Bridge House (Oxfordshire) Limited

Bridge House

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on 18 April 2016. This was an unannounced inspection. Bridge House nursing home is registered to provide accommodation for up to 71 older people some of whom are living with dementia and require personal or nursing care. At the time of the inspection there were 69 people living at the service.

At a comprehensive inspection of this service in January 2015 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to people not being protected from the risk of infection as well as people's records not being current and accurate. At this inspection in April 2016 we found the required actions had been taken. We found improvements had been made at this inspection. People were protected from the risk of infection and their records were current and accurate.

There was a registered manager in post. 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. The registered manager worked closely with the business and clinical manager.

People who were supported by the service felt safe. Staff understood how to safeguard the people and protect their health and well-being. People's medicines were stored safely and people received their medicines as prescribed.

There were enough suitably qualified and experienced staff to meet people needs. However, there was poor staff engagement with people. The registered manager had recently recruited new staff who were still undergoing the provider's induction programme.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care.

People received care from staff who understood their needs. Staff received adequate training and support. People felt supported by competent staff. Staff benefitted from regular supervision (one to one meetings with their line manager) and team meetings.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005. Where people were thought to lack capacity, assessments in relation to their capacity had been completed in line with the principles of MCA.

The registered manager and staff understood their responsibilities under the Deprivation of Liberty

Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People's nutritional needs were met, however the dining experience varied. Staff did not always speak with people during meals. People were given choices and received their meals in timely manner.

There was a calm, warm and friendly atmosphere at the service. Staff we spoke with were motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. People's choices and wishes were respected and recorded in their care records.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

People had access to a variety of activities and stimulation from staff in the home, however, these were not always structured to people's interests.

People told us the management team were open and approachable. The provider had quality assurance systems in place. The provider had systems to enable people to provide feedback on the support they received.

The registered manager informed us of all notifiable incidents. The registered manager had a plan to develop and improve the home. Staff spoke positively about the management and the direction they had from the registered manager.

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.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse. Staff had a good understanding of the safeguarding procedures. The service had effective procedures in place to ensure people were safe from abuse.

Medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

People were supported in line with the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who treated them with dignity and respect.

Visitors to the service spoke highly of the staff and the care delivered.

People were pleased with the quality and consistency of care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive activities or stimulation which met their needs or preferences.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's care plans were current and reflected their needs.

Is the service well-led?

Good

The service was well led.

People and staff told us the management team were open and approachable.

The leadership created a culture of openness that made people feel included and well supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

Bridge 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, 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 18 April 2016 and was unannounced. The inspection team consisted of three inspectors and two experts 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.

Before the inspection we reviewed the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We contacted commissioners of the service. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

We spoke with twenty people and seven relatives. We looked at seven people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the business manager, the clinical manager and eight staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included seven staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

When we last inspected Bridge House in January 2015, we found people were not always protected from the risk of infection. These concerns were a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan following that inspection setting out what improvements they would make to the service. At this inspection we found the required improvements had been made. Staff were aware of the providers infection control polices and adhered to them. Staff followed the correct procedures to ensure people were protected from the risk of infection.

The environment was clean and tidy and had a homely feel. Equipment used to support people's care, for example, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, checks were conducted by maintenance staff to ensure they were working correctly. We observed staff using equipment correctly to keep people safe.

People told us they felt safe and supported by staff. One person told us, "Yes I feel safe here and nobody has been aggressive towards me". Another person said, "Yes of course, there is nothing to make me feel unsafe". People's relatives told us their family members were safe at Bridge House. Relatives said; "I can rest easy knowing he (person) is not alone if anything should happen" and "She (person) couldn't live alone anymore and this is a good compromise".

Risks to people's safety had been assessed and people had plans in place to manage the risks. Risk assessments were reviewed and updated promptly when people's needs changed. Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. Risk assessments included areas such as falls, using bed rails and moving and handling. Ways of reducing the risks to people had been documented and staff knew the action they would take to keep people safe. For example, staff always ensured people had call bells and drinks within reach to prevent them falling whilst trying to reach for them. Some people had restricted mobility and information was provided to staff about how to support them when assisting them to move around the home.

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding and whistleblowing procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us, "It's important for all staff to recognise signs of potential abuse and report them to senior staff. We have all received the training".

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected

anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff gave a clear account of how they would whistle blow and the steps they would take if concerned about a staff member's practice.

