BM Care Warwick Limited

Bromson Hill Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Bromson Hill Care Home on 1 December 2015. The inspection visit was unannounced.

Bromson Hill is divided into two separate floors and provides personal and nursing care for up to 32 older people, including people living with dementia. There were 28 people living at the home when we inspected the service.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection. We refer to the registered manager as the manager in the body of this report.

A full record of each person's individual care and support needs was not maintained. People's care records did not reflect the care and support they received from staff on a daily basis. However, permanent staff knew people well and could describe people's care and support needs. Improvements were being made to the checking of care records to ensure they were kept up to date in the future.

People received medicines to maintain their health and wellbeing. The latest guidance on the administration of certain medicines needed improvement to ensure people received their medicines safely. People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health.

People were protected against the risk of abuse as the provider took appropriate steps to recruit staff of good character, and staff knew how to protect people from harm. Safeguarding concerns were investigated and responded to in a timely way to ensure people were supported safely. There were enough staff to care for people effectively and safely, and meet people's individual needs.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. Complaints received were fully investigated and analysed so that the provider could learn from them. People who used the service and their relatives were given the opportunity to share their views about how the service was run. Quality assurance procedures

identified where the service needed to make improvements, and where issues had been identified the manager took action to continuously improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicine administration procedures and medicine records required improvement to ensure people received their prescribed medicines safely. There were enough staff available to care for people effectively and safely. People felt safe living at the home. People were protected from the risk of abuse, as staff knew how to safeguard people from abuse. The provider recruited staff of good character to support people at the home.

Is the service effective?

Good

The service was effective.

Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. People received food and drink that met their preference, and supported them to maintain their health. Where people could not make decisions for themselves, people's rights were protected; important decisions were made in their 'best interests' in consultation with health professionals.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and kindness. Staff knew people well, and respected people's privacy and dignity. Staff supported people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were supported to take part in interests and hobbies that met their needs. People did not always have an up to date record of their care and support needs, or of the care they received each day, to ensure care was delivered consistently by staff. People were able to raise complaints and provide feedback about the service, which was acted on by the provider.

Is the service well-led?

Good

The service was well led.

The manager was accessible to people who used the service, their relatives, and members of staff. People were asked for their feedback on how the service could be improved, and feedback was acted upon. Quality assurance procedures identified areas where the service could improve, and the manager took action to improve the service.

Bromson Hill 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 was 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 1 December 2015. The inspection was unannounced. This inspection was conducted by one inspector, a specialist advisor, and an expert-by-experience. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home.

Some people had limited verbal communication skills, and so we spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who lived at the home and four people's visitors or relatives. We spoke with seven members of staff including two nurses, one of which was the deputy manager, three members of care staff, and one member of the building maintenance team. We also spoke with the registered manager at the home.

We looked at a range of records about people's care including three care files, and other records relating to people's care, for example, medicines records and fluid charts. This was to assess whether the information needed and the care offered to each person was available.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback from people about whether they received their prescribed medicines safely. One relative told us, "They were not giving [Name] their eye drops after they had been prescribed by the hospital." We spoke with the manager about the person, who explained that this had been an error with the pharmacy, and that the person now received their medicine as prescribed. Another person told us, "Medication is given on time by regular staff, they never miss my medication."

We observed medicines being administered. Staff who administered medication were trained nurses, and had received specialised training in how to administer medicines safely. Nurses confirmed this included checks on their competency. Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed. We reviewed the MAR for nine people at the home. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use temporary or agency staff to administer medicines who might not know the people there. Daily checks were undertaken by nurses to check people received their medicines. Medicines were stored safely.

Some people received medicines that were prescribed on an 'as required' (PRN) basis, such as pain relief. This meant the medicines should only be given when people were in pain. We saw the MAR did not describe the signs of pain people might display to ensure staff knew when to give them their medicine. However, where people were unable to speak, and so could not inform staff of when they were in pain, staff could describe to us the visual signs of pain people might display. The manager had also implemented a tool to assist staff in recognising the signs of pain, so that staff could assess whether people needed their medicine.

We found staff were not always following the latest recommended protocol to administer some types of medicines. Some people required their medicine before they were able to have a meal. For example, one person needed to have their medicine at least 30 minutes before their breakfast. This was so the medicine did not cause the person a reaction to the medicine. This had not happened on the day of our inspection. We brought this to the attention of the nurse responsible for administered medicines, who immediately updated their protocol to take into account the latest guidance.

