Brendoncare Foundation(The)

Brendoncare Ronald Gibson House

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

Summary of findings

Overall summary

We conducted an inspection of Brendoncare Ronald Gibson House on 25 and 26 January 2016. The first day of the inspection was unannounced. We told the provider we would be returning for the second day.

We undertook a focussed inspection of this service in August 2015 to check that the provider had followed their action plan in relation to breaches previously found in February 2015 in relation to medicines management and good governance. During that inspection we found improvements had been made in relation to medicines management, but some inconsistencies remained in relation to assessing people's pain and in record keeping. The provider sent a plan after this inspection setting out how they planned to address these issues. We also found improvements had been made in relation to good governance, but found some gaps and inconsistency in completing some aspects of record keeping. We conducted this inspection to check that improvements were being sustained in accordance with the provider's latest action plan and that remaining issues had been addressed.

Brendoncare Ronald Gibson House is a care home with nursing for up to 56 people. There are three units at the home, all overseen by a deputy manager who is a registered nurse. Winsor unit is based on the ground floor and is an intermediate care unit, providing short term rehabilitation services for people to support them to return home, if appropriate, after injury or illness. Wessex unit, also on the ground floor provides care for people living with dementia. Warwick unit provides care for frail or older people, some of whom were receiving palliative care.

There was a registered manager at the service. 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.

Staff had completed medicines administration training within the last year and were clear about their responsibilities. Pain assessments were carried out appropriately and these were monitored by the GP.

Risk assessments and support plans contained clear information for staff. All records were reviewed every month or where the person's care needs had changed.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. However we saw examples of people's rights not being observed under the MCA 2005.

Most staff demonstrated an understanding of people's life histories and current circumstances and supported people to meet their individual needs in a caring way.

People using the service and their relatives were involved in decisions about their care and how their needs were met. People had care plans in place that reflected their assessed needs.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role. Staff were provided with appropriate training to help them carry out their duties. Staff received regular supervision. There were enough staff employed to meet people's needs.

People who used the service gave us good feedback about the care workers. Staff respected people's privacy and dignity and people's cultural and religious needs were met.

People were supported to maintain a balanced, nutritious diet. People were supported effectively with their health needs and were supported to access a range of healthcare professionals.

People using the service and staff felt able to speak with the registered manager and provided feedback on the service. They knew how to make complaints and there was a complaints policy and procedure in place.

People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. An activities programme was in place which covered seven days a week and this included a mixture of one to one sessions and group activities.

The organisation had adequate systems in place to monitor the quality of the service. Feedback was obtained from people through biannual residents meetings and annual questionnaires using the service and the results of this were positive. There was evidence of auditing in many areas of care provided as well as significant monitoring from senior staff members within the organisation.

We found one breach of regulation in relation to consent. You can see what action we asked the provider to take at the back of the full version of this 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. The service had adequate systems for recording, storing and administering medicines safely and all previous concerns had been rectified.

The risks to people's health were identified and appropriate action was taken to manage these and keep people safe.

Procedures were in place to protect people from abuse. Staff knew how to
identify abuse and knew the correct procedures to follow if they suspected
abuse had occurred.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not consistently effective. The service was not consistently meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff demonstrated a good knowledge of their responsibilities under the MCA. However, there were some discrepancies in relation to obtaining people's valid consent.

People were supported by staff who had the appropriate skills and knowledge to meet their needs. Staff received an induction and regular supervision and training to carry out their role.

People were supported to maintain a healthy diet. People were supported to maintain good health and were supported to access healthcare services and support when required.

Is the service caring?

Good

The service was caring. People using the service and relatives were satisfied with the level of care given by staff.

People and their relatives told us that care workers spoke to them and got to
know them well.

People's privacy and dignity was respected and care staff provided examples of how they did this. People's cultural diversity was respected and celebrated.

Is the service responsive?

Good

The service was responsive. People's needs were assessed before they began using the service and care was planned in response to these.

People were encouraged to be active and participate in activities they enjoyed. There were two dedicated activities coordinators who ran an activities programme that covered seven days a week. This included group activities, one to one sessions and outdoor visits.

People told us they knew who to complain to and felt they would be listened
to.

Is the service well-led?

Good

The service was well-led. Staff gave good feedback about the registered manager.

Quality assurance systems were thorough. Feedback was obtained from people using the service in the form of questionnaires as well as in person through biannual residents meetings. The registered manager completed various audits and further auditing of the quality of the service was completed by senior management within the organisation.

