Brandon Care Limited

Brandon House

Inspection report

29 Douglas Avenue
Exmouth EX8 2HE
Tel: 01395 267581
Website: www.brandonhouseexmouth.co.uk

Date of inspection visit: 5 and 8 October 2015
Date of publication: 02/02/2016

Ratings

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

Overall summary

An unannounced inspection took place on 5 and 8 October 2015. It was carried out by two inspectors. Brandon House provides accommodation for up to 35 people and 34 people were living at the home during our visit. The service provides care for older people; some people are living with dementia.

A registered manager was 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 Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection, no applications had been made to the local authority in relation to people who lived at the service as the registered manager had judged that currently there were no people who required this safeguard.

Summary of findings

Improvements were needed to the monitoring of infection control practice in the laundry. Medication was generally well managed but some improvements were needed to make practice safer. The registered manager had implemented changes to address inconsistencies in the management of supervision and training.

People looked confident as they moved around the home and people told us they felt safe. For example, "The carers here are wonderful... X (registered manager) chooses good staff." Staff knew to report poor or abusive practice.

Accident and incident records were analysed and action taken. Risk assessments were in place for people's physical and health needs. Care records were personalised. People had access to health services.

Staff treated people as individuals and checked how they wished to be supported. Staff understood the importance of gaining consent. People benefited from a staff group that were trained and worked as a team.

Staffing levels met people's care needs. The atmosphere was welcoming and friendly. Staff were calm and unhurried in their approach when they supported people. People commented favourably about staffing levels and told us, "If you want something they're there straight away"; "Always responded to promptly" and "They respond fairly quickly." Staff had the skills and compassion to provide quality end of life care.

People complimented staff on their friendliness and kindness. People said "Everybody's nice and staff are helpful" and "The girls are so kind and such fun." Another person said there was "Fantastic care" and a fourth person commented, "It's lovely, everybody so helpful to me."

The service was well run by a committed manager, who people said was approachable. Safety checks were up to date and the home was well maintained. The home was clean and there were no unpleasant odours.

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?

Good

The service was safe.

Medication was generally well managed but some improvements were needed to make practice safer.

Infection control practice was generally well managed but improvements were needed to make practice safer in the laundry.

The risks to people were assessed and actions were put in place to ensure they were managed safely.

The registered manager could demonstrate that staff were suitable to work with vulnerable people before they started working with people.

Staff knew their responsibilities to safeguard vulnerable people and to report abuse.

Is the service effective?

Good

The service was effective.

People were supported by committed staff who were trained to meet their emotional and health care needs.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered. The registered manager knew their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to protect people.

Staff received support to develop their skills and ensure they were competent in the work.

People were supported to access healthcare services to meet their needs.

Is the service caring?

Good

The service was caring.

People were treated with dignity and with kindness and respect.

People were involved in planning their care and support and their wishes respected.

Staff understood people as individuals and communicated effectively with them about their support.

Staff had the skills and compassion to provide quality end of life care.

Is the service responsive?

Good

The service was responsive.

People's individual care needs were assessed and care plans written in conjunction with individuals.

Staff were attentive and recognised changes in people's health and well-being.

People were asked about their preferences and encouraged to follow their interests.

People's care was responsive to their individual needs.

Summary of findings

Is the service well-led?

Good

The service was well-led but improvement was needed in some areas of quality assurance.

The home was well-run by a committed registered manager who supported their staff team and knew the people living at the home well.

People who lived at the service, their relatives and staff were positive about the running of the home and the quality of the care.

There were systems in place to monitor, identify and manage the quality of care.

Brandon 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 5 and 8 October 2015 and was unannounced. There were two inspectors. One inspector used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not comment directly on the care they experienced. An expert-by-experience was also part of the inspection; 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 our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

During our visit we met with 18 people staying at the home and spoke with 15 people about their experiences of care. We met with two visitors who shared their views with us. We met with six staff who carried out a range of roles within the home, and spoke with the registered manager. We looked at records which related to four people's individual care, including risk assessments, and people's medicine records. We checked records relating to training, supervision, complaints, safety checks and quality assurance processes. We looked at four staff recruitment files. We also contacted two health professionals for their views on the quality of the care at home and spoke with a social care worker from the local authority.

Good

Is the service safe?

Our findings

The home was clean and there were no unpleasant odours either in communal areas or in people's bedrooms. However, infection control practice within the home's laundry increased the potential of cross infection. For example, soiled shoes were left in the sink and a staff member picked these up without gloves and then handled clean laundry. Staff had not ensured they had soap, gloves, aprons and paper towels in the laundry to promote good infection control practice; they showed us that these items were available in the home. The size of the laundry impacted in creating a clear dirty to clean laundry system to reduce cross infection. The registered manager said work was planned to expand the size of the laundry. They were clear that the poor practice in the laundry was not acceptable and would be addressed. Training records confirmed infection control training had been provided for staff.