Some people were prescribed creams for their skin. These were administered by care staff at the home, and separate records were kept to record when the creams were administered. We found that the charts for the recording of when creams were given were not consistently completed. For example, on one person's chart we found there were gaps on four consecutive days in November. In another person's chart we saw entries had not been completed on eight different occasions in November. However, one person who was administered creams to their skin told us, "The carers are really good, they really look after my skin well. All the sores that I had when I came here have now healed." After speaking with people and staff we concluded that inconsistencies in the charts were in relation to poor record keeping, rather than the administering of the medicines. The manager had recently implemented a monitoring and auditing tool to check people's medicine records and charts, and was using the tool to monitor any gaps in records, and follow up on any discrepancies.

People gave us mixed feedback about whether there were enough staff at the home to care for people safely. One person said, "I don't think there are always enough staff, they seem to be pushed." Another person said, "Sometimes in the afternoons there are no staff around."

However, staff told us they thought there were enough staff to care for people safely. One member of staff said, "Yes there are enough staff at the home, day and night." Another staff member explained, "We have just been through a bad patch with staffing but everything is fine now. Some staff left a few months ago, we used agency staff until we had recruited to all the vacancies."

We asked people if staff answered their call bell straight away when they needed assistance. We received mixed feedback from people at the home. One person said 'yes', another person stated, "When I press my buzzer, they don't always come quickly." We spoke with two members of staff about their responsiveness to call bells. One member of staff told us, "There are enough staff now that we have filled all the vacancies, and staff respond to call bells as quickly as we can." Another staff member said, "We always attend to people when they call their bell." The manager explained they had recently introduced a call bell auditing system to track the time taken to answer call bells. This was to ensure the home had the right numbers of staff available.

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, and by the needs, or dependency levels of each person. We saw each person had a completed dependency tool in their care records, which assessed how much care and support they required. The manager used this information, along with auditing information and staff feedback, to determine the numbers of staff that were needed to care for people safely and effectively.

We asked the manager about the number of staff vacancies at the home, they told us they had just completed a recruitment campaign, and filled all the vacancies for staff. However, they were still using some agency staff, whilst newly recruited staff were checked to ensure they were of good character, and had received sufficient induction training.

During our inspection visit we observed there were enough staff to care for people effectively and safely. Staff were available at all times in the communal lounge area of the home. In addition to the nurse and care staff, the manager was available to cover care duties at the home. The activities co-ordinator also spent most of their time in the lounge area, and were available to assist people if they needed support. Following our visit the manager implemented a system where staff checked the communal areas in the home every ten minutes, to ensure people were offered the support they needed.

All the staff knew and understood their responsibilities to keep people safe and protect them from harm. All the people we spoke with told us they felt safe at the home. One person said, "Of course I feel safe." Another person told us how staff responded to a concern about their welfare, they said, "I told a member of staff about an incident with a staff member that concerned me, straight away they reported it to the manager who looked into it."

The provider protected people against the risk of abuse and safeguarded people from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. Staff attended safeguarding training regularly which included information on how staff could raise issues with the provider. Staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone. They were

confident the manager would act appropriately to protect people from harm.

Staff told us, and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of candidates prior to them being recruited to work at the home. For example, criminal record checks, identification checks and references were sought before staff were employed to support people.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Risk assessments were detailed, and reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, one person was at risk of falling, and could injure themselves. There were plans for staff to follow in how the person should be assisted to move around, and what equipment should be in place to minimise the risk of them falling.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as the manager's unexpected absence were planned for and there was a plan in place for a deputy to step in, so that any disruption to people's care and support was minimised. This was to minimise the risk of people's support being provided inconsistently.

Good

Is the service effective?

Our findings

We received mixed feedback from people about whether the staff had the right skills they needed to care for people effectively. One person told us, "Most carers know what they are doing." Another person said, "The staff could clean my relative's hands much better." A third person told us, "The staff are very good; they are 1st rate."

Staff told us they received an induction when they started work which included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. Staff told us in addition to completing the induction programme; they had a lengthy probationary period to check they had the right skills and attitudes for the people they supported.

Staff told us the manager encouraged them to keep their training and skills up to date. The manager maintained a record of staff training, so that they could identify when staff needed to refresh their skills. Staff told us that each member of staff received an individual training programme tailored to their specific job role. For example, nursing staff received specialist training in medicine administration. One member of staff told us, "Yes, the training is good and we have the skills we need." Another member of staff told us, "If we want any further training in something we just ask, and it's organised for us." Staff told us the provider also invested in their personal development, as they were supported to achieve nationally recognised qualifications.