Brendoncare Ronald Gibson House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and sustaining improvements previously made to the service, 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 25 and 26 January 2016. The inspection team consisted of one inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection the specialist adviser was a social worker with expertise in dementia care. The first day of our inspection was not announced, but we told the provider we would be returning for a second day.

Prior to the inspection we reviewed the information we held about the service. We contacted a representative from the local authority safeguarding team and spoke with four more professionals who worked with the service to obtain their feedback.

During the inspection we spoke with 11 people using the service and five relatives of people using the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with 11 care assistants, four nurses, two activities coordinators, the chief operating officer of the organisation, a manager of another service who was conducting audits at the service, the training coordinator, the deputy manager and the registered manager of the service. We looked at a sample of eight people's care records, 10 staff records and records related to the management of the service. We also spoke

with four healthcare professionals to obtain their views of the service.

Good

Is the service safe?

Our findings

At our previous inspection which took place in August 2015 we found that serious concerns in relation to medicines management had been addressed. However, we found some inconsistency in the assessment of people's pain and some minor inconsistencies in recording. At our recent inspection we found all inconsistencies had been addressed and the service was following safe practices for the administration and storage of medicines.

People who were in receipt of regular pain medicines had pain assessments completed at least every month or more where required and these were overseen by the GP. People had separate pain records known as a "pain pathway" and these included detailed records of monitoring of people's pain. We saw associated medicines care plans which included details of their other medicines, any allergies and other relevant information.

Medicines were delivered on a monthly basis for named individuals by the same pharmacy. Controlled medicines were stored safely for each person in a locked cupboard within a medicines storage room and other medicines were stored in people's rooms. We saw the temperature in the medicines storage rooms was controlled, monitored and recorded on a daily basis. The temperature was at a safe level on the day of our inspection.

We looked at the three controlled drugs cabinets within three separate medicines storage rooms. We saw that controlled drugs were stored in an appropriately constructed safe which was within another cabinet which was also locked. These medicines were recorded in a separate book and the amounts were checked twice a day by two nurses. We did a physical count of the controlled drugs in each room and saw the amount recorded tallied with the amount available.

We saw examples of completed medicine administration record (MAR) charts for six people for the month of our inspection. We saw that staff had fully completed these. The deputy manager retrieved medicines from people's rooms with their permission and we counted the amounts stored. We saw these tallied with the records kept.

We saw copies of monthly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. The checks we saw did not identify any issues.

Nurses had completed medicines administration training within the last two years. When we spoke with the nurses, they were knowledgeable about how to correctly store and administer medicines.

At the time of our inspection staff were in the process of implementing a new electronic medicines administration system. We spoke to the lead member of staff from the external company implementing the system. They explained that a member of their organisation had been at the service to cover the previous 24 hours to ensure a swift handover of all data to the new system. We found a member of their team was

available to answer questions for the duration of our inspection which included the night shift. We spoke with nurses who had been trained in using the new system and they demonstrated a good level of knowledge in how to use it.

People told us they felt safe using the service. Comments included "I feel safe here" and "It is a safe home."

The provider had a safeguarding adults policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated a good understanding of how to recognise abuse. Staff knew how to report safeguarding concerns and explained the various signs of abuse and different types of abuse. One care worker told us "There is not just one type of abuse. For example it could be financial or emotional." We spoke with a member of the safeguarding team at the local authority and they confirmed they did not have any concerns about the safety of people using the service.

The provider had a whistle blowing policy in place and staff explained this to us. One care worker said "We have a whistle blowing policy. So if nobody's listening to my concerns I will look at this and go up the ladder." Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

Staff received emergency training as part of their mandatory training which involved what to do in the event of an accident, incident or medical emergency. Staff told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. For example one care worker told us about an accident one person had previously. They told us how they had responded to the accident and how they had changed their practice and learned from this. There was an emergency call bell in place to alert all staff in case of an emergency and this could be heard by staff in the entire building. We saw call bells were in place in people's rooms and that these were within reach and working.

We asked nurses about what they would do in the event of a medical emergency and they explained what training they had done to respond to these situations. Nurses were aware who was for and was not for resuscitation. These details were in people's files on "Do not Attempt Resuscitation" forms which had been signed by the GP. However, one nurse was not sure if one person was for resuscitation or not.

We looked at eight people's support plans and risk assessments. Initial information about the risks to people was included in an initial needs assessment. This information was used to prepare care plans and risk assessments in areas including manual handling, skin integrity, falls and continence. The information in these documents included practical guidance for care workers in how to manage risks to people. Risk assessments were reviewed on a monthly basis or sooner if the person's needs changed.

