Akari Care Limited

Bridge View

Inspection report

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Ratings

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

Overall summary

The unannounced inspection took place on 8 and 10 April 2015. We last inspected the service on 12 August 2014. At that inspection we found the service was meeting the regulations that we inspected.

Bridge View provides residential and nursing care for up to 61 people, some of whom are living with dementia. At the time of our inspection there were 39 people living at the service.

The service had 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.

Staff did not always manage medicines safely. For example people who received 'as required' medicines did not have written guidance for staff to follow. We also found people did not always have medicines risk assessments in place to ensure people remained safe while taking their medicines.

Summary of findings

Risk assessments related to people's care were completed accurately, which meant people were kept safe. Care records were reviewed regularly. Accidents and incidents were recorded and monitored to ensure lessons were learnt.

Staff understood safeguarding procedures and were able to explain what they would do if an incident occurred. We were confident staff would raise any concerns should the need arise.

People told us they felt safe and were treated with respect and dignity.

We found the service to be clean, tidy and odour free with maintenance kept to a good standard.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). Staff followed the requirements of the Mental Capacity Act 2005 (MCA) and DoLS. MCA assessments and 'best interests' decisions had been made where there were doubts about a person's capacity to make decisions. Applications to the local authority had been made where a DoLS was required.

People told us they felt there was enough staff to look after them. The registered manager monitored staffing levels to ensure there was enough trained staff available. The registered manager had procedures in place to ensure any staff recruited were suitable to work within the home.

There was a training programme in place, but more in-depth and up to date training was needed in the areas of end of life and dementia care. Staff were supervised and received appraisals and support but we found areas for improvement in the approach to supervision sessions which the registered manager agreed with.

People were offered a selection of food types and told us they enjoyed the food available. Staff supported people to ensure they received adequate food and refreshments.

People told us staff were caring. We heard one staff member say to a person during a meal time, "Don't worry if you can't manage it, it makes no difference, just eat what you can." People told us they would have liked staff to spend more time talking to them. We noted that conversations between staff and people were sometimes lacking or limited when opportunities arose for this to take place.

Activities were available for people to participate in. The registered manager told us a relatively new activity coordinator had been employed and was designing an updated programme of activities and events for people to participate in.

People told us they had choice. People chose what meals and drinks they would like and where they would like to have them.

People and their relatives knew how to complain and where complaints had been made, the registered manager had dealt with them effectively.

The provider had systems and procedures in place to monitor the quality of the service provided. When issues or shortfalls were identified, actions had not always been recorded as taken and on occasions issues had not been identified (as with medicines).

Information was displayed around the service for the benefit of people and their relatives.

People and relatives who knew the registered manager thought she was good.

We recommend the service ensures staff are up to date with the latest guidance and training on caring for people who are living with dementia and who have end of life care needs.

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?

Requires Improvement

The service was not always safe.

We found staff did not always follow safe procedures in medicines management.

Staff were aware of their safeguarding responsibilities and knew what to do if they had any concerns. Emergency procedures were in place to keep people safe.

Adequate recruitment procedures were in place and there was enough staff employed at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

We found areas for improvement in staff supervision and training.

The registered manager and staff were aware of the Mental Capacity Act 2005 and of the Deprivation of Liberty Safeguards and worked within the legal guidelines of the act.

People received, or were supported with nutritious meals and were helped to remain hydrated, with special diets being prepared for those that needed them.

Is the service caring?

Good

The service was caring.

People and their relatives felt staff were caring. We observed people being treated as individuals and shown kindness with their dignity being maintained.

Where staff supported people with personal care, they did so with respect.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in people's care needs.

People had choice in their day to day lives.

The provider had a new activities coordinator who had a programme of stimulating activities for people to participate in.

The complaints procedure was available and on display within the service and people who had complained had those complaints dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Summary of findings

The service had a registered manager. The provider had appointed a deputy manager and a clinical lead who would be starting work in a few weeks.

We noted the registered manager did not always attend meetings held for people at the service and meetings for people and staff did not always show evidence of actions taken to issues raised.

