# Kirklees Metropolitan Council

# Castle Grange

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 |

# Summary of findings

## Overall summary

The inspection took place on 10 August 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Castle Grange in September 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Castle Grange is a 40 bed care home that provides permanent and short stay care for older people with dementia-related conditions. Nursing care is not provided. At the time of our inspection there were 34 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the service had taken steps to safeguard people from avoidable harm and abuse and responded appropriately to any concerns about their safety. Measures were in place to reduce risks associated with people's care and to ensure that care was provided in a safe, clean and well-equipped environment.

New staff had been thoroughly vetted to check their suitability to work with people who may be vulnerable. Enough staff were deployed for safely meeting people's needs and providing continuity of care. Staff were given the necessary training and support to enable them to care for people effectively.

The service worked with external healthcare professionals in maintaining and promoting people's health and welfare. Care was planned to meet people's nutritional needs and a balanced diet with choices of meals was offered. Most people enjoyed a pleasant mealtime, though we raised practice issues about the support available in one area of the home.

People's rights under mental capacity law were understood and protected. Wherever possible, people were encouraged to exercise control and make choices within their daily lives. Formal processes were followed where people were unable to make significant decisions about their care and treatment.

Our observations confirmed that staff were caring and respectful of people's privacy and dignity. People and their representatives were supported to express their views about the care provided and the service in general. Feedback had been used to influence changes at the service, including enhancing areas of the home and efforts in improving activities to help meet people's social needs.

Care planning was personalised to the individual's needs and preferences, giving guidance on what was important to the person, their preferences, and the support they required. People's care was kept under regular review and adapted when there were any changes in their needs. The service was responsive to any complaints and those received had been properly investigated and resolved.

The registered manager was proactive in working inclusively with people, their families and the staff. Standards were continuously monitored to assure the quality of the service and the care that people experienced. However, improved oversight of medicines management was needed to ensure people always received their medicines as prescribed and to clearly address shortfalls in administration and recording with staff.

## 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.

Appropriate systems were in place to safeguard people against the risks of harm and abuse.

Risks were assessed and managed to protect the personal safety of people using the service.

Sufficient staff were employed to ensure people received safe care.

Arrangements were made for managing people's prescribed medicines.

### Is the service effective?

Good

The service was effective.

Staff were given appropriate support in their roles and were provided with training relevant to the needs of the people they cared for.

The service worked within the principles of mental capacity law to uphold the rights of people who were unable to consent to their care and treatment.

People were supported in meeting their health care and nutritional needs to maintain their well-being.

### Is the service caring?

Good

The service was caring.

Staff were kind and caring and had developed supportive relationships with the people who used the service.

People and their families were given the information and support they needed to make decisions about their care.

The staff treated people with respect and protected their privacy and dignity.

## Is the service responsive?

Good

The service was responsive.

Care planning was focused on people's individual needs and welfare.

People were offered opportunities to engage in activities to prevent social isolation.

Complaints about the service were taken seriously and properly investigated.

## Is the service well-led?

Requires Improvement

The service was well-led.

An experienced registered manager was in post who promoted an open culture and provided leadership to the staff team.

Feedback from people, their families, and staff was sought and acted upon to influence the standards of the service.

Quality assurance methods were in place to monitor and develop the service, though improved oversight of medicines management was recommended.

# Castle Grange

**Detailed findings**

## Background to this inspection

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

The inspection took place on 10 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

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 home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We received no feedback from other stakeholders that we contacted about the service.

During the inspection we talked with four people and a relative and observed how staff interacted with and supported people, including during a mealtime. We spoke with the registered manager, the service manager, a deputy manager, two team leaders, the chef, three support staff and asked the views of a visiting health care professional. We reviewed four people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

# Is the service safe?

## Our findings

The service had made suitable arrangements for the ordering and storage of prescribed medicines. These ensured there were enough stocks of people's medicines and that they were held securely. All staff involved in the handling of medicines were appropriately trained and had a thorough assessment at least annually to check their knowledge and competency.

A person we talked with told us staff managed their medicines and they always received them at the times they required. People using the service had well-recorded medicines profiles that informed staff about their individual regimes, any allergies, and had photographs for identification purposes. We observed directions for medicines authorised to be given covertly (disguised in food or drink) were not clearly stated within two people's profiles. Some directions for the application of creams and ointments were also unclear and we were informed this would be followed up with the supplying pharmacy.