Staff told us they felt there were enough of them on duty to do their jobs properly. Comments included "Yes, I think there are enough staff now" and "Things are ok at the moment".

The registered manager explained that the number of staff members on duty at any time was originally negotiated as part of the initial contract with the Clinical Commissioning Group (CCG). This was reviewed according to the needs of all new people being admitted to the service. If more staff were required this could be renegotiated. Senior staff at the service assessed people's needs on admission to determine whether they could be appropriately cared for. Some people with higher needs had their dependency assessed using a specific tool and we saw two examples of this whilst looking at care records. The results of these assessments were used for renegotiation purposes where necessary. We reviewed the staffing rota for the

week of our inspection and this accurately reflected the number of staff on duty.

We looked at the recruitment records for 10 staff members and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms. Records of nurses also included their Nursing and Midwifery Council registration details.

Requires Improvement

Is the service effective?

Our findings

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.

We checked whether the service was working within the principles of the MCA, and found that the provider was not consistently meeting the requirements of the MCA. Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent.

However, we saw examples of people's rights not being observed under the MCA. For example we saw care records of two people who were deemed to have fluctuating capacity and had bed rails in place. We saw evidence that both people had mental capacity assessments conducted appropriately in respect of the decision to implement bed rails. However, there was no valid DoLS authorisation in place for either person. We were given one copy of an application for a DoLS authorisation for one of these people, but no application had been made for the other person.

We also queried the decisions being made for one of these people. We were told they had a Lasting Power of Attorney in place to make decisions on their behalf. However, when shown the documentation to authorise this we found this person was only authorised to make financial decisions for this person and not health and welfare decisions.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff had the appropriate skills and knowledge to meet their needs. A relative said, "They're pretty good. They know what they're doing and they get on with it" and "They do their jobs well." The registered manager told us, and care workers confirmed, that they completed training as part of their induction as well as ongoing training. Records confirmed that all staff had completed mandatory training in various topics as part of their induction. These topics included safeguarding adults, medicines administration and dignity. There was also more specialist training available where required, for example in the week following our inspection we saw a session in dementia mapping was arranged. We reviewed the training matrix and found that staff had completed training in the mandatory topics within the last two years.

The registered manager told us, and care workers confirmed, that they discussed person centred care during their induction and this was also part of an ongoing discussion as well as the training in dementia mapping which was planned. Care workers told us these discussions focussed on how to deliver a service based on people's individual needs. Care workers gave us practical examples of how people's individual

choices were at the centre of the work they did and were able to describe people's health conditions, how these manifested themselves as well as people's habits and routines. Care workers also demonstrated knowledge of people's relatives and their life histories.

Care workers confirmed they could request extra training where required and they felt that they received enough training to do their jobs well. One care worker told us, "We get loads and loads of training."

Staff told us they felt well supported and received regular supervision of their competence to carry out their work. We saw records to indicate that staff supervisions took place every three months. We were told by the registered manager and care workers that they used supervisions to discuss individual people's needs as well as their training and development needs. The registered manager told us annual appraisals would be conducted of care workers performance once they had worked at the service for one year. Staff who had worked at the service for over a year told us they had received an appraisal of their performance and we saw records to demonstrate this.

People were encouraged to eat a healthy and balanced diet. People's care records included information about their dietary requirements which included details about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. This included specific risk assessments in eating and drinking and a separate swallowing risk assessment was also completed when necessary. We found details of involvement from multi-disciplinary teams where required which included dietitians and speech and language therapists. Where referrals were required, we saw from records that these were done and advice was obtained and implemented. Where monthly monitoring was required, for example monthly weight checks, we saw this was done and recorded. We found specific nutrition support plans which included specific targets that people wanted to achieve and these records were evaluated and updated on a monthly basis.

People told us they liked the food available at the service. Comments included "The food is very good", "I like the food" and "It's plain cooking, very well done." We spoke with the chef about the food available. They explained that they obtained feedback about the food from the care workers and from people using the service directly. The chef altered the menu each month depending on the feedback received and we saw a copy of the menu for the month of our inspection. Food was seasonal and variations were made according to the season. We sampled the lunch on the first day of our inspection. The food was appetising, of a good portion and served at the correct temperature.

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care, and senior staff told us they were in regular contact with people's families to ensure all parties were well informed about peoples' health needs. When questioned, care workers demonstrated they understood people's health needs. For example, all care workers told us how people were feeling on the days of our inspection and if they had any specific health conditions. We saw that GPs visited the service on a daily basis. We spoke with two different GPs during our inspection. They provided explanations of their working relationship with staff and gave good feedback about the care provided.

