Braeside Residential Care Limited

Braeside Residential Care Home

Inspection report

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Ratings

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

Overall summary

Braeside Residential Care Home provides accommodation and personal care and support for up to eight people, with learning or physical disabilities. At the time of our inspection there were five people living at the service.

This inspection took place on 19 and 20 February 2015 and was unannounced. The last inspection we carried out at this service was in September 2014 when we found the provider was not meeting all of the regulations that we inspected, including cleanliness and infection control, management of medicines, the safety and suitability of premises, supporting workers and assessing and monitoring the quality of service provision. The provider submitted action plans linked to these regulations,

Summary of findings

stating how and by when they would meet the requirements. At this inspection we found that improvements had been made in all of the regulations that had previously been breached.

A registered manager is required under this service's registration with the Care Quality Commission. The registered provider had taken on this role as he was in day to day charge of the service and care provision. 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.

None of the people who lived at the home were able to converse with us verbally due to their complex health conditions. They appeared comfortable in the presence of staff and their relatives told us they had no concerns about their safety or the care they received. Safeguarding procedures were in place to protect people from abuse and there were channels through which staff could raise concerns.

People's needs and the risks that they were exposed to in their daily lives were assessed, and these were regularly reviewed. Regular health and safety checks were carried out on the building and aspects of care delivery, to ensure that the people, staff and visitors were protected.

Medicines were managed safely and recruitment processes were thorough and included checks to ensure that staff employed were of good character, appropriately skilled and physically and mentally fit. Staffing levels were appropriate and we were satisfied that people's needs were met.

Staff training was under review and progress had been made in this area since our last inspection. Some training in key areas still needed to be undertaken. Supervisions were carried out regularly and some staff had received their annual appraisal within the last year, but not all. The provider told us he was in the process of addressing this.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. They are safeguards which exist to make sure people are cared for in a way that does not inappropriately restrict their freedom, where they do not have the capacity to make informed choices themselves. Records showed the provider had applied for DoLS authorisations for each of the five people living at the home and these had been granted. Although people's ability to make informed decisions had been assessed, and the 'best interest' decision process was followed in practice, these decisions were not always fully documented within people's care records. The provider gave his assurances that records held in relation to this would be improved.

People's general healthcare needs were met and where there had been any concerns about their care, or a change in their needs, external healthcare support had been requested (when appropriate to do so). People's care plans and risk assessments had also been regularly reviewed and where necessary, amended accordingly. People were supported to eat and drink in sufficient amounts.

Our observations confirmed people experienced care and support that protected their privacy, dignity and where possible, promoted their independence. Staff displayed caring and compassionate attitudes towards people, and people's relatives spoke highly of the staff team. Individualised care records were available for staff to follow and they were very aware of people's diverse needs and how to deliver effective, personalised care. People enjoyed regular activities within their daily lives and they were supported to enter the community safely.

Systems were in place to monitor the service provided and care delivered. Where issues were identified there was evidence to show that these had been addressed and changes made, for example, to care delivery, and care plans or risk assessments as a result. We received positive feedback about the provider from people's relatives and staff, primarily about his approachability and values related to the provision of care within the service.

The provider had not notified us of all of the relevant matters that they are required to, in line with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. However, since our inspection the provider has sent in all of these notifications retrospectively and he has given us his assurances that all future matters and incidents that the service need to notify the Commission of, will be forwarded promptly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

People were comfortable in the presence of staff and in their surroundings. Staff were aware of their personal responsibility to safeguard vulnerable people from abuse and systems were in place for referring matters of a safeguarding nature to the local authority for investigation.

Recruitment checks were robust and staffing levels were maintained at a level that ensured people's needs were met. Health and safety checks on the premises had been carried out and risks associated with care delivery had been assessed and reviewed.

Medicines were managed safely.

Is the service effective?
The service was effective

Good

Staff were in the process of updating their skills and had received refresher training recently. This process was on-going and training in some key areas was still to be undertaken. Regular supervisions took place and the provider was in the process of ensuring each staff member had received an appraisal.

People received care that met their requirements. Nutritional needs had been assessed and where necessary people received the support they needed to eat and drink in sufficient amounts. People were supported to access care and support from external healthcare professionals to maintain their health and wellbeing.