The registered manager told us they had enough staff. However, people and staff had different views on staffing levels. Staff told us, "It is very rare we are short. Sometimes we use agency staff but we are fine", "There is enough staff on books but we have a lot of new staff. We are often short on ground floor" and "I do think we need more staff. It sometimes affects people and it's the little extras we cannot provide". People told us; "They (staff) haven't got enough help. They've got so much to do" and "They (staff) seem to go. We don't know why they go. Even the staff say they aren't enough". During our inspection staff were busy but not rushed in their duties. Call bells were answered promptly. There were newly employed staff shadowing experienced staff and this slowed down their pace and impacted on the time spent with people. Staff told us staffing levels had improved a lot as compared to before. We did not see staff engage with people in any activities on the ground floor unit. We raised this with the registered manager and they told us they had new members of staff in induction some of whom were still shadowing experienced staff. They also had three more staff waiting to start induction. We were assured staffing levels were improving. The registered manager recognised the impact on people due to some staff shadowing as they were new and the impact this had to meet people's needs.

Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The service used a dependency assessment tool at the beginning of care provision to assess the need for staff adjustment. The registered manager considered sickness levels and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. The registered manager told us recruitment was on going and the service was using less agency staff.

Safe recruitment procedures were followed before staff were appointed to work at Bridge House home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Medicines were stored and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescription. Where people had limited capacity to make decisions about their medicines, the provider had a detailed covert medicines policy which they followed. The policy stated how the covert medicines were to be given. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why.

People had personal emergency evacuation plans to ensure their safety during emergencies. Risk factors were identified which included mobility, hearing, eyesight and mental capacity in relation to understanding the layout of the building. Plans to guide members of staff on how to support people during evacuations were clearly documented in the care plans.

Good

Is the service effective?

Our findings

Staff were knowledgeable and skilled to carry out their roles and responsibilities. People and their relatives spoke positively about staff and told us they were skilled to meet people's needs. Comments include; "The girls know what to do when I need help", "Yes they are knowledgeable" and "I think so, considering some are not medics". One member of staff commented, "We have to develop our skills and I am hoping to enhance my skills in wound management and venepuncture (taking blood for testing)".

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. One member of staff told us, "Induction involved e-learning and a period of three days a week in a supernumerary capacity while shadowing experienced staff".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. One member of staff said, "I think the training is good. I can ask for further training and I know I will get it". Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and could identify any need for extra training.

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. Staff comments included; "I get supervisions and they are useful" and "I just had my supervision last week. I get good support". Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process.

People were supported to stay healthy and their care records described the support they needed. People had access to healthcare services and on-going healthcare support. Staff accompanied people to specialist appointments such as dentists and opticians. One person told us, "I have to get help for my eyes at the main hospital and they (staff) will take me there".

People told us they enjoyed their food. Comments included, "Food is just perfectly normal, nothing grand. There are no special dishes", "Very good food, good choice and you can get what you want day or night" and "Food is average, plain. Good really". People were supported to have a meal of their choice by organised and attentive staff. Relatives complimented on the quality of food. One person's relative told us the quality of food was "good and they get choices".

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. The chef told us, "We are made aware of all dietary requirements well in advance". The kitchen staff knew all the residents and had flexible menus.

Some people had special dietary needs, and preferences. For example, people having diabetic diet, pureed food or thickened fluids where choking was a risk. Where some people had lost weight there was a plan in place to manage weight loss. The home contacted GP's, dieticians, speech and language therapists as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. Snacks were available for people throughout the day, such as fruit, cakes and biscuits. Staff were aware of how much food and fluid people needed on a daily basis.

During lunch time we observed people having meals in all the three dining rooms. The dining experience was varied. In the third floor and ground floor dining rooms, the atmosphere was pleasant. There was conversation and chattering throughout the dining rooms. People chose where they wanted to sit and did not wait long for food to be served. People were given choices for each course of meal. People were supported to have a meal of their choice in a dignified way by attentive staff. Staff sat with people and supported them to have their meals at a relaxed pace. People were supported with meals in their rooms having the same pleasant dining experience as those in dining rooms. Staff asked people if they wanted more and this was provided as needed. However, in the first floor dining room, there was hardly any verbal interaction between people and staff. Staff who supported people with lunch hardly spoke with them and looked task orientated. Some of the people could not communicate due to their conditions. We discussed this with the registered manager and they told us some people preferred not to have conversations during meals, however, they would look into improving staff interaction.

People's consent was sought before any care or support was given. Staff knocked on people's doors and sought verbal consent whenever they offered care interventions. One member of staff told us, "I talk to residents and ask for their permission". Records showed people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, one person's relative who had lasting power of attorney for the person's welfare had refused permission for the person's photograph to be used in any marketing or publishing by the provider. We confirmed this person's wishes were respected. One person told us, "They (staff) ask for my permission when they are helping me with dressing. I have the highest regards for them".

Staff were aware of their responsibilities under the Mental Capacity Act 2005(MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions at a certain time. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests. Staff commented; "MCA is whether they have capacity to decide themselves. We always work in their best interest" and "MCA is about choices".