The provider had a quality assurance programme and where actions were identified, they were monitored and tasks followed through to completion. However, we noted issues we had found with medicines had not been raised as part of the usual audit process.

Bridge View

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 8 and 10 April 2015 and was unannounced. The inspection was carried out by one inspection manager, two inspectors, one expert by experience and a specialist advisor in medicines. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a person who specialises in a particular area of health and social care. On the first day of inspection we arrived early to observe morning procedures.

Before the inspection, 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 reviewed the PIR and other information we held about the service, including the notifications we had received from the provider about deaths, deprivation of liberty applications and serious injuries. We also contacted the local authority commissioners for the service, the local Healthwatch, the local authority safeguarding team, deprivation of liberty safeguards team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. On the day of our inspection we spoke with a health care professional who was visiting a person using the service.

After the inspection we spoke with Public Health England. Public Health England is a government body set up to protect and improve the nation's health and wellbeing, and reduce health inequalities.

During this inspection we carried out three observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 15 people who used the service, nine relatives and two visitors. We also spoke with the registered manager, a regional manager, three nurses, eight care staff, the cook, the activities coordinator, the administrator, and a visiting auditor. An auditor is a person whose job it is to carefully check the accuracy of business records. We observed how staff interacted with people and looked at a range of care records which included the care records for eight of the 39 people who used the service, medicines records for 39 people and recruitment records for eight staff.

We looked at staff rotas, handover documents, maintenance records, survey information, health and safety records and information, quality assurance checks and compliments and complaints.

Following the inspection visit we asked the provider to send us additional information. For example, a copy of their medicines policy and training matrix. They did this within the agreed timescales.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with said they felt safe and were not concerned about the safety of themselves or items of their personal belongings. One person told us, "Yes, I feel safe in my own room." Two people told us of concerns they had experienced, although when we investigated we found these experiences were not founded due to their dementia related conditions. One relative said, "Staff are spot-on, really great, I've got total peace of mind." Another relative whose family member was living with dementia said, "My mother is very safe here, I put my total trust in the staff."

There had been an increased number of deaths at the service during March 2015 compared with the same period over previous years. We discussed our findings with the registered manager who showed us a report they had produced for the provider. We found no areas of concern but passed the information to the clinical commissioning team and the contracts and safeguarding teams for their information. We also passed this information on to Public Health.

We observed medicines being given out to people on both floors of the service during the first day of our inspection. Medicines (including controlled medicines) were ordered, stored, handled and disposed of appropriately. Controlled medicines are usually given for severe pain and have more restrictions on the way they are stored and monitored. One member of staff said, "There have been very positive changes in the home over the last year, across the board and in medicines, if there hadn't been I wouldn't have taken a job here." People told us they had no concerns with receiving their medicines and one person said, "I cannot see so well now and would probably forget to take them, but the staff keep me right and help me. They are good."

Good hand washing practices were observed during medicines 'rounds'. For example before commencing and after giving insulin or eye drops. Permanent staff knew how to support people at the service with their medicines, for example, one person preferred to have their medicines after their breakfast and another who was hard of hearing was shown their medicines while another had their medicine cut in half. However, we noted that information relating to how people preferred to take their medicines was missing from the medicines administration records (MAR) system that the provider used. This meant new or agency staff would not have easily accessible information to support them with administering people's medicines in the way they preferred. We discussed this with the registered manager and they told us the information would be updated immediately.

People who received 'as required' medicines did not have written guidance for staff to follow. We also found people did not always have medicines' risk assessments in place to ensure people remained safe while taking their medicines. For example, one person's records showed they were prone to hiding and not taking their medicines. We discussed this with the registered manager who told us this information should have been in place. On the second day of our inspection staff had put people's medicines' risk assessments in place and the registered manager was in the process of ensuring all other documentation was up to date.

Staff knew the procedures to follow if they suspected any type of abuse. Training records confirmed staff had received safeguarding training and there were policies and procedures in place related to safeguarding and whistleblowing to support staff. One staff member told us, "I would report anything out of the ordinary to the manager, I could not just ignore that sort of thing."