Staff used their skills to assist people at the home. For example, staff used appropriate moving and handling equipment and techniques when they assisted people during our inspection. We saw one person being moved using a hoist and 'handling belt'. Staff explained to the person what they were intending to do, and offered the person reassurance. The person's privacy was maintained, and the transfer was completed safely.

Staff used their skills to support people at mealtimes. Staff supported people to eat their meals in a calm and unhurried manner. People were given time to eat their meal at their own pace, and staff waited for clear signals from people before offering them more food. Staff explained to people what they were eating, and were patient. Most people enjoyed the food on offer. One person said, "The food is OK, and there are choices about what you want to eat." Another person told us, "The food needs some improvement like more fresh vegetables, but they are trying different things based on our feedback." Relatives told us people were offered a choice of meal, and had individualised food that met people's preferences and dietary options.

Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet and gluten free diets. A daily menu of the food on offer was displayed on the notice board at the home, so that people could choose each day what they wanted to eat. People were able to choose from a range of options and staff asked people for

their food choices before their meal was prepared. Where people were unable to make decisions themselves staff made choices based on the individual's likes and dislikes, which were recorded in the care records we reviewed. We saw people could chose alternative foods if they did not like what was on offer at the mealtime. The manager confirmed, "If people don't like the food, we can offer alternatives at each mealtime."

Where people needed to receive a specific amount of food or fluid to maintain their health each day, people had their food and fluid intakes monitored by nursing staff. All staff were directed by the nurse on duty to record how much people consumed using a chart system. We found the fluid and food charts were not consistently completed, or audited each day to check people received the amounts they needed. In addition, the charts did not contain information on what the target intake was each day for staff to check against. For example, in one person's charts it showed that they only consumed 600mls fluid on one day in November 2015, on other days there was nothing recorded. This was below the recommended daily amount of fluid adults should drink each day. We spoke to a member of staff about the person, they said, "The person is drinking more each day, but some staff just forget to write it down." The manager confirmed, "People are having enough food and fluids to maintain their health, it's just not accurately recorded." The manager had already identified the need to update charts more accurately in a recent audit. Following our inspection they immediately implemented a daily checking system. A nurse we spoke with after our inspection confirmed this, they said, "We check the records each day now to make sure things are recorded and people are receiving the fluid they need."

We saw a drinks tray with pre-prepared drinks was also available for people to help themselves in the communal areas of the home. Staff offered people drinks throughout the day, which helped people maintain their health such as tea, water and juice. Staff waited for a response from people regarding their preferences before preparing their drink.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Mental capacity assessments were completed when people could not make decisions for themselves. Staff demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. Where people could not make decisions for themselves, records confirmed important decisions had been made in their 'best interests' in consultation with health professionals.

The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Where people required a DoLS application to be made, the manager had made the appropriate applications to the local authority in accordance with their guidance.

Staff were able to respond to how people were feeling and to their changing health or care needs because

they had a verbal handover at the start of each shift. We observed a shift handover during our inspection, attended by the nurse and care staff. The handover provided them with information about any changes since they were last on shift. Staff explained the handover was recorded, so that staff who missed the meeting could review the records to update themselves.

Staff and people told us the provider worked in partnership with other health and social care professionals to support people. One person told us, "They are good here, they organise transport to take me to the dentist and back." Another person said, "If I need a doctor, one is called straight away." Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, speech and language therapist, mental health practitioner, dietician and dentist where a need had been identified. The manager told us the doctor and other health professionals visited the home each week, for example, the doctor visited the home each Wednesday. We found changes were made to people's care following advice from medical professionals.

Good

Is the service caring?

Our findings

People and their relatives told us staff treated them with respect and kindness. One person said, "I'm really happy here." Another person said, "The care staff have been really good to me here." They added, "It's lovely here". A relative commented, "The staff seem caring."

One person told us the manager had a caring attitude, and encouraged staff to be caring towards people at the home. They said, "Once a member of staff wasn't very nice to me. I reported it to the manager and they dealt with it, they bought them to me to apologise." We spoke with a commissioner of the service who said, "The staff really seem to care."

Staff told us they enjoyed working at the home, because of the interaction they had with people who lived there. We observed staff interacting with people at the home. Staff communicated with people effectively using different techniques. We observed staff touching people lightly on their arms or hands to provide them with reassurance. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them.