On the day of our visit, a new monthly cycle of medicines and medicines administration records (MARs) had started. We saw that a person who received their medicines covertly had not been given any of their morning and lunchtime medicines, which remained in the blister packaging. A code, explaining that the person was asleep had been entered into the MARs, though a team leader told us the person had been woken in order to have food and drinks. Information from the person's GP specified four of their medicines as being most important to be given, though none had been administered by the time we checked in the afternoon. The person's previous month's MARs also indicated inconsistencies in their medicines being administered. Another person had not received their morning dose of a medicine for diabetes that helps control blood sugar levels. This medicine was seen to be in their blister pack and staff had not recorded any explanation for why it had not been administered. We highlighted our concerns about these people's doses of medicines being missed and the registered manager instigated an immediate audit into why this had happened. The other records we examined were appropriately completed, including medicines prescribed on an 'as required' basis and controlled drugs (medicines liable to misuse). We have recommended the service implement improved governance around the management of medicines.

The guide to the service set out the provider's commitment to provide 'quality services which safeguard and promote the well-being and safety of those people in the community who are in the greatest need'. Local authority safeguarding information was also made available to people that informed them about their rights to be protected from abuse. The people we talked with told us they felt safe at the home and no-one expressed any concerns about the way they were treated.

There were established systems for safeguarding people against the risk of abuse and for responding to any alleged abuse. Safeguarding and whistleblowing (exposing poor practice) policies and procedures were in place which were introduced to new staff during their induction. Staff were trained in safeguarding every two years and safeguarding issues were discussed at staff meetings to further raise awareness. Safeguarding concerns raised over the past year had been reported to the relevant authorities and appropriately acted upon.

The staff we spoke with understood their responsibilities for reporting any concerns or suspicions of abuse and poor practice. One staff member said they would "Always report concerns to the manager or Gateway to Care (within the local authority)". They were aware of the signs and symptoms people being abused might present and told us they had never had cause to report any concerns in the 10 years they had worked for the service.

The registered manager had begun to disseminate guidance about the 'duty of candour' to the staff team. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. Discussions were also taking place at a senior level within the local authority to look towards developing a policy on the duty of candour.

We checked the safekeeping of people's personal finances. Cash held on behalf of people was stored securely and transactions were suitably recorded, witnessed and backed by receipts. Weekly checks of the cash and balances were conducted to make sure people's money was handled safely.

The home was well equipped to deliver people's care and good standards of hygiene were maintained. A relative told us they felt the home was, "Comfortable and kept very clean." Various checks of safety and the upkeep of the environment were carried out and there were robust processes for ensuring maintenance and repairs were reported and completed. Contingency plans were in place for emergencies, including people's safety in the event of needing to be evacuated from the home.

An electronic system was used to report any accidents and incidents, which were reviewed and analysed by the local authority's health and safety department. The registered manager also completed their own analysis which had led to updating risk assessments and, where applicable, the provision of further safety aids and equipment for people.

Potential areas of risk were identified as part of people's initial assessments. These addressed areas of personal safety such as moving and handling, falls, use of equipment, bed-rails, skin integrity, diet and harmful behaviours. Further areas of risk were screened including health issues, fire safety and the person's ability to use the call system to summon assistance. Where risk factors were highlighted, specific plans had been put in place with measures to guide staff on safely supporting the person. Risk management was regularly updated including, for example, when a person was re-admitted to the service for another period of respite care. Care records also prompted any known history or risks of infectious diseases, along with contact details for obtaining advice on providing care in isolation to prevent the spread of infection.

The registered manager told us that following recent recruitment, the home would soon be in the position of having a full staff team. Staff records showed that a robust recruitment process was followed with all necessary pre-employment checks being carried out before new staff were appointed. Volunteers who worked at the home were subject to the same level of checks to ensure their suitability. External agency staff had been providing cover for absence and this was expected to cease as new bank/casual staff had been employed. Existing part-time support workers also picked up extra shifts to provide continuity of care.