There was one entry point into the service and this was secured by a coded door. Visitors were required to sign in and out of the service and this was completed in a book held in the external lobby area. That meant that no unauthorised visitors were able to obtain access to the building without staff knowing.

We did not identify any trip or other hazards as we walked about the service, with communal areas and people's rooms being clean, well decorated with no unpleasant odours. Staff had a good awareness of the safety of people and helped them to move and to sit comfortably using appropriate moving and handling techniques. Risk assessments were in place for individuals and for risks in general, for example 'fire risk to the premises' or 'risk of falls for people'. These had been reviewed regularly and monitored for any changes. The service had emergency and local contingency plans in place, including the full evacuation to other local suitable premises should the need arise. These plans also included the personal emergency evacuation details for people in the building, which would be used to support staff and emergency services to evacuate should, for example, a fire or flood occur.

Requires Improvement

Is the service safe?

Fire checks and drills were carried out in accordance with fire regulations and regular testing of electrical equipment was carried out. There was evidence of regular servicing and testing of moving and handling equipment. We received confirmation from the local fire service on 23 March 2015 that Bridge View was meeting all of the statutory fire safety regulations. There were arrangements in place to manage the premises and equipment. Where any maintenance issues were identified, these were dealt with quickly.

The provider protected people's safety and their exposure to further risk by monitoring accidents and incidents. An analysis was completed and both the registered manager and the provider monitored this information and reacted to any concerns. Where issues had been identified, staff had made appropriate referrals to health care professionals or other action had taken place.

People and relatives we spoke with thought there were enough staff at the service to meet their daily needs. We checked staffing levels at the service and found they were adequate to meet people's needs. We checked staff rosters over a period of four weeks and the tool the registered manager used to calculate the number of staff required at any one time. We found the provider had employed enough staff throughout the service and was able to cover times of sickness and holiday by using current or agency staff. The registered manager told us, to ensure a consistent and safe level of care was provided, the same agency staff member would be requested but sometimes this was not always possible. The registered manager also explained a number of vacancies had been filled and staff would be starting within the next few weeks, including a new deputy and clinical lead. Throughout the inspection we observed staff supporting people safely in accordance with their needs and call bells were normally answered quickly.

We found appropriate recruitment procedures had been followed, including application forms with full employment history, experience information, eligibility to work and reference checks. Before staff were employed, the provider requested criminal records checks through the Governments Disclosure and Barring Service (DBS) as part of its recruitment process. Nurse PIN numbers were regularly checked by the provider. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN. These checks are used to assist employers in making safer recruitment decisions. Where staffing issues had been raised and disciplinary procedures had been implemented, the provider had followed their procedures fully.

Requires Improvement

Is the service effective?

Our findings

People thought the staff were good at their jobs. One person said, "I am pleased I chose here because I will be here until I am not here." Another person said, "The staff are lovely, they're great." One relative told us, "The staff are very good, they pick up on things that might be wrong and let me know." They explained their relative had not been well recently with a urine infection and staff had spotted something was wrong very quickly.

Staff had received a comprehensive induction to the service. This had included an introduction to equality and diversity, peoples' rights, privacy and dignity and information on how to conduct and follow risk assessments. There was a focus on ensuring staff understood the individual needs of people before they provided care or support. For example, all staff were given a personal introduction to people at the service and were required to read their individual care records. One member of care staff explained, "The on-shift support for new starters is really good. I got to know people because my mentor introduced me and I got to spend time chatting to them. My mentor also showed me information on their life histories in the care plans; that helped a lot." Another member of care staff told us, "When I first started I shadowed an experienced member of staff for three days. They explained everything I needed to know about the home and helped me get to know everyone."

A training programme was in place to ensure staff were suitably trained to support the people in their care. For example, staff had undertaken a 'person-centred approach to a positive risk assessments' course they had taken, which meant that they could conduct risk assessments that prioritised people's independence and dignity. A member of care staff explained, "Staff are more than capable and competent in identifying people's needs because we're all well trained. The manager is excellent at getting us any extra training we need or ask for. Something we do need urgently though is extra training in end of life care. We have this to a basic level but it's not enough, at the moment, we get by based on our own experience and we need some more training in helping high-dependency people." We asked staff questions about people living with dementia and their answers did not always show a clear understanding of people with this condition. A number of staff told us they required training in dementia, although records showed that dementia awareness training had been completed by the majority of staff in 2014. We discussed end of life and the effectiveness of dementia training with the registered manager. They confirmed they would look into these elements of training for all staff to ensure the service could meet people's needs.