People told us staff treated them with respect. Staff we spoke with knew people's preferred name, and spoke of people in respectful and positive ways. Staff told us they always explained to people the support they were offering before proceeding. One person said, "The staff are respectful." People told us they chose how to spend their time, and staff respected their decisions. They explained they could spend time in the communal areas of the home, or in their bedrooms. We saw most people spent time in their bedrooms during the day. One person said, "I tell the staff what I want to do, and they support me."

People and their relatives were involved in care planning where possible, and made decisions about how they were cared for and supported. For example, people had information recorded in their records about their religious beliefs, and their personal history, so that staff could support people in accordance with their wishes. One person told us, "We have regular church services."

Some people at the home had been consulted about their wishes at the end of their life. We reviewed care records which documented their preferences. Staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs.

People told us their dignity and privacy was respected by staff. Staff knocked on people's doors before entering, and announced themselves when they entered people's rooms. One member of staff explained how they respected people's dignity, and gave people privacy when they needed it. They said, "We always knock on people's doors before entering. We also always use a privacy screen when we a moving people so that people aren't observed." We observed care staff respected people's privacy. On one occasion a person was being hoisted into a chair, the member of staff made sure the person's privacy was protected with the use of a privacy screen, so that they were not exposed to other people during the transfer.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and

relatives in private if they wished. People made choices about who visited them at the home. One person told us, "Family members can visit me without any restrictions." We saw people and their visitors were offered drinks and snacks and used communal areas of the home to meet which helped them maintain links with family and friends.

People were supported to access advocacy services. Most people had a relative they could ask for support from, however, where people did not, the manager provided access to advocacy services. We saw advocacy services were advertised and promoted in prominent places around the home. An advocate is a designated person who works as an independent advisor in another's best interest. Advocacy services support people in making decisions, for example, about their finances which could help people maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

Care records gave staff information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs, and their personal preferences. People and their relatives told us they had been involved in planning their care, to ensure plans reflected people's individual needs. One relative confirmed how they had been involved, they said, "There is a care plan in place which we were consulted about, and we are having a review on Friday."

Some of the care records we reviewed were not always up to date. For example, we saw one person required specialist equipment to assist them to eat. We saw the person's needs had recently been reviewed by a specialist dietician. As a result changes had been made in the volume of nutrition the person consumed. Although the person was receiving the care they needed, and their weight had increased, care records had not all been updated to reflect the changes. We brought this to the attention of the nurse and manager during our inspection, who agreed to update the care records immediately.

In another person's care records we saw they needed to be re-positioned by staff throughout the day, as they were cared for in bed and were at risk of developing damage to their skin. Charts were in place to record when the person was re-positioned, however these did not consistently document when the person was re-positioned. For example, on 13 November 2015 there was a gap on the chart of seven hours, on another date there was a gap of more than nine hours. We spoke with the manager regarding our concerns. They stated, "People are being re-positioned as they should be, but the charts are not always being updated." One member of staff confirmed this and said, "Sometimes staff forget to fill in the paperwork. They manager is always telling us we should do this." Following our inspection the manager implemented daily checking of the re-positioning charts. One nurse we spoke with after our inspection visit confirmed the monitoring was now taking place daily by nursing staff.

Some people required assistance with wound management at the home. We reviewed three care records to assess how staff were managing people's wounds and to ensure they received the best care and treatment for their skin. The three people were having regular visual checks to their skin by staff, to make sure their skin did not deteriorate. We saw all three of the records did not consistently record the skin checks were taking place. In addition, wound management records did not always contain a detailed description of the wound to establish an accurate grading of the wound and to assist staff in monitoring the effectiveness of wound treatments. This put people at risk of wounds deteriorating as staff did not have all the information they needed in the records. We brought this to the attention of the manager during our inspection. Following our feedback the manager arranged for daily audits to take place of skin checking, and additional training for nursing staff on tissue viability immediately following our inspection.

Although care records were not always up to date, staff could describe to us the support needs of people at the home. The information matched what people told us, which demonstrated permanent staff knew people well. However, because the home was using agency staff, care records needed to be kept up to date to ensure all staff had the information they needed to support people according to their personal needs and preferences.

We asked people how staff were meeting their personal preferences. One person told us they could not always have a bath or shower when they wanted one. Other people told us staff responded to their individual bathing preferences. One person said, "They are really good at helping me maintain my personal hygiene, and the staff are really responsive to my needs." We asked staff about how people were bathed and showered at the home. The home had a bathing schedule in place to ensure people were offered a bath or a shower at least once a week. One staff member said, "We have a bathing schedule, people are allocated a time each week to have a bath or shower. However, some people have more than this, if they want them."