There was evidence that consideration had been given to people's ability to make informed choices in line with the Mental Capacity Act (2005) and applications had been made to the local safeguarding team to ensure that no person had their freedom inappropriately restricted.

Is the service caring?
The service was caring

Good

Staff interacted with people in a polite, pleasant and respectful manner and treated people with dignity and respect. People were encouraged to remain as independent as possible.

People were given choices wherever possible and their relatives told us they felt involved in their relation's care and were kept fully informed.

No person living at the home currently accessed support from an advocate.

Is the service responsive?
The service was responsive

Good

Summary of findings

People's care was individualised and where necessary adjustments had been made to people's care in response to changes in their needs.

Care records and risk assessments were person centred, regularly reviewed and updated when necessary.

There had been few complaints about the service but where there had been a complaint, we found this was dealt with and investigated appropriately. People's relatives, staff and external healthcare professionals were given the opportunity to feedback their views about the service either directly to the provider, or via questionnaires or meetings.

Is the service well-led?

Requires Improvement 

The service was not always well led.

People's relatives and staff said they were happy with the leadership of the service and staff told us that morale had improved over recent months.

Audits, checks and monitoring tools were in place to ensure that people received safe and appropriate care. Where any issues had been identified, we saw that these were addressed.

The provider was not meeting the requirements of the Care Quality Commission (Registration) Regulations 2009, in that they had failed to notify us of all matters they were required to.

Braeside Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 February 2015 and was unannounced. The inspection was carried out by one inspector.

Prior to our inspection we reviewed information held within our records at the Care Quality Commission (CQC) about the service. This included reviewing any statutory notifications the provider had sent us in the 12 month period prior to our inspection. We also contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch (Northumberland). Healthwatch is an independent consumer champion organisation, who gather and represent the views of the public about health and social care services. None of these organisations or people we contacted raised any concerns about this service.

Most of the people who lived at the service were not able to converse with us verbally so we were not able to gather their views of the care and support that they received. We exchanged pleasantries with people and some people had a limited understanding when we spoke with them. We observed the care delivered by staff using a tool called the Short Observational Framework for inspection (SOFI). SOFI helps us understand the experience of people who were unable to communicate their views and feelings to us verbally.

During our visit we also spoke with two members of staff and the registered provider. We reviewed a range of records related to people's care and the management of the service. These included looking at; three people's care records; nine staff files (including recruitment, induction and training records); all five people's medication administration records; financial records; and records related to quality assurance and maintenance of the building, premises and equipment used within the home.

Following the inspection we contacted two people's relatives and two healthcare professionals involved in people's care, to gather their views of the standard of service that people received.

Good

Is the service safe?

Our findings

People were not able to converse with us directly about whether they felt safe living at the home. One relative told us, "I have no concerns about X's (person) safety". Another relative reiterated this saying, "I am not worried at all about Y (person)". A healthcare professional involved in the care of several people living at the home told us, "I am not worried about people's safety".

Risks that people were exposed to in their daily lives, which were linked to their needs and health conditions, had been assessed and documented. There was evidence within individual's care records, that these risk assessments had been regularly reviewed and the provider told us these were updated as necessary. Environmental risks had also been assessed and there was information available to staff on how to manage risks within the environment so that people were not exposed to any health and safety dangers.

Accidents and incidents that occurred within the home, or when people were escorted out into the community, were recorded and monitored to see if any action needed to be taken, or if any amendments were required to people's risk assessments. This showed the provider sought to protect the health and safety of people and staff.

Staff supported people with their mobility appropriately and safely. We had no concerns about people's safety or how they were treated by staff. There were two staff on duty on the day of our visit and staff rotas showed that this staffing level was consistently maintained. Staff told us that they were able to meet people's needs and we saw that they were not rushed and had time to engage with people socially. On-call arrangements were in place where staff could telephone senior members of the staff team, or the registered provider directly if they needed assistance outside of normal working hours.