Regular staff supervisions and yearly appraisals were completed. In most cases, supervisions were focused on staff discipline and behaviour rather than constructive development. For example, in the 'performance' section of one care worker's supervision record, the supervisor had written "no issues". A supervisor had written in one care staff record, "I wish they'd use their initiative." One member of care staff said, "Supervisions do serve a purpose, they can guide someone away from bad practice." We discussed supervisions with the registered manager, including clinical supervision for the nursing staff. The registered manager agreed that this area required improvement. The registered manager emailed us after the inspection with, "We have not followed any clinical guidance tool per say, we aim to follow the new NMC Code and intend to record on the attached supervision format." We also received a further email from the registered manager detailing the format for future supervisions and confirming they would be in place by the end of May 2015.

Public Health England had been contacted in January 2015 due to an outbreak of diarrhoea and vomiting. This was to ensure all necessary actions had been followed. We discussed the outbreak with a number of staff and they were fully aware of how the service would appropriately respond should an outbreak occur again. This meant the staff followed best practice to keep people protected from the risk of infection.

We reviewed the care records of eight people to check whether the provider had ensured that where required, an assessment of a person's capacity was undertaken as required by the Mental Capacity Act 2005 (MCA). The MCA is legislation used to protect people who might not be able to make informed decisions on their own, about the care and support they received. We saw these had been completed. The staff we spoke with could explain how they used the MCA to ensure people were involved in decisions made about their care. The registered manager could explain the processes they followed when applying for authorisation for Deprivation of Liberty Safeguards (DoLS) to be implemented to protect people within the service. They

Requires Improvement

Is the service effective?

told us they had DoLS in place for six people but that the paperwork had not been sent from the DoLS team although verbal authority had been given in the interim. We spoke with the DoLS team to confirm that information.

Staff knew people well and were able to adapt their communication to individuals, such as by speaking more slowly to someone who was living with dementia or loudly to someone with a hearing difficulty. Staff had designed pictorial food charts to be used with people who found it difficult to express their food choices, for example, those living with dementia.

All of the people that we spoke with told us they thought the food was good. One person said, "You cannot beat mince and dumplings, that's my favourite." Another person said, "They [kitchen staff] do a canny [good] job." People were effectively supported to have enough to eat and drink by staff. We observed breakfast and lunch during our visit and saw there was a suitable choice of fresh foods available for people to choose from. Refreshments were freely available for people throughout the day and we observed staff ensuring people were able to have a drink regularly. Where people were identified as being at risk of fluid imbalance or malnutrition, food and fluid charts were in place to help staff monitor how much people were eating and drinking. We spoke with kitchen staff about special diets, such as how they catered for diabetics and people identified as having swallowing difficulties. Their responses and records showed they had a good understanding of people's dietary needs and how to meet them.

All of the people we spoke with told us they had access to health care professionals, such as, opticians, dentists, GP's and chiropodists. The registered manager told us if people required an appointment with a health professional, a member of staff would go with them when it was needed, to offer support.

The service was adapted to allow people to move freely around both with the support of staff and independently. Doors were large enough for wheelchairs to pass through and lifts were available to take people, staff and visitors between floors. More than half of the people at the service lived with dementia and we noted that on a number of the toilet and bathroom doors, no signs describing the room were present. That meant it was difficult for the people living with dementia to navigate their way to those rooms with any confidence. We spoke with the registered manager about this and they told us the signs had been ordered and would be in place soon.

We recommend the service ensures staff are up to date with the latest guidance and training on caring for people who are living with dementia and who have end of life care needs.

Good

Is the service caring?