The numbers of people using the service, along with a dependency tool were used to calculate the necessary levels of support staff. At the time of our visit, staffing was six support workers across the day, supplemented by one to two team leaders, and four staff during the night. The hours worked by the registered manager and deputy managers were in addition to these numbers. Support staff were dedicated to each of the four suites in the home and rosters were organised to include staff who worked between the suites to help out at busy times. Separate ancillary staff were employed for catering, housekeeping, laundry and maintenance duties and business support was provided by an administrator.

None of the people or staff we spoke with had any concerns about the staffing levels and we observed that staff worked at a steady pace. A relative told us, "There's enough staff." An on-call system was operated between the provider's care services that enabled staff to get advice or support and to escalate any emergency circumstances to senior management.

Good

# Is the service effective?

## Our findings

New care staff received an induction which was aligned to the 'Care Certificate' before starting work with people. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. Thereafter, staff received a combination of classroom-based and e-learning mandatory training in safe working practices such as safeguarding, fire safety, moving and handling, and health and safety.

The staff we spoke with confirmed they had received an induction when they first commenced their employment and told us they received regular mandatory training. One staff member described how they were able to request training in additional areas and told us the service was supportive of this. We examined the training matrix and found the overall compliance with mandatory training was at 94%. The matrix was updated and reviewed on a regular basis and there was an appropriate system in place for monitoring when staff training was due to be refreshed.

Support staff were offered opportunities to achieve nationally recognised care qualifications and were given training appropriate to the needs of the people they cared for. This included courses in dementia awareness, positive behaviour management, dignity in care, support planning and mental capacity law. Senior staff also received advanced training in line with fulfilling their roles and responsibilities.

A delegated system was in place for providing staff with supervision and annual appraisals. The registered manager told us they aimed for staff to have supervision every six to eight weeks. They acknowledged this frequency was not always being achieved and were working with staff to address this on an individual basis. Staff records indicated the majority of staff had received supervision in line with the provider's policy of six per year. Staff members confirmed they received regular supervision, during which training and support were covered in addition to reviewing their performance. Annual appraisals were due for most staff and where they had not already taken place, were planned in over the coming months.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service worked within the principles of the MCA to uphold people's rights. A good level of information was obtained about people's individual communication methods, their abilities to understand and make decisions about their care and if they were able to agree to their care plans. For example, one care plan we reviewed provided the following advice to staff when communicating with the person, '[Name]

prefers face-to-face communication. Please speak clearly to [name] and repeat the information to make sure [name] has understood'. Another care plan stated the person was unable to sign to agree their care plan and confirmed the content had been discussed with them and signed by a relative on their behalf.

Care records showed people had been asked to formally consent to their plan of care and treatment. In one example, we saw the person was unable to sign to agree their care plan and their care plan stated the content had been discussed with them and signed by a relative on their behalf. The staff we spoke with were aware of the need to seek people's consent prior to providing any care and support.

Formal processes had been followed to assess mental capacity and for decisions to be made in people's best interests. We saw relevant representatives were involved in 'best interest' decision-making and such decisions were clearly documented. A number of people living at the home had DoLS authorised to ensure they received the care and treatment they needed. DoLS were monitored and there was a system for taking action to extend the safeguards, where appropriate.

People's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool for identifying whether adults are malnourished or at risk of malnutrition. Appropriate care plans had been devised to minimise risks in relation to people's nutrition, including the provision of special diets.

People's weights were monitored on a regular basis and referrals were made to relevant healthcare professionals where there were concerns. For example, a person had been referred to their GP and subsequently to a speech and language therapist who had recommended a pureed diet. The person's care plan had been updated to reflect this. Care records also captured details of the support people required, for example, 'Staff to sit with [name] and assist them to eat their meal. [Name] needs to be sat upright and wear an apron to protect their clothing'. Where there were concerns about people's food or fluid intake, charts were used to document this and monitor whether further action, such as dietetic advice, was required.

The chef confirmed they had been informed of any special dietary needs as well as people's food preferences. Information was held in the kitchen about people's requirements and the chef told us they were updated by staff whenever an individual's needs had changed. The service had a four week menu in place. Copies of the menu were displayed in the home and the chef told us they regularly sought feedback from people about the meals. We saw people were offered choices at mealtimes and that alternatives to the menu could be readily prepared. Water coolers and juices were made available to people in each of the lounges to promote good hydration. There were tea and coffee-making facilities on each suite and a selection of drinks and snacks were provided to people throughout the day.