Staff understood what constituted abuse and they were clear about the procedures they would follow if they witnessed abuse taking place. Each member of staff we spoke with was aware of their own personal responsibility to report any concerns. Our records showed that no safeguarding or whistleblowing concerns had been reported to the Commission within the 12 months prior to our inspection. Systems were in place to protect people from abuse and the provider was aware of his responsibility to report any safeguarding matters to the local authority safeguarding team for investigation. We reviewed the management of people's finances and found the systems that were in place, were robust.

Standards of cleanliness within the home had improved since our last inspection. Infection control measures that were not in place when we last inspected had been introduced. For example, red laundry bags were used for the safe transportation of soiled laundry around the home and these were readily available in communal bathrooms and toilets, alongside abundant supplies of protective gloves, aprons, hand wash and paper towels. A clinical waste contract had been arranged with an external waste disposal firm. New cleaning rota's had been introduced, and staff told us this had led to improvements within the home as there was accountability if staff did not carry out their designated tasks in this area.

The safety and suitability of the premises had improved and the home had been redecorated in many areas as part of an on-going refurbishment programme. New furniture had been purchased and improvements had been made in the upstairs bathroom. Overall, the home had a more 'homely' feel and the external garden areas at the front and rear of the property had benefited from some attention. In relation to the security of the building, shortfalls that we had previously found had been addressed. The laundry door had been secured, and a window restrictor had been fitted to the ground floor kitchen window, preventing it from opening fully.

We identified an issue with one door on the ground floor at the back of the building which was left unlocked during the day and could be accessed from the garden area. As this door was not alarmed, there was a risk that people could enter or exit the building undetected. The provider acknowledged our concerns about the security of the premises and immediately locked this door, giving his assurances that this would become common practice.

Checks that had not been carried out related to the safety of the premises at our last inspection, had been undertaken. These included a range of fire safety checks, an inspection of the electrical installation within the home and the introduction of control measures to minimise the risks of Legionella bacteria developing within the water supplies. The provider told us that a Legionella risk assessment was due to be carried out on the building

Good

Is the service safe?

imminently. Fire safety shortfalls had also been addressed and remedial work carried out. Evidence showed that checks on the safety of electrical equipment in use within the home had been carried out in January 2015.

Medicines management had improved and the processes and systems that were in operation were now more robust. Appropriate arrangements were in place for the ordering, storage, recording, administration and disposal of medicines (that were no longer required). We observed staff supporting people to take their medicines at lunchtime and found that best practice guidelines were followed. The provider told us that a full review of medicines management within the service had been carried out by an external pharmaceutical company and the advice they had given, had been put into practice. The provider also explained, and records showed that staff had received training and competency assessments since our last inspection to ensure their skills in this area were up to date. The provider told us there had been a marked improvement in staff practice and where there had been an occasional error in the recording of a medication administration (for example, where a staff member had forgotten to sign the medication administration record), he had discussed this individually with the staff member concerned.

Recruitment procedures were thorough and protected the safety of the people who lived at the home. Application forms had been completed by staff before they were employed, in which they provided their employment history. Staff had been interviewed, their identification checked, and references had been obtained from their previous employers or people who could vouch for their character. Appropriate checks had been undertaken with the Disclosure and Barring Service (DBS), before staff started work, to ensure they were not barred from working with vulnerable adults. There was evidence in staff files that the provider had taken disciplinary action against staff, where necessary. This showed the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

Information was available to staff, to assist them in an emergency situation. For example, contact details for all staff, the local police force, fire service, NHS team, family members and maintenance contractors. The provider told us individual personal emergency evacuation plans were not in place as each person was independently mobile and would be able to leave the building in an emergency under the guidance of staff.

Good

Is the service effective?

Our findings

People's relatives told us they felt the service was effective and their relation's needs were met. One relation said, "They know X's (person) needs especially if something is wrong". Another relative told us, "I think the care is good. Y (person) seems very happy". A healthcare professional involved with the care of people living at the home commented, "I would say that they (staff) do look to support X (person) as best as they can".

Staff were very knowledgeable about people's needs and we saw they used such knowledge to provide personalised and effective care and support. Due to the nature of people's conditions, staff told us they had learned to communicate effectively with people in non-verbal ways, and to interpret their expressions and behaviours to establish their mood or what they were trying to communicate. One staff member explained to us what one person meant when they made a particular noise and hand signal.