Our findings

People told us staff were caring but would have liked them to spend more time talking to them. One person said, "Staff are too busy." Another person said, "They [staff] are lovely, and work very hard. They don't always have time to just sit and talk. That would be nice sometimes." We spoke with the activities coordinator who told us that part of their role was to have one to one sessions (chats) with people and we saw this documented in their activity records. The relatives we spoke with thought the staff were very caring and praised them. One relative said, "Staff are spot-on, really great." Another relative told us, "Staff are very good, they cannot do enough to help." An agency nurse working at the service told us, "Carers are very, very good. I often do spot checks on them when they're giving personal care and I've never had any concerns. They are always so caring and friendly when speaking to residents."

Over 25 compliments had been received at the service in the last year, most of these from relatives expressing their gratitude to staff for the care provided to their loved ones.

During observations we found care staff did not always participate in conversations with people when the opportunity arose. For example, we noticed two care staff did not talk to the person they were supporting while they helped them move from the lounge to the dining room. We also heard limited conversations taking place within the dining room while people had their meals. One person told us it was 'depressing' in the dining room during meal times. We discussed this with the registered manager who thought it was because staff were nervous of an inspection taking place. They also said the concern would be brought up with all staff at the next team meeting.

Staff were seen to be caring and compassionate. For example, a member of care staff moved one person out of the glare of the sun after asking permission to do this first.

Another staff member stroked a person's hand while talking softly to them after they appeared to become upset. One member of care staff said to a person, "Don't worry if you can't manage it, it makes no difference, just eat what you can."

All of the people we spoke with said their privacy and dignity was respected and staff knocked on their bedroom doors before coming in. One person told us they were due a family visit. We saw the family arrive and staff welcomed them. The person told us their family made themselves at home and usually made themselves a cup of coffee. The person also told us, "They [relatives] can come at any time really, the staff don't mind and they are always made welcome." Pets were able to come to the service with visitors. For example, we saw a dog being taken to see one person with their visitor.

People had personalised their bedrooms to meet their diverse needs and values. Pieces of furniture, pictures and other items were on display in many of the bedrooms, and people had chosen items personal to them. One person showed us needlework pictures they had made and said, "It's nice to have some of your own things around you."

Information to support people and their families was available in the reception area and in other parts of the service. For example, complaints procedures, advocacy information and activities to take place. We noticed that the activities coordinator had placed posters of forthcoming activities in the lift areas at different heights and told us this was to cater for people in wheelchairs.

Information was available on advocacy services although at the time of the inspection the registered manager told us no person required the use of this type of service. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

Is the service responsive?

Our findings

People were involved in their care and treatment. One person said, "Yes, I completed something but don't ask me what." Another three people told us they felt fully involved with their care and a further two relatives told us they were happy with their relatives care and treatment. Two people told us they had completed some paperwork with staff but could not remember what it was. Two relatives told us they had been involved when the health needs of their relative had changed but that the process was 'informal' and not recorded.

We reviewed people's care records and found people had been assessed when they first moved into the service and details were collected about their health and personal history, including information about their families. People's needs had been identified, including mobility, personal care, communication and medicines with care plans put in place. Where a risk had been identified, risk assessments were in place which supported people to live as independently as possible. People's records were reviewed monthly, although it was not clear that people or their relatives had always been involved. We asked staff about this and they confirmed it was not always clear from the paperwork if people or their relatives had been involved, but they assured us they always tried to involve people and the relatives.

The registered manager told us staff were in the process of completing individual person centred summaries of each person living at the service which would be displayed on the entrance to their bedrooms. They explained the person and their relatives had been asked to support the activity coordinator to complete this document, which would be used to help staff better support the people in their care.

Staff handovers took place at the beginning of each shift. Staff explained that during handovers each person was spoken about and any changes in their care needs were discussed. This ensured staff could provide responsive care. We looked at the handover notes and saw a written record existed of key issues which had been passed on to incoming staff.

One person who had a telephone and internet privately installed in their bedroom said staff would assist them to Skype if they were experiencing difficulties. There was a focus on reducing social isolation and staff encouraged people to take part in activities. For example, a member of care staff offered positive encouragement to someone who had spent a period of time sitting alone, by saying, "Wouldn't it be nice to sit and have some time with your friends?" We noted there was a bingo session and a cookery session which took place during our visit and relatives were also able to join in and support their family member. We saw one relative doing just that.

