One relative told us, "The staff are mostly the same as when [Name] was here ten years ago." Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff told us and their training records showed that they were kept up-to-date with safe working practices. They undertook a range of other courses to ensure they had the knowledge to meet people's care and support needs. Training courses included dementia care, positive behaviour, equality and diversity, mental capacity and deprivation of liberty safeguards. Planned training included palliative care and emergency first aid.

One staff member told us, "I'm studying for a management qualification at level five." Another staff member commented, "We receive plenty of training. " Other staff comments included, "There are loads of training opportunities", "There are opportunities to progress and for staff development", "I've done local authority safeguarding training" "Staff training happens at night as well" and "We've received positive behaviour training."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 25 DoLS applications had been authorised by the relevant local authority and other applications were being processed. There was evidence of mental capacity assessments and best interest decisions in people's care plans.

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people at risk of poor nutrition were regularly monitored using a recognised nutritional screening tool. One relative commented, "They [staff] go over and

above to make sure [Name] eats and they have put some weight on." They also said, "Staff have even popped over to the chip shop to get something [Name] would fancy." Care plans were in place that provided guidance about people's nutritional needs.

Food was well presented and looked appetising. A choice of main meal was available at each meal. People and relatives were positive about the food saying there was enough to eat. One person told us "The food is very good, can't fault it." Another person said, "I get three meals a day, I don't need anything else." A third person commented, "We get plenty to eat and drink." Other comments included, "That was a lovely meal" and "I really enjoyed that."

Requires Improvement

Is the service caring?

Our findings

There were several cards of appreciation thanking staff for the care provided. All comments showed people were overwhelmingly satisfied with the service. People and their relatives told us they were treated with kindness and compassion. One person told us, "I am well cared for here, I know I'm not right at the moment, but I am cared for." Another person commented, "The staff put themselves out, they are very good to us." A third person said, "I am settling in okay." A relative told us, "I can't praise the staff enough for their care and support, I think they are so undervalued." Another relative commented, "They are all such lovely people here." Other comments included, "The staff are caring and nice to me", "[Name] is much happier since they've come here", "It's amazing here", "The staff are all very nice", "Staff can't do enough for [Name], brilliant care", "[Name] came here for respite and when I came to collect them they asked if they could stay", "The staff are very kind", "I couldn't wish for better. It's very homely", "I'm well-looked after" and "Staff see them, my relatives as individuals, and I appreciate that."

Staff appeared to have a good relationship with people and knew their relatives as well. A relative told us, "The staff are all long term, I got to know them well." The atmosphere in the home was calm, friendly and welcoming. One relative told us, "We're always made welcome." Staff promoted positive and caring relationships. A person commented, "I've made some good friends here." People were spoken with considerately and staff were polite. We observed people were relaxed with staff. Staff interacted in a caring and respectful manner with people. Staff acted with professionalism, good humour and compassion.

When staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and compassionate manner. Support workers were caring and patient. For example, they talked gently to a person and reassured them as they supported them to stand.

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person told us, "I get up later as I like a long-lie in bed." Another person told us, "I can have a shower or a bath." We heard staff ask people for permission before supporting them, for example with personal care or assisting them to mobilise.

We observed the lunch time meals in the dining rooms. We saw the meal time was relaxed and unhurried. People sat at tables set for three or four people. To the top floor we considered improvements were required to the organisation of people's dining experience. Due to staff deployment and the mealtime organisation some people waited 30 minutes sitting at the table before they received their meal, they did not receive a drink as they waited. Tables were set with plastic table cloths but condiments and napkins were not available. Menus were not displayed advertising the food available. We observed a member of staff ask a

person if they wanted salt on their meal and they collected the condiments from the staff room for the person's use. People were told verbally of the choice of meals but visual prompts were not used such as showing two plates of food, to help a person make a choice if they no longer recognised the verbal prompt. Staff when they did provide assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. For example, "Would you like some salt" and "Do you want a drink now?" The meal time organisation to the top floor was discussed with the deputy manager who told us it would be addressed.

There was information displayed in the home about advocacy services and how to contact them. The deputy manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes. They told us an Independent Mental Health Advocate(IMHA) was involved with a person due to a health care need where surgery was recommended by health care professionals.

One relative who was very appreciative wanted to tell us about the care of their recently deceased relative they told us, "[Name], staff member, reassured me and supported me during the night and explained everything that was happening and why they were doing certain things." Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we had found a breach with regard to person centred care. Records at this inspection showed some improvements had been made to ensure people received care that was person centred. However, we considered more improvements were needed with regard to record keeping to ensure they reflected the care provided by staff.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of people's needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, mobility and falls and personal hygiene. Most evaluations were detailed and included information about people's progress and well-being.

Charts were not all in place for people who were receiving end of life care to record any staff intervention with the person. For example, when staff turned the person in bed, to help reduce the risk of developing pressure areas. When a person was offered some hydration, or mouth hydration to keep them comfortable. When personal hygiene was attended to and other interventions to ensure peoples' daily routines were carried out. One relative told us, "[Name] bathed my relative three times during the night to make sure they were comfortable the whole time." They also told us, "During the night staff checked [Name] every half an hour and then every twenty minutes and then ten minutes." These records were needed to make sure staff had information that was accurate so people could be supported in line with their current needs. This was attended to immediately by the deputy manager who set up the relevant daily accountability records for people.

Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day. The food charts however did not accurately record the amount of food a person had eaten in order to monitor their nutritional intake. The recordings were subjective as they stated 'all' food eaten when it was not known how much had been offered in the first place.

Most care plans reflected people's needs. However, they were not all up to date. Emergency care plans were not in place for people who were receiving end of life care. This was addressed by the deputy manager at the time of inspection. Care plans that were in place required more information and guidance for staff about people's care needs and how they liked to be supported. They were not broken down to detail the guidance for staff to show what intervention was required by them and what the person was able to do themselves to help maintain their independence. A care plan for nutrition contained contradictory information as it did not accurately record the guidance provided by the speech and language team with regard to the amount of

thickener that was required in a person's fluids. We checked this with staff who had been following the specialist guidance and using the correct amount. The deputy manager told us this would be addressed and the care plan amended to record the correct amount.

The deputy manager told us if there were any concerns about a change in a person's behaviour a referral would be made to the challenging behaviour team or the department of psychiatry of old age. Staff told us they followed the instructions and guidance of the behavioural if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

Records were in place to provide some guidance to staff if a person became distressed. However, one care plan advised four members of staff were required to support a person if they became distressed and agitated when they received personal care. The care plan contained some information but it was not broken down to give staff instructions with regard to how to support the person as personal care was carried out, to help reduce the anxiety and distressed behaviour and alleviate the person's embarrassment.

Information was available for some people in the form of a life history and a record of their likes and dislikes, which had been collected before they began to use the service. However, this information was not detailed for all people to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. We discussed with the deputy manager the need to ensure the pre-admission process involved collecting this information from relatives if necessary. This information would give staff some insight into people's previous interests and hobbies when people could no longer communicate this information themselves.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People confirmed they had a choice about getting involved in activities. One person told us, "I have been playing dominos this morning but I didn't win." Another person commented, "I've seen lots of activities going on here." A relative said, "[Name] joins in the activities with staff." The registered manager told us two activities posts were available in the home. One post was currently vacant and the other person was absent. In their absence activities were being carried out by staff.

Staff told us they had time to engage in activities with people before lunch and early afternoon. Activities available included board games, bingo, relaxation and music, art and crafts, sing-a-long, pamper sessions and film afternoons. Other activities included pet therapy, reminiscence and armchair exercises. Church services took place regularly and the hairdresser came in weekly. Forthcoming events and entertainment were advertised and these included fund raising events and fayres. One relative told us, "Christmas here was outstanding, they [staff] really go out on a limb, each person received an individual present and card." People were supported to access the local community to go shopping.

Monthly meetings were held with people who used the service and their relatives. The meetings provided feedback from people about the running of the home. One relative told us, "I find the meetings very positive, we discuss fund raising events and entertainment."

People using the service and their relatives told us they were aware of whom to complain to and expressed confidence that issues would be resolved. Most said they would speak to the registered manager or a senior member of staff if they had any concerns. One relative told us, "It's amazing here, I have no complaints all." A copy of the complaints procedure was clearly available in the hallway and information was given to each

person about how they could complain. A record of complaints was maintained and we saw one complaint had been received since the last inspection and it had been investigated and resolved.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had become registered as manager for Ella McCambridge Care Home in May 2014. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

Records showed audits were carried out regularly and updated as required. However, the audit and governance processes had failed to identify deficits in certain aspects of record keeping as identified at inspection.

The deputy manager told us monthly audits were carried out and the results were signed off by the operational manager from head office. Monthly audits included checks on care documentation, staff training, medicines management, home presentation, complaints management, health and safety and accidents and incidents. Other audits included for health and safety and infection control.

Monthly visits were carried out by a representative from head office to speak to people and the staff regarding the standards in the home. Reports showed they also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, social activities, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Staff were positive about the management of the home and had respect for them. One staff member commented, "The registered manager is really approachable." Another staff member told us, "I enjoy coming to work." Other staff comments included, "We're a staff team we work well together" and "The management team are really supportive." Staff told us morale was good and the management structure of the home had been strengthened to provide assistance to the registered manager.

The atmosphere in the home was lively and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. One relative told us, "The registered manager is always available and we can go to them for anything. People and relatives told us they were listened to by the registered manager.

The registered manager said they introduced changes to the home to help its smooth running and to help ensure it was well-led for the benefit of people who used the service. They responded quickly to address any concerns, if they were raised and readily accepted any advice and guidance.

The registered manager assisted us with the first part of the inspection, when they were not available we were then assisted by the deputy manager. Records we requested were produced promptly and we were able to access the care records we required. The deputy manager was able to highlight the priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager said they were well supported in their role by the provider and area managers. Staff

told us and meeting minutes were available to show that regular staff meetings took place and these included general staff meetings, management meetings, domestic staff and kitchen staff meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues and developments.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and visiting professionals. We saw copies of the survey results for the quality assurance audit for 2016. The registered manager told us the results were analysed by head office and the service. We saw findings from the survey were overwhelmingly positive and where suggestions for improvement were made action was immediately taken to address the issue.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records did not accurately reflect the care provided by staff. The registered person did not maintain an accurate, complete and contemporaneous record for each person who lived at the home. Regulation 17 (2)(c)