Staff training had been updated since our last inspection in a variety of key areas and the provider had registered with a local training initiative run by Northumbria Healthcare. Staff told us, and records confirmed they had completed training in the safe handling of medicines, safeguarding and infection control since the start of January 2015. In addition, some staff had completed e-learning courses in other areas such as dementia, learning disability awareness and nutrition awareness. Staff explained they still had several courses to complete, such as training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), but that these were scheduled for completion in the next few weeks. The impact of staff having completed refresher training in key areas was evident in the respect that, for example, improvements had been made to cleanliness standards within the home and medicine administration practices. There was still some progress to be made in terms of staff training and the provider assured us that the improvements made so far in this area would continue.

The provider had developed an in-depth induction booklet which incorporated, amongst other things, the principles of care, communicating effectively and maintaining safety. The provider told us this induction booklet would be used and completed by any new members of staff who were employed in the future. Staff told us, and records confirmed they had received regular supervisions within the last six months and there was evidence that the provider was working towards completing appraisals for each staff member. Supervision records showed the provider offered a supportive environment for staff and that he promoted the importance of them developing their skills further and improving their overall performance.

Records showed that people were supported to attend routine healthcare appointments when required, such as those with a dentist or in a specialist hospital setting. In addition, there was evidence that people had input into their care from specialist healthcare professionals such as psychiatrists. This showed the provider responded promptly to changes in people's needs and supported them to maintain their health and wellbeing.

Kitchen stores showed there was a variety of healthy food options available to people, and staff informed us all meals were home-cooked on the premises. Staff told us they offered a flexible menu and people could choose an alternative food if they did not like the meals planned for that day. Where people had specialist dietary requirements or nutritional needs, we saw staff supported them appropriately and ensured they got the food and fluids they needed, in a safe way, in order to remain healthy. For example, care records showed that one person required their food cut up into bite sized pieces and we observed that staff provided food in this manner at lunchtime. The provider told us, and care records confirmed that this person was awaiting an assessment by a speech and language therapist, due to suspected swallowing difficulties.

We reviewed how the MCA had been applied in respect of care delivery and whether due consideration had been given to people's levels of capacity in a variety of areas. We found that decisions had been made in people's 'best interests' in line with the MCA. However, written evidence detailing how some individual decisions had been made, and by whom, was not always available. For example, a best interest decision had been made by a district nurse, a family member and care staff to give one person a preventative treatment, but this was not appropriately documented as a best interest decision within the person's care records. We discussed this with the provider who said that records about such decisions would be reviewed immediately and in future, more detailed information would be maintained.

Good

Is the service effective?

The provider had applied for Deprivation of Liberty Safeguards (DoLS) authorisations to be put in place for all five people who lived at the home and these had all been granted. DoLS are part of the Mental Capacity Act 2005 (MCA). They are a legal process that is followed to ensure that people are looked after in a way that protects their safety and wellbeing, but does not inappropriately restrict their freedom.

Good

Is the service caring?

Our findings

People's relatives told us they were happy with the staff who worked at the service, as they displayed caring attitudes towards their family members. One relative said, "The staff are brilliant with X (person)". A second person's relative told us, "I think they are caring". One visiting healthcare professional told us "They do care about X (person). I feel the staff are very supportive". One member of staff shared their views of the service with us. They said, "I have never worked anywhere where people are treated with such respect. They are treated as people in their own right here".

People were well presented, and they looked happy and well cared for. Staff interacted with people in a polite, caring, pleasant and respectful manner. There was a calm, happy atmosphere within the home, and people appeared very comfortable in the presence of staff. Staff engaged with people when delivering care and support, and they were not rushed when assisting them. Staff informed people what they were going to do in advance of any interactions with them and people were involved in their care. For example, we saw and heard one member of staff kindly ask one person if they could take their cup off them as they had finished their drink, before removing it once they had agreed. In another example, one person was kindly asked by a staff member if they would mind vacating the chair they were sitting in, so that a different person could receive a massage from a visiting aromatherapist. The person willingly stood up and moved to another chair.