Staff had a good understanding of their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. People who had a DoLS in place were being supported in the least restrictive way.

Good

Is the service caring?

Our findings

People were positive about the care they received. Comments included; "Carers do treat me with kindness and compassion especially the foreign staff", "Yes they treat me very well with kindness and respect" and "They (staff) have a caring approach. It's not just a job, they really look after us". One person's relative told us, "Overall they treat my mother with kindness. We feel at peace with her being here". Some people in the home could not communicate verbally due to their condition. We observed these people being supported and staff did so in a caring manner.

The home had a key worker system. The key worker was the main point of contact for a person and their relatives for any matters relating to their care. Staff told us the key worker system allowed them to have more interactions with the people allocated to them and their relatives. People and their relatives knew their key workers and met with them regularly to discuss any changes in care. This formed meaningful relationships between people, their relatives and staff.

During our inspection we observed many caring interactions between staff and the people they supported. People were relaxed in the company of staff. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. For example, one person was sat in the lounge and wanted to go to the dining room for lunch. Two staff assisted the person from an armchair to their wheelchair. The person was independently mobile but unsteady on their feet when standing. Staff gave minimal assistance and encouraged the person with the transfer. Both staff gently held the person's arms to steady them. Throughout the transfer staff praised the person for their efforts and they responded with jokes and smiles. Once in their wheelchair the person thanked the staff. One staff member held the person's hand and said, "That's what we are here for". The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of humour throughout the day.

Staff had a caring approach to their work. Comments included; "It's very caring here, I love it", "I love working here. I love the residents and we have a good team" and "It is okay here and I do enjoy the work. I love the residents". People recognised care workers and responded to them with smiles which showed they felt comfortable in their company. Staff took time with people. Tasks were not rushed and they worked at the person's own pace. People were given options and the time to consider and choose.

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. This helped staff build positive relationships with people by communicating in ways that were appropriate to them. For example, one person could not verbally communicate. This person' care plan stated 'uses minimal communication as well as blinking and hand gestures'. Staff were guided to speak with this person slowly and observe for the hand gestures and blinking. Staff followed this guidance.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us they would explain care to be given and seek the person's consent to ensure dignity was respected. Staff

comments included; "I always acknowledge them when I enter their room. I engage with them and I am respectful", "I treat people how I would expect to be treated. I knock on doors" and "I shut doors and I put up the private sign to keep things private".

People's records included information about their personal circumstances and how they wished to be supported. This allowed staff to plan the people's care and support them to maintain their independence regardless of their level of disability. Staff told us how they would let people do as much for themselves as they could with minimal support and prompting. Staff commented; "If they can do it for themselves I let them. I also encourage them to do things, you have to know them", "I let them do what they can and I always encourage them to help themselves" and "When I assist with showers I try to let them do what they can do. If they can do it we let them do it".

Staff understood and respected confidentiality. One member of staff told us, "We do not discuss information with other people. We don't talk of the home outside the home". We saw records were kept in locked offices only accessible using a keypad. People's care records were electronic and we observed staff logged off whenever they were leaving the computers.

People were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person was approaching the end of their life. The person had stated they did not want 'medical assistance should it be required for recovery'. A do not attempt cardio pulmonary resuscitation (DNACPR) order document was in place. The person had stated they wished to remain at the home and they had planned their funeral. The person had stated they wished to be 'cremated'. We saw the person and their family were involved in this decision. People, their families and professionals contributed to the plan of care so that staff knew people's wishes and made sure people had dignity, respect and comfort at the end of their lives. Relatives told us end of life care was provided in a compassionate and supportive way. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. Staff told us how they would maintain people's dignity and comfort and involve specialist nurses in the persons care.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in January 2015 we found people's care records were not always current and accurate. People were at risk of receiving inappropriate care and treatment. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements had been made at this inspection.

The provider employed an activities coordinator. People were offered a wide range of activities including games, quizzes, sing a longs, arts and crafts, keep fit, and gardening. The home also organised religious services and trips out. For example, we saw one planned trip was a visit to a local bowling alley. Hairdressers attended the home regularly and people were encouraged to go out with families and friends or on their own where they were able. However, records showed activities were not based on people's life history, social and family circumstances or preferences. There were no group or one to one activities recorded in care plans for people who stayed in their rooms.

Throughout our inspection staff spent time with people. On the ground floor most people went for periods of time without engagement from staff and seemed to occupy themselves in their rooms. The lounges and social areas were deserted most of the day. We discussed these concerns with the manager who told us they would review and provide staff training on people engagement and improve activities to match people's interests.