Good

Is the service caring?

Our findings

People who used the service gave us good feedback about the care workers. Comments included "Staff are nice" and "The carers are excellent and give 110%. You can't beat these carers." Relatives also told us they were happy with the care provided. A relative told us "I'm very happy with the care."

Most staff demonstrated a good understanding of people's life histories. Senior staff and care workers told us they asked questions about people's life histories and people important to them when they first joined the service, however, we saw varying levels of detail recorded in people's care records. Some care records included a document which had details of people's life histories, but some did not. Most staff members told us details about people's lives and the circumstances which had led them to using the service. Most were well acquainted with people's habits and daily routines. For example, staff were able to tell us about people's likes and dislikes in relation to activities as well as things that could affect people's moods. However, two members of agency staff had very little knowledge of the life histories of the people they were caring for.

People we spoke with told us they were able to make choices about the care and support provided and told us their wishes were respected. One person said "They ask me what I want and do what I ask." Staff told us they respected people's choices and encouraged them to be as independent as possible. Comments included "We encourage people to do as much for themselves as possible" and another care worker told us one person "Has deteriorated sharply. But he can still make decisions about how he wants things done, so that keeps him involved."

We saw good levels of interaction from care workers during our inspection. Some interactions we observed and conversations we overheard demonstrated that staff knew people well and were on friendly and familiar terms. We observed the lunchtime period and saw staff helping people with their food, having conversations with people as they were doing so. We saw people's relatives visited the service throughout the day and they also appeared to be on familiar terms with staff. We saw there was a family room with a sofa bed for relatives to use if they needed to stay with their family member.

People we spoke with told us their privacy was respected. One person told us, "They respect me."
Care workers explained how they promoted people's privacy and dignity. Their comments included "I make sure the doors are closed when I give personal care. I also cover the person with a towel when they don't need to be exposed" and "I always knock on people's doors before going in." We observed staff speaking to people with respect and knocking on doors before entering their rooms.

Care records demonstrated that people's cultural and religious requirements were considered when people first started using the service. We saw initial assessments included details of people's cultural and religious requirements. We saw one care worker speaking to a person who spoke the same language and we were told they helped them regularly.

People told us their religious needs were met. For example one person told us "I see the priest every week"

and we saw evidence that the service had good links with other religious leaders in the community. For example, members of the local mosque had visited recently to give a talk on the Islamic faith and answer any questions people had.

People's cultural identity was also celebrated. For example, on the day of our inspection we were told it was "Burns night". Activities focussed on celebrating the famous Scottish poet as well as Scottish customs and traditions.

Good

Is the service responsive?

Our findings

Relatives we spoke with told us they were involved in decisions about the care provided and that they were aware of their relative's care plan. A relative told us, "They keep me informed of what's going on and I have seen [my relative's] care plan."

People were encouraged to express their views and be involved in decisions regarding their care. People were given information when first joining in the form of a brochure which included details about the service provided and the core values of the service. Residents meetings were previously held biannually, but this had recently been changed to quarterly. We saw minutes relating to these meetings and saw various topics were discussed and actions had been taken to rectify issues raised. Care records also included details about people's views and staff explained that they prioritised people's choices in relation to their care. For example care workers gave us numerous examples of how they respected people's choices in their daily lives. They told us people's food preferences, their preferred routines and their preferred activities. One care worker also added "I always double check that I'm doing things right and that they haven't changed their mind on anything, because we can all change our minds about what we want and what we like."

People's needs were assessed before they began using the service and care was planned in response to these. Assessments were completed in various aspects of people's medical, physical and social needs. The care records we looked at included care plans in areas including nutrition, continence and moving and handling which had been developed from the assessment of people's individual needs. Care records showed staff prioritised people's views in the assessment of their needs and planning of their care. Care plans included details about people's likes and dislikes in relation to a number of different areas including nutrition and activities. People's progress was reviewed at meetings with their key worker every month. People's views were then used to formulate future goals.

People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. The service had two full time activities coordinators who implemented an activities programme that spanned seven days a week. Activities were planned for the month in advance and they were displayed on noticeboards on both floors of the building.

The activities coordinators spoke with people and obtained their feedback in relation to activities. They had dedicated activities care plans which recorded these details. We read three different care plans and saw they included some details about people's life histories and how these had informed their current preferences in relation to activities. The care plans also included advice about how to help different people participate in activities, some of whom had specific cognitive diagnoses including dementia and some with other short term memory problems. The activities coordinators spoke passionately about including all people in the activities programme. One told us "There is always something you can do for people." We were told that one person with a deteriorating health condition who could not leave their bed enjoyed listening to music and having conversations. The activities coordinator told us they visited this person for one to one sessions with another person living in the home. We saw one to one sessions were included in the activities programme and we observed part of a one to one session taking place where the activities coordinator played the violin

to one person who appeared to enjoy this.