Medicines were generally well managed but some improvements were needed to make practice safer. There was an incorrect record for a medicine requiring specialist storage and recording. However, the registered manager said the amounts had tallied when she had investigated the discrepancy. There had been pharmacist advice visits on a regular basis and regular medicine administration record audits by the registered manager. However, there were no stock control audits and one medicine was still stored in the home although the person had left in July 2015.

Each person had a care plan which stated how their medicines would be managed. A code was used to show staff what level of support the person needed. However, one person told us sometimes the staff left the medicine with them to take later but it was not at their request and did not reflect their care plan. For example, "Medicine is given to me on time, sometimes they watch to make sure I take it as they did in the early days but most of the time they trust me." The registered manager said they would address this issue with staff.

Staff had experienced some difficulties getting people's prescribed medicines delivered when needed which had led to some not being available for the person. The registered manager said they had many conversations with the pharmacy about the problems. We were shown emails confirming this and an example of a current medicine issue, which was out of the home's immediate control.

People were supported to manage their own medicines, if this was their preference and once a risk assessment had been completed. The arrangements varied according to the person's choice and abilities. For example, for one person kept their own medicines in a locked cabinet in their room. They said, "I manage my own." Another person said "The staff stay to make sure I don't forget to take them", a third person said, "They stand and watch you take your tablets", and a fourth person said their medicine was "Always given at the correct time." People were encouraged to use a monitored dosage arrangement but some chose to use a box system for their medicines. The registered manager said how important it was that, if people managed their own medicines, they could continue with the method they were familiar with. This was especially important if their residence at Brandon House was temporary and they would be returning home.

Medicines were recorded into the home as part of the audit system of their use. If staff were unsure of any medicines, for example, if the prescription said 'use as directed' staff checked what that meant so its use would be in accordance with the person's needs. Other good practice used at the home for safe medicine management included body maps for consistency when applying pain relief patches, faxing changes to people's prescriptions and using codes if a medicine was not taken. Medicines information was also available for staff to refer to. This included any possible side effects to the medicines people were prescribed. Medicines were kept securely in a locked room.

Staff had completed application forms and interviews had been completed. The provider sought evidence of conduct in previous employment, including information from previous care work employers. This meant the registered manager could demonstrate that there was a system to ensure new staff were suitable to work in a care setting.

Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Good

Is the service safe?

Staff were knowledgeable about how to recognise signs of abuse and how to whistle-blow on poor or abusive practice. They knew who they should contact to make a safeguarding alert either within the company or via an external agency. They knew where the safeguarding policy was kept. Four people commented to us that they felt safe living with one person stating, “Yes, I feel very safe here.” People living at the home had also commented on feeling safe in a quality assurance survey earlier in the year.

Some people living at Brandon House were vulnerable to risks from pressure damage, losing weight and falls. However, staff were well informed of those risks because each person’s folder had the level of risk clearly displayed on the front using a colour coded system, red being high risk. The risks were regularly reviewed and changes made to people’s care plan as necessary. Where equipment was required to reduce a risk, such as pressure damage, this was in place. One person who required such equipment said it was available immediately it was needed and described their care as “Fantastic.” Health professionals told us the staff were quick to pick up on changes to people’s health and reacted quickly to increased risks. For example, they told us the staff were pro-active by putting pressure relieving equipment in place promptly and seeking advice from the community nurse team.

The premises and equipment were kept in a safe condition. Discussion and records showed that risk was assessed in relation to people’s rooms and the shared areas of the home. Where a risk was identified measures were taken to reduce the risk, with people’s agreement, such as securing wardrobes to the wall to remove the risk of them falling if pulled upon. There were contracts in place to ensure regular servicing of equipment so it was safe for use and met legal requirements. Records showed that any fault or concern was followed up promptly, such as gas safety.

There were sufficient staff to meet people’s needs. The registered manager was part of a management team. She was training two deputy managers, who were supported by team leaders. Rotas showed there were usually six care staff on duty until 2pm, which reduced to four care staff after 2pm. The registered manager said they had reviewed staffing levels at night and there were now three waking night staff, which the rotas confirmed. The activities person also worked five days each week, including afternoons and weekends. Care staff were supported by laundry, cleaning and kitchen staff. Staff were calm in their approach with people and did not look rushed.

People commented favourably about staffing levels and told us, “If you want something they’re there straight away”, "Always responded to promptly” and "They respond fairly quickly.” The registered manager explained how they could audit response times to call bells and she explained they could only be cancelled by a staff member in the person’s room. People told us call bells were accessible and were mobile so they could be placed near to them. One person used their call bell while we sat with them in their room and it was answered quickly, within three minutes.

Good

Is the service effective?

Our findings

The service was effective and the registered manager ensured training and supervision was provided. Staff members said they had access to formal supervision sessions, which records confirmed. They also told us they could request support on an informal basis from their colleagues. However, when we checked how often supervision occurred, records showed these did not take place on a regular basis for all staff. In a team meeting in August 2015, the registered manager advised staff the management of supervisions would soon be changing and delegated to other members of the management team.