People living or staying short term at the home had access to a full range of healthcare services. This included referrals for specialist support when needed, such as input from teams specialising in continence management, prevention of falls and tissue viability. Visits from or contact with external healthcare professionals was documented, along with details of any treatment or advice provided. People and their families had also been consulted about end of life care and treatment, including resuscitation, to ensure their wishes were known and adhered to.

Good

# Is the service caring?

## Our findings

The people we talked with told us they were very happy with the caring nature of the service. One person said, "Staff are brilliant, there's no other word for it, they respect you, make sure you get what you want and if you don't like something they will always find you something else." Another person told us, "Staff always address me with my Christian name." The person's care plan showed that this was their preference.

Other people's comments included, "Staff make it so it is liveable here", "It's caring", "I'm very happy here", and, "Staff are nice to everyone." We were told that relatives could visit at any time. One person said, "My wife comes frequently, she can visit whenever she wants." A relative told us they were impressed with the service and found the staff to be kind and caring. They commented, "It's a hard job, but they're always bright and breezy. All the staff know people well." A visiting health professional told us, "Staff know people well, they seem interested and bothered about the welfare of the people they are caring for."

The care environment was light, spacious and comfortable, with clear signage to help people find their way around and identify areas and rooms. There were interesting displays which supported people to engage and reminisce and a room designated as a pub for socialising in. Each suite had a noticeboard to help orientate people to the date and day, and gave details of the staff on duty, the day's menu and social activities on offer.

An informative guide was made available that described what people could expect from living or staying at the home. A range of information was also displayed around the home for people and their visitors to refer to. This included staff photographs with names and roles, details of how to make a complaint, social activities, and the action taken by the service in response to the annual satisfaction survey. The home was signed up to campaigns which promoted people's rights to be treated with dignity, and championed best practice in caring for people with dementia-related conditions.

We saw that people were encouraged to exercise control by making every day choices and decisions. The home was divided into four suites and people were able to move freely around and go into the enclosed gardens. People told us they chose the times they got up and went to bed and where and how they spent their time. One person told us, "I got up late today and have just had a nice breakfast." A relative commented, "My [family member] is given plenty of choices."

Care records guided staff on how to maximise opportunities and support people with dementia-related conditions to make their own decisions. For example, by eliminating distractions, discussing issues in simple terms, and giving the person appropriate time to respond.

A staff member told us they encouraged people to give their opinions about the service and said, "I hold service user meetings whenever I have chance." Staff were aware of people's personal preferences regarding their care and told us these were recorded in their care plans and were respected. Where people were unable to express their views, relatives often advocated on their behalf. People could also be referred to an independent advocacy service if they did not have family to represent their views.

During our visit there was a warm, inclusive atmosphere in the home. We observed that staff were polite, patient and caring in their approach towards people and their visitors. The staff were knowledgeable about the people they cared for and were able to tell us about individual's likes and dislikes, as well as the level of care and support they required. One staff member we spoke with explained how they used personal information gathered as a means of starting to become familiar with people and have conversations with them. Interactions we observed were positive and we saw people and staff sat and chatted with one another in a friendly way.

The guide to the service set out aims and objectives which included people's privacy, dignity and rights being respected at all times. Staff understood the need to maintain people's privacy and dignity and gave examples of how they did this, such as covering people to protect their dignity when providing personal care. During our visit we observed good practice, including staff knocking on bedroom doors prior to entering and the registered manager asking a person's permission for us to look into their room. One person, whose room was located on the ground floor overlooking the garden, told us they had a privacy curtain so that they could see outside but people couldn't see in. Another person told us they felt, "Very privileged to have a key" (to their bedroom).

A relative told us that staff were very good at encouraging their family member, who had a poor appetite, to eat and this was confirmed by our observations. A staff member actively supported and involved the person to choose what they would like to eat and there was friendly banter between them about attempting to eat a little more. However, we observed there was an inconsistent level of support offered to people during lunch. On one floor we found the lunchtime experience was very relaxed. Condiments were available on the tables and people were provided with napkins and aprons to protect their clothing. Where people required one to one assistance we saw this was provided in a caring and dignified manner.