We spoke with the activities coordinator who had recently been appointed to the position. They showed us a plan of activities which had been devised with the people and staff at the service. The plan included baking, bingo, singing, church services and various events. The coordinator was keen to get people involved and told us they also completed one to one 'chats' with people living at the service and said, "It's important for people to be able to have a chat."

People were encouraged to raise complaints and the registered manager responded to complaints in a timely manner. Four complaints had been recorded and effectively dealt with. Staff were able to confirm this when we asked them. The people we spoke with did not raise any concerns with us in relation to the complaints process or how complaints were handled by the registered manager. The complaints procedure was displayed throughout the service for people, relatives or visitors to the service.

People told us they had the choice to do what they wanted, including getting up at a time that suited them and having meals in the room of their choice. For example, people could eat in the dining room, lounge or their own bedrooms. We confirmed not all people were up early, two people were up and dressed upon our arrival at the service, but many others remained in bed until a time that suited them.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was a registered manager in place. The registered manager was a trained nurse who had worked at the service for five years. A new deputy manager and clinical lead had been appointed and would be starting work at the service in the next few weeks.

Meetings for people and staff were held monthly. We noted from the minutes of meetings for people living at the service, that the manager did not always attend. A recent meeting for people had been minuted and showed a range of topics had been discussed, including food choices, activities and any general day to day issues. For example, it was recorded that some people thought the quality of food was improving. It was also recorded that some people were unhappy with the cleanliness of their rooms. We did not find evidence that this had been followed up and two care staff we asked about this did not know if action had been taken. One person told us, "I don't usually go to the meetings, I find out what I need to from the staff when I ask." We noted that dates of meetings were not displayed and when we mentioned this to the registered manager they told us the activity coordinator was in the process of putting this information on notice boards.

A recent staff meeting included topics such as medicines safety and team cohesion but there was no evidence from the minutes of staff feedback or involvement. We asked a member of care staff about this and they explained, "Meetings are quite formal. We can bring up problems and I think they do get fixed." Overall, we found that if actions were taken this had not always been recorded and it was not always clear if staff had been given the opportunity to feedback or be fully involved in meetings. Heads of department meetings took place, however there were no integrated meetings which one staff member felt led to people not working as a team. Staff felt meetings for the whole staff team from time to time would be beneficial.

The provider had distributed an 'On-going in-house survey' in 2015 to people and their relatives. People had generally rated the cleanliness of the home, the variety of food and the friendliness of staff as good. There had been a number of issues identified through the survey. For example a number of relatives did not know how to feedback to senior staff or had not received a copy of the service user guide. Although issues had been summarised by the manager we did not find evidence that these issues had been followed up or addressed.

A staff survey had been distributed in 2014. Very few staff had completed this and from those who did, there was no information given that would indicate how they felt about working at the service or what their needs were in terms of training and support.

We noted that the issues we raised around medicines had not been identified through the registered manager's quality monitoring checks and audits. Quality monitoring reports were completed by the regional manager. These included checks on the number of people with skin damage, safeguarding incidents, staffing and numbers of infections. These were monitored for trends and where issues were identified these were acted upon. There were also audits and checks on all elements of the service completed by the registered manager, including care plans, food, accidents and incidents. Action plans had been drafted to rectify any concerns identified. A referral had been made requesting a local pharmacist to visit the service and review medicines systems and processes. This has been completed and the report was favourable. No significant concerns were raised, although some minor learning was identified and this has been incorporated into the providers audit process. A home development plan was also in place to monitor any outstanding developments or issues at the service and this was reviewed regularly.

People who knew the registered manager told us she was good and that she always asked if they were alright. One relative told us, 'The service was well led and well organised.'

A newsletter had been produced by the activities coordinator and this was available throughout the service, showing activities due to take place and other points of interest in connection with the service.

The service had policies and procedures in place that showed a clear vision and set of values that included honesty, dignity, respect and equality and safety. The manager said these were regularly discussed during staff meetings and through observations to ensure staff understood and consistently put these values into practice.