The second floor of the home was a unit for people who were living with dementia. There was an indoor garden filled with plants. People were also able to engage in gardening and we saw named pots contain flowers people had planted. There were sitting areas with dolls and soft balls for people to engage with. There was a sensory room for people to provide gentle stimulation of sight, sound, touch, taste, smell and movement in a controlled way. People's bedrooms were personalised and contained photographs, pictures and the things each person wanted in their bedroom. People's doors were a different colour to the walls. Staff told us this enabled people to recognise their rooms. However, names and door numbers were in small print and could be difficult for people to identify their rooms. There were no memory boxes to personalise people's doors. There were alternating coloured walls which could be confusing for people living with dementia. Ensuite doors were the same colour as the walls without any signage. Toilets and furnishings were the same colour which could be difficult for people to identify. We discussed these findings with the registered manager and they told us this was already being addressed as part of the provider's current business plan. The provider was working towards improving the environment for people living with dementia.

Before people came to live at the home their needs had been assessed to ensure they could be met. These assessments were used to create a person centred plan of care which included people's preferences, choices, needs, interests and rights. Records showed people were offered trial periods before they decided they wanted to stay at Bridge House.

Care planning was focussed on a person's whole life, including their goals skills and abilities. The provider used a 'This is me' document which captured people's life histories including past work and social life to enable staff to provide person centred care and respecting people's preferences and interests. However, this information had not been used to provide people with meaningful activities based on their interests. People's care records contained detailed information about their health, social care and spiritual needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up. People and relatives confirmed they were involved in planning their care. One person's relative said, "I have seen my mother's care plan and I have reviewed it with her key worker".

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, staff noticed one person was experiencing 'low moods, low motivation' and they were 'constantly tired'. Staff spoke to the person and referred them to their GP and the person's care was reviewed. As a result the person's medication was changed. Records confirmed the person's condition had since improved. We saw the care plan had been updated to reflect the changes.

Feedback was sought from people through regular relatives and residents meetings as well as quality assurance surveys. Records showed that some of the discussions were around menu choices, staffing and activities. For example, people had suggested help was needed during meal times and the service had employed serving hostesses. Records showed that the feedback was very positive.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People commented; "If there is something I am not happy with, I would complain to the person I wasn't happy with and if no joy, then the manager or senior person on duty" and "If it's more serious I would complain to the manager. If no good I would speak to the chairman of the home, I have his number".

We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt the service was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Good

Is the service well-led?

Our findings

The service was managed by the provider and a registered manager who were supported by a business and a clinical manager. The registered manager had been in post for a year. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

The manager had an open door policy and was always visible around the home. One person's relative said, "There is an open door policy". People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. People and relatives could drop in anytime to speak with the manager. The provider had facilitated a resident and relative survey.

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was open and honest. Staff comments included; "What you see is what you get here. We don't always get everything right but we try our best. There are no secrets", "Yes I do believe this is an open and honest service. I could own up to any mistake quite happily" and "I am not aware of any culture of blame at all".

Staff were complimentary about the registered manager. Comments included, "It's a nice place. The manager is very supportive", "She (manager) is brilliant. If I raise an issue we will talk about it and she will deal with it" and "She is approachable and reassuring". Staff told us they felt valued and respected by the provider and registered manager. Staff told us their views were listened to and good practice was promoted.

Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff were involved in discussion about 'Home champions'. These were staff members who had lead roles in areas such as dementia, wound management and palliative care. The champions attended meetings and training updates which were fed back and shared throughout the team to improve people's care. Records showed this had had a positive impact on people's care.

The registered manager spoke with us about their vision for the service. They told us, "It' a working progress and we aim to get things right". People's well-being was the central focus of the planning, assessment and the delivery of care. The aims of the home were included in the statement of purpose and staff handbook. The registered manager told us they had struggled to recruit staff in the past but they had now recruited enough staff. However, most of the new staff were still in induction and the registered manager recognised how this impacted on people.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. There were a range of quality monitoring systems in place to review the care and treatment provided at the service. These included regular audits of medicine administration records, care plans, and gathering peoples experience of the service through satisfaction

surveys and other feedback. Where any issues had been identified, an action plan was put into place to address them and this was followed up to ensure actions had been completed.

The provider conducted regular checks around the home to monitor the service. These visits generated action plans to improve the service. For example, one visit identified the need to improve the dementia unit environment. Records confirmed these actions were in progress. During our inspection we saw the improvements that had already commenced.

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people who used the service were documented, investigated and actions were followed through to reduce the chance of further incidents occurring. For example, a person who was mobile fell and the registered manager investigated for possible causes. The person was referred to a GP and tests confirmed they had an infection. Records showed the person had received treatment and recovered well. The registered manager discussed accidents and incidents with staff and made sure they learnt from them. All accidents and incidents were audited and analysed every month by the registered manager. The registered manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.