In another dining area we noted only one support worker was serving food and drinks. Specialist crockery was used to help people with eating independently, though no condiments were provided. Another staff member administered medicines, meaning people were interrupted whilst eating, and this impacted on the support available during the meal. One person, who appeared to need prompting with eating (as they had difficulties concentrating and co-ordinating cutlery and food), was not appropriately supported. They were given different meals and snacks, one after the other, most of which they looked at and did not attempt to eat. There were also delays in the next course being served to people and at least one person left the table as they had waited too long. We brought these issues to the attention of the registered manager. They acknowledged our findings and assured us they would take action to ensure this experience was not repeated.

Good

# Is the service responsive?

## Our findings

One person explained how staff responded to their requests, telling us, "I only have to ask if I need anything and they will get it straight away." A second person commented, "Even out of hours I get what I ask for. I'm regularly asked during the evening if I want a cup of tea." A relative told us their family member was, "Very happy and well settled at the home", and added that, "There is plenty of stimulation and activities for people."

The registered manager told us the service was able to be responsive to people's needs and there was capacity to increase staffing levels when required. This had been arranged for people who needed one-to-one support for set periods of time in order to safely meet their needs. A visiting health professional told us, "They always follow recommendations, for example if we suggest a GP visit they will do this. They always follow through with things."

In the care records we reviewed pre-admission assessments had been completed. These covered areas such as personal details, medical history, professionals involved in the person's care and a high level overview of the areas where support was required. When a person joined the service we saw a further full assessment was then carried out on admission. A staff member told us, "We also ask the families and social workers for information about people."

Information gathered from the assessments were used to draw up care plans for each identified care need. The care plans provided guidance for staff on the level of assistance the person needed and what they could do independently. They stated how each person preferred their care to be given, including whether they wished to be assisted with personal care by male or female staff. Care plans were evaluated on a regular basis to ensure they remained accurate and met people's needs. A staff member told us, "The care plans are reviewed monthly or if anything changes." We saw that where there was a change in needs, care plans had been updated, giving staff detailed instructions about how best to provide the person's care.

We found that people's care was planned in a person-centred way. Life history information had been obtained, helping staff to become familiar with the person's background, personality and interests. Care and support needs were thoroughly assessed and set out in personalised care plans. People were also allocated a named keyworker with particular responsibilities for their care. The staff we talked with understood the value of following care plans. A typical comment made was, "The care plans provide information about people and how we support them."

Care plans and risk assessments had been discussed with the person and their family members. Individual reviews of people's care were also held. These were evident in care records and were generally completed on a six monthly basis or when any significant changes in a person's needs occurred.

During our visit we saw notices displayed throughout the home about the activities available for people that month. They included film nights, bible studies, visits from a pianist and bingo. The registered manager informed us that the social activities provided were an area they were looking to improve. This was following

some feedback being received from people and their relatives about there not being much happening in the way of activities. As an interim solution a new programme had been created and volunteers were being used to deliver some of the activities. The service was also in the process of recruiting an activities co-ordinator to take a lead on organising activities and events.

Comments from people and their relatives had also been taken into account in improving the ambience of the service. For example, a survey previously carried out had asked whether there was a homely feel and negative comments had been received about the corridors and the garden. In response, the service had introduced memorabilia, pictures, reminiscence and information boards to enhance the corridors and the grounds were now being better maintained. We saw evidence of this during our visit and a person we spoke with confirmed a considerable amount of work had been done to improve the garden.

The complaints policy was provided to people in the guide to the service. Information was also on display in the home advising people and their visitors of the importance of raising any concerns or complaints they might have. This included details of other agencies which could be contacted for support if anyone was not satisfied with the response they received from the service.

The people and relatives we spoke with felt they could raise any concerns and were confident they would be appropriately responded to. Their comments included, "I feel able to complain", "They're aware if anything is wrong", "I've no complaints but wouldn't hesitate to raise one if there was anything", and, "Complaints are accepted and put right straight away."

We viewed the service's complaints records which were held electronically. The log provided an overview of each complaint, including the date received, the complainant's details, the nature of the complaint and the action taken by the service in response. 13 complaints had been received in the last year. Clear records were maintained of the actions taken to resolve complaints and where appropriate full written responses had been provided to people.

The service had also received a range of compliments from people, their relatives and external professionals which were displayed on a noticeboard. They included, 'What a lovely crew you have aboard. Cannot fault any of the staff who I find very friendly and willing to help with any problem. Keep it up', and, 'My [relative] is the same age as clients here and if they were to go into a home I would be more than happy for them to stay at Castle Grange and be cared for here'.