Outings were arranged and these included trips to religious services, pub lunches or days at the seaside. Other types of activities on offer were cake decorating, flower arranging and a session called "Oomph" among others. People gave good feedback about the "Oomph" sessions in particular. This session involved light exercise to music, using pom poms. We saw the activities coordinators were wearing specially made "Oomph" t-shirts on the day of our inspection and were encouraging people to take part.

We observed other activities taking place on the day of our inspection. For example we saw a volunteer attend the service with a dog and some home-made cake. The subsequent activity was vibrant and lively. People enjoyed playing with the dog, having conversations, listening to the music and enjoying the cake and hot drinks on offer. The activities coordinator explained the therapeutic benefits to people through interacting with the dog and also explained another programme they had designed through research which focused on music, singing and lyrics.

The service had a complaints policy which outlined how formal complaints were to be dealt with. People using the service told us they would speak with a staff member if they had reason to complain. We saw records of complaints and saw these were dealt with in line with the provider's policy. Care workers we spoke with confirmed that they discussed people's care needs in their supervision sessions and their team meetings. They told us if there were any issues or complaints they would discuss them at these times.

Good

Is the service well-led?

Our findings

The service had an open culture that encouraged people's involvement in decisions that affected them. Staff and relatives told us the registered manager was available and listened to what they had to say. Comments from staff included "He's a good manager, he speaks with respect" and "I feel comfortable talking to him." We observed the registered manager interacting with people using the service throughout the day in a friendly manner.

The registered manager told us various staff meetings were held weekly and monthly and full staff meetings were held biannually in addition to daily handover meetings which took place twice a day. Staff told us they felt able to contribute to these meetings and found the topics discussed were useful to their role. We read the minutes from the most recent biannual full staff meeting. These showed that numerous discussions were held with actions and identified timeframes for completion.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was received during residents meetings. People told us they found these meetings helpful and felt comfortable speaking in them. We were told by the registered manager that if issues were identified, these would be dealt with individually and we were given an example of when this had happened. The service also conducted an annual "Your care rating" questionnaire which asked people various questions about the quality of care they were experiencing. This was run by volunteers in order to ensure impartial results. We saw a copy of the previous year's findings and a subsequent action plan which had been devised in response to the results.

We saw records of complaints, and accident and incident records. There was a clear process for reporting and managing these. The registered manager told us they reviewed complaints, accidents and incidents to monitor trends or identify further action required and we saw evidence of this. They told us all accidents and incidents were also reviewed by senior staff within the organisation who also monitored the results for trends and made further recommendations where required. This data was also reported every quarter to the Clinical Commissioning Group (CCG) which conducted the same function.

Information was reported to the Care Quality Commission (CQC) as required. We spoke with a member of the local authority and they did not have any concerns about the service.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

The provider had systems to monitor the quality of the care and support people received. We saw evidence of numerous audits covering a range of issues such as medicines, falls, deaths and the use of agency staff. Reporting on all of these issues was also made to the organisation's "care and clinical governance" board

which monitored the results for trends, issues and otherwise made recommendations where necessary. The registered manager conducted a weekly check of call bell records to ensure calls were being answered in a reasonable timeframe. A weekly "snapshot audit" was also conducted. This involved auditing three people's care records. We saw a written record of this which included further actions for improvement. We also saw evidence of a monthly home review which was conducted by the organisation's chief operating officer who was also in attendance during our inspection. This involved a review of numerous areas of the organisation including training and performance. The chief operating officer then produced a report of their results with further actions for the registered manager.

We also saw records of extensive involvement in the home from other managers of other homes within the organisation. During our inspection we met the manager of another home who was conducting audits for Ronald Gibson House. They explained that some auditing and investigations were conducted by other managers within the organisation to promote impartiality.

The provider worked with other organisations to ensure the service followed best practice. We saw evidence in care records that showed close working with local multi-disciplinary teams, which included the Behaviour and Communication Support Services, the GP, Trinity Hospice and local social services teams among others. We spoke with three health and social care professionals and they commented positively on their working relationship with staff at Brendoncare Ronald Gibson House.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 in circumstances where service users may have lacked capacity to consent to decisions regarding their care (Regulation 11(3)).