People told us they were comfortable at the home and staff responded to their requests. One person told us, "I am really happy here. Staff are really helpful." Another person said, "Staff will do as I ask." We asked people about the support they received to take part in activities and interests that stimulated them, and they enjoyed. Some people told us they took part in the arranged group activities at the home. One person said, "I sometimes take part in the quiz." Another person told us, "I don't like some of the activities. I don't need to take part if I don't want to though."

People were asked what group activities they enjoyed during regular meetings. A list of planned activities was displayed in the communal areas of the home for people to access. The activities co-ordinator updated people's care records to show what activities people took part in, so that information was available about what people might enjoy in the future. People also told us they regularly went out in their local community. One person told us, "The home is in a pleasant location and there is a bus so that we can regularly go out and about." They added, "I went shopping yesterday."

In addition to arranged group activities everyone at the home had a personal activity plan which detailed what things they liked to do. Staff provided one to one time to people based on these preferences, including engaging people in conversations and providing them with nail care. One person told us about having their nails done, and added that the home had arranged a party and celebrations for them when it was their birthday.

There was information about how to make a complaint and provide feedback on the quality of the service available in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One person told us, "I have no concerns, if I did I know who to tell." In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The provider had also acted on the feedback they received in complaints to improve the quality of their service. For example, a relative had made a complaint about their relative's care, and the manager had implemented improvements. Complaints were analysed to identify any trends and patterns, so that action could be taken to continuously improve the service provided.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. The manager encouraged a culture of openness and transparency and worked in an office alongside the communal lounge area so that they were visible to people and their relatives. People told us the manager was available to speak with 'most days.' The manager operated an 'open door policy', and people were confident in approaching the manager and the provider. One person told us, "Yes, I feel confident in approaching them."

There was a clear management structure within Bromson Hill to support staff. The registered manager was part of a management team which included a deputy manager who was also a nurse. Nurses were available to support staff on each shift. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. Staff told us there was always an 'on call' number they could call outside office hours to speak with a manager if they needed to. One member of staff said, "I think the manager is good. We have the support we need, we can go and see them at any time." Another member of staff said, "The nurses are great, they do help us."

The manager told us the provider was supportive and offered regular feedback and assistance to support them in their role and their professional development. For example, the provider visited the service every two weeks to hold meetings with the manager, and discuss issues around quality assurance procedures and areas for improvement at the home. The manager said, "The provider is really supportive, and will discuss anything I ask for to improve the home."

The provider completed regular checks of different aspects of the service. This was to highlight any issues in the quality of the care provided, and to drive forward improvements. For example the provider conducted regular checks in medication administration, care records, call bell response times, and infection control procedures. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. Action plans following audits were monitored for their completion. For example, the provider had recently identified additional checks needed to take place to improve record keeping at the home. One staff member confirmed the checks had been implemented, they said, "The manager is checking everything is written down properly." They added, "They are always encouraging staff to do this in the daily handover and meetings." This demonstrated the provider took action to continuously improve the quality of the service they provided at the home.

Staff were supported with regular meetings with their manager to review their performance and had yearly appraisals. Staff told us regular meetings with their manager provided an opportunity for them to discuss their individual personal development and training requirements. Regular meetings with their manager enabled the manager to monitor the performance of staff, and discuss performance issues.

Staff had regular team meetings with the manager and other senior team members, to discuss how things could be improved at the home. Staff meetings were planned each month, and included invitations for all staff at the home to attend. An agenda for each meeting was drawn up before the meeting, which staff could input into. One staff member told us, "There are regular staff meetings and minutes are taken, copies are

available for all staff to review." A recent meeting record showed staff had discussed the needs of people in their care, staff vacancies, and staff training. Staff told us they had an opportunity to raise any concerns they had, or provide feedback and ideas about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements.

People could provide feedback about how the service was run, which was acted on by the provider. One person said, "We have resident's meetings and sometimes our suggestions are acted upon." The manager told us they encouraged feedback from people, visitors and relatives in the form of regular meetings with people at the home and an annual survey to gather feedback. There was a comments book in the reception area. We saw that feedback was analysed and where the provider could make improvements, things were acted upon. For example, recent feedback had generated a request for the introduction of more vegetables on the menu.

The provider had sent notifications to us about important events and incidents that occurred at the home. The manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations. Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements, to minimise the chance of them happening again.