Requires Improvement

# Is the service well-led?

## Our findings

The home had an established registered manager who was well-experienced, with 18 years of working in and managing care services, and qualifications in leadership and management. They understood their management responsibilities and registration requirements, and had kept the Care Quality Commission (CQC) notified of any events which affected the service.

The registered manager was supported in their role by departments within the local authority including human resources, recruitment, safeguarding, estates and finance. They had regular contact with their line manager and met with their peers from the provider's other care services to keep appraised of current policies and practice. The registered manager told us they were keen to continue their personal development, identified and completed relevant training, and kept abreast of legislative changes.

There was a clearly defined senior staff structure that supported the running of the service. Three deputy managers were in post who had designated responsibilities for monitoring and implementing different areas. These included lead roles accountable for rosters, staff training, medicines management, infection control, and health and safety. Team leaders led shifts and handovers took place between shifts, ensuring any changes or incidents affecting people's well-being were properly communicated.

People told us they felt the home was well-managed. One person said, "Managers are very good", and another commented, "I can't criticise anything." A person pointed out the registered manager to us and said, "She's a nice lady." A relative told us, "The home is well-managed. The manager knows people and knows what's going on." A visiting health professional was complimentary about the service, telling us, "They're very organised, there's always someone to assist", and, "It's a really good service, I would recommend it to people."

The staff we talked with described the home as a nice place to work. They spoke highly of the registered manager, who they said was approachable and responded promptly to concerns or any issues raised. One staff member said, "I can approach [registered manager] at any time and she responds quickly."

Regular meetings were held with all grades of staff, giving them opportunities to air their views about the service and discuss practice and employment matters. Employee assistance was offered in the form of schemes and a helpline which staff could access for support with health care, counselling, personal and legal advice. We were told reasonable adjustments could also be made to support staff in carrying out their duties when necessary.

The service recognised good practice, including giving a monthly award to staff who had especially promoted caring behaviour. For instance, the previous month the award had been given to a staff member for displaying respectful behaviour towards others. The registered manager told us, equally, that poor practice would not be tolerated. Where conduct issues arose, disciplinary procedures were followed and staff were supported through retraining and working under extra supervision. Learning and reflecting on practice also took place from complaints and when incidents and safeguarding concerns occurred,

including analysis and discussion at staff meetings. A staff member told us, "We're very open as a staff team."

Systems were in place for monitoring the quality of the service. A range of audits into different aspects of the service and observations to validate people's care experiences were conducted. These included checks of health and safety, the environment, care plans, medicines management, and personal finances. The findings were fed into a monthly 'quality assurance framework', based on, and rated against, the CQC's fundamental standards of quality and safety for care services. This was reviewed by the home's service manager who checked the progress of any corrective actions required to ensure that standards were being met.

The quality system had not been fully effective in identifying how deficits in medicines administration and recording were addressed with staff and the impact on people's support of medicines being administered during the mealtime. The registered manager gave us assurance the medicines audits would be subject to closer scrutiny and that they would reinforce the importance of protected mealtimes with staff.

We recommend the provider makes arrangements to ensure there is more robust governance of the management of medicines.

The management aimed to work inclusively and used meetings and surveys to capture people's views and help them influence improvements to the service. Results of the latest relative's survey were provided to us and we were told a similar exercise to previous years, drawing up a 'You said, we did' to demonstrate actions taken in response, would be undertaken. The survey had asked about the five key questions that CQC inspect and feedback was predominantly positive. One relative had commented, in respect of whether the service was well-led that, "The care is of the highest quality and it permeates throughout the staff. No doubt good leadership skills account for this." Another relative, who had given less satisfied responses, indicated their confidence in the management and stated, "If asked these questions in six months' time, I am optimistic that I will be giving more positive feedback."

The registered manager confirmed a number of developments in the service had been completed over the past year. These included the use of a dependency tool to help determine staffing, further recruitment to fill vacancies, implementing efficient communication systems, embedding the quality framework, and evaluating feedback about the service. Further developments were in progress with the induction training of new support staff, improving social activities provision, and continuing to review care planning to ensure people's individual needs and choices were met.