Relatives told us that they felt informed about their relations' care. Comments from relatives included, "They keep me informed" and "I always get an update about X (person) and I am told about everything that has happened when I visit". Staff were knowledgeable about people's needs, their likes, dislikes and the activities they liked to pursue. One staff member said, "X (person) loves to go to knitting club once a fortnight and Y (person) likes to go out for walks".

Staff demonstrated understanding of people's diverse needs and were able to tell us about non-verbal actions and signs that people used to communicate their needs. All members of staff, and the provider, regularly interacted with each person who lived at the home, throughout our inspection. This demonstrated that staff involved people and this in turn helped to promote their well-being.

Staff told us that communication systems within the service worked fine and the manager passed messages amongst the staff team as and when required. A communication book was in use where important messages could be passed between changing staff shifts. One healthcare professional told us following our inspection that communication between the service and themselves could be better. They said that whilst there had been no impact on one person using the service, there had been occasions when they felt they could have been better informed about certain (low level) aspects of their day to day care.

Our observations confirmed that people's privacy, dignity and independence was promoted by staff. For example, they encouraged people to assist with their own personal care tasks wherever possible, in order for them to remain as independent as possible. We observed one person was given privacy in the bathroom once they had been assisted onto the toilet, and in another situation we were politely asked to leave a communal area so that a person could independently move from their wheelchair to a comfortable lounge chair, without being watched, as this unsettled them. Staff encouraged another person to put their own shoes on independently, but when they needed assistance to tie their laces, this was promptly given. At lunch we saw some people had been provided with adapted cutlery and plates so that they could eat independently.

The provider told us that nobody using the service currently had an advocate acting on their behalf; other than those family members who were actively involved in their care. Advocates represent the views of people who are unable to express their own wishes, should this be required. The provider explained that they would contact people's care managers to arrange an advocate should they require one in the future, if they had no family members who were both willing and able to support them.

Good

Is the service responsive?

Our findings

People's relatives told us they were satisfied that the service responded to any changes in people's needs. One relative told us, "They are very proactive in getting healthcare people in if needed and they keep me informed. However, sometimes there are inconsistencies in how different staff do things". Another person's relative said, "The staff pick things up very quickly and they act on things straight away. These comments were reiterated by a healthcare professional who told us, "I would absolutely agree that they seek out appropriate healthcare support when needed".

Care was person centred. We observed one person being asked by a staff member what they wanted for lunch and refusing four or five different options offered to them, by shaking their head and making a particular noise. The staff member proceeded to get a picture book to show the person pictures of different meals, so that they could choose the meal they wanted. Staff told us they could tell when people were not happy and some people communicated via specific sounds, the meaning of which staff had learned to interpret.

We observed staff promoted choice throughout our inspection and people were offered options around what they ate for lunch, whether they required pain relief medicines and whether they went out to socialise within the community. People pursued a range of activities individually, and sometimes together, and the provider and staff told us that extra staff were brought in to enable people to go out in the local community, or further afield, for a day visit or afternoon out. Some people attended local day care activity centres during our visit, and one person was going on a three night activity holiday the following day. This showed the provider supported people to pursue activities they liked, which in turn developed their social skills and involvement within the community.

People's care records were individualised and provided the reader with information about the person, including their care needs, communication skills, risks that they were exposed to in their daily lives, likes and dislikes, medication needs and goals for the future. Staff were armed with the key information they needed to ensure the care they delivered, was both appropriate and safe. The service operated a keyworker system where individual staff members were allocated to different people living at the home. These staff members held the responsibility for ensuring that the person they were keyworker for, received the most appropriate care for their needs and that their care records were up to date.

Care monitoring tools such as charts to monitor people's behaviours, falls records, personal hygiene charts and weight monitoring sheets, were in use where required. For example, a chart to record the number and nature of falls had been introduced for one person, who over a short period of time, had experienced some minor falls due to being unusually unsteady on their feet. The provider had also contacted the person's general practitioner to discuss this matter. Another person's care records showed that temporary measures had been put in place to adapt to their changing needs associated with food intake, whilst they awaited an assessment from a speech and language therapist. At lunch, staff presented food to the person in the manner specified in their recently updated care plan. This showed the provider responded promptly to changes in people's needs and adapted care delivery accordingly.

We reviewed how the provider handled complaints received within the service and found that there had been one complaint since our last inspection. This complaint had been reported to an external organisation by a third party. Records held within the service showed the provider had worked closely with this external organisation, and investigated the matter accordingly, taking the necessary action to bring the matter to a close. The provider had a complaints policy in place and this was followed in practice.

Questionnaires to gather the views of people's relatives had been issued recently, which they confirmed they had received. The provider had also drafted a questionnaire which he had sent out to external healthcare professionals whom the service engaged with, in order to gather their views of the service. One returned questionnaire contained the comment, "I am very satisfied with care – think staff do an excellent job". Staff told us they had the opportunity to feedback their views via supervision sessions, staff meetings or directly to the provider, at any time. This meant the provider had channels in place through which he could gather information about the quality of the service and respond to any issues raised.

Requires Improvement

Is the service well-led?

Our findings

People's relatives, staff and external healthcare professionals, overall, gave positive feedback about the provider. Comments included, "There are no problems with X (provider name), or how he is" and "X (provider name) listens to my issues, but sometimes I feel they are not always acted on. Having said that, I like the way X (provider name) thinks of the residents as individuals. He knows about them and what they like to do". One healthcare professional told us that some areas of leadership within the service could be improved.

Staff told us that morale within the service had improved since our last inspection with the changes in practices and the increased levels of accountability that the provider had introduced. One member of staff said, "There has been a vast improvement in staff focus. We were all devastated after the last inspection. X (provider name) is very much more on our case now – making sure we are doing things. There is a lot more accountability for staff now". Staff spoke highly of the provider who they said was very approachable. One staff member told us, "X (provider name) has always been supportive of staff. Also, he makes sure that people are treated as individuals and he makes sure that people do what they want. It is so much better than where I used to work. There is real attention for the clients".

The provider told us he had worked hard to improve the standards within the service, where we had previously identified shortfalls, and that he recognised the importance of his role as the "leader" of the service. Improvements were evident in a variety of different areas, such as cleanliness levels and quality assurance, and the provider told us that he was exploring other avenues in which he may diversify the business.

Whilst we saw improvements with quality assurance systems and the overall governance of the service, we established that we had not been notified of several incidences and matters in line with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications are changes, events or incidents that the provider is legally obliged to tell us about. For example where there has been a serious injury or death relating to anyone who uses the service. The submission of notifications is a requirement of the law. They enable us to monitor any trends or concerns related to the service.

The provider acknowledged he had failed to make the necessary notifications and said this was due to a lack of understanding of the requirements of this regulation. He gave his assurances that this would not happen again and advised that he would submit the missing notifications retrospectively, which he has done since our inspection.

Audits and checks carried out regularly showed the provider had taken a more thorough approach to identifying concerns and acting on them. For example, we saw that where medicines administration errors had been identified in weekly medication audits, these had been formally addressed with the relevant staff members in supervision sessions, and the discussion that had taken place had been documented. Medication competency assessments had been carried out for each member of staff since our last inspection and there had been regular team meetings via which the provider had relayed important messages about changes he had introduced within the service. A training matrix had been created by the provider so that he could monitor the progress made in relation to updating staff training. In respect of infection control, the provider had introduced new cleaning schedules which staff had to complete and sign when they had carried out certain tasks. This meant that staff were accountable for their actions and the provider could use this to monitor staff practice, and address any shortfalls.

Checks related to the maintenance of the building, and health and safety checks such as fire safety checks, had all been carried out consistently since our last inspection. We found the provider had documented any issues that needed to be addressed and action had been taken to rectify these.

The provider had also introduced, since October 2014, a 'Registered provider visit' which looked at any building issues/health and safety matters, any developments needed, complaints, views, suggestions, positive developments and development requirements. The new approach by the provider showed they had taken a more active role in monitoring the service overall and the safety

Requires Improvement

Is the service well-led?

of the building. There was evidence available to support that, when necessary, the provider had acted appropriately to protect the health and welfare of people, staff and visitors.

Records were well maintained and stored securely. The provider told us he was looking at restructuring care plans and moving to electronic records which would allow for ease of updating.