People told us about the skills of the staff who cared for them. They commented on their friendliness and positive approach. For example, "The carers here are wonderful...X (registered manager) chooses good staff." People living at the home had commented on the skills of the staff in a quality assurance survey earlier in the year. The registered manager and staff showed a strong commitment to providing good quality care in their discussions with us.

Staff demonstrated their understanding of their responsibilities and the skills they needed to effectively support people. Staff talked to us about their training opportunities, which included training in safeguarding, moving and handling, infection control, and where appropriate medication training. One staff member said additional training had been arranged for their specific role as activities co-ordinator. Other staff said recent training on dementia awareness had been an 'eye opener' and had positively influenced their practice. Staff were able to give other examples where training had improved their understanding, for example monitoring the health changes in people living with diabetes.

Staff had an induction period, which varied in length depending on the person's level of experience. During this time, they were provided with relevant policies and participated in training. Feedback was also provided by staff who worked with new staff on their induction to help the registered manager make a judgment on their competency. Records showed that new staff members' practice was observed when they joined the service to ensure they worked in a safe way, for example moving people safely. This approach was confirmed by staff who said they were encouraged to identify if new staff members needed additional support. The registered manager had updated their understanding of the national care certificate, introduced to the care section April 2015, and instigated this training in the home for new employees.

The registered manager demonstrated an understanding of the Mental Capacity Act (2005) (MCA) in their discussions about people's ability to make decisions and how they should be involved in day to day decisions. Staff practice showed they understood the principles of the Act, although staff records did not show that training had taken place. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. There was a policy in place to provide staff with guidance. The registered manager advised there was no one currently who required a deprivation of liberties application. They said there was no one under constant supervision who did not have the mental capacity to agree to living in the home. Staff members confirmed the accuracy of the registered manager's assessment.

People told us staff knew their preferences and how they chose to be supported. For example, one person said they were never expected to get up or go to bed, or anything, else, if it was not what they wanted. Five other people confirmed they got up and went to bed at times of their choice. Staff checked with people about how they wanted to be supported and gained their consent before assisting them. Staff knew people's personal preferences and people's choices were recorded in their care plans. We saw people being involved in day to day decisions, such as whether to have a bath or a shower. Staff took time to explain choices to people and did not rush them.

Staff checked with people how they wished to be supported and listened to their opinions. People told us how they had been involved in decisions around their care. For example, one person had moved rooms on several occasions because of their changing health needs and told us they had been asked their opinion and been in agreement each time. At the time of the inspection, the registered manager had been discussing with another person about changing their room again because of health changes. But the person had chosen to stay in their current room, which the registered manager was clear was their decision and should be respected.

Good

Is the service effective?

Staff handovers took place at the beginning of shifts and communication books were in place; staff took the responsibility to read these to update their knowledge about people's care needs. People told us they had access to health professionals; we saw records of visits in people's care records and information in staff communication books. During the inspection, health professionals visited the home and staff consulted with them to ensure they were meeting people's care needs. Health professionals said they were contacted appropriately and the staff followed their advice. Health professionals visiting the service included a chiropodist. The registered manager and staff recognised changes in people's health and made referrals in a timely manner. For example, working with community nurses and a chiropodist to support a person who had recently moved to the home with an on-going health issues.

People's weights were monitored and staff were attentive during a lunchtime meal to help ensure people ate and drank adequately. For example, subtly prompting a person to eat independently when they lost focus and forgot to eat. A person told us there was always plenty to drink and staff ensured people's drinks were replenished and were prepared to the individual's taste. A visitor told us their friend had put on weight since moving to the home, which they saw as a positive sign as they used to previously struggle with meals and maintaining weight.

Eleven people shared their views on the quality and range of food. There was a mixed response; two people said the food was "Adequate" and "The food is okay, sometimes it could be better, could be something to do with when the cooks change shift". But the majority of people were more positive. For example, other people said, "I think it's quite good and there is plenty of choice" and "I think it's excellent, I feel there is plenty of choice." However, several people said they would like more vegetables; staff told us vegetables were with every main meal but sometimes were within the dish, such as a casserole. One person said, "We get quite a lot of casseroles; it suits me ... although staff will help if needed. I'm trying to be as independent as possible."

The registered manager explained that a survey had been sent in June 2015 to gain people's views on the food. The responses had been compiled and where appropriate, changes had been made. People were provided with choices for each meal. But a person also said "You can always ask for something if it's not on the regular menu." Care staff spent time with people who needed additional help to complete the menu card.

Staff working in the kitchen were knowledgeable about people's individual like and dislikes and had their preferences listed for reference. They explained how they met with people living at the home to discuss the menu with them; the menu was on a four weekly cycle and seasonal. They said there was good communication between them and the care staff so that people's changing health needs could be catered for. For example, a person who required a gluten free diet and another person who needed a smaller portion and a softer diet. Staff working in the kitchen were clear about risks to people's health, including allergies, and a person living with diabetes told us their dietary needs were well managed. Catering staff said they were encouraged to attend care staff team meetings. This was confirmed by the minutes from staff meetings, and they said they felt very much part of the team.

Good

Is the service caring?

Our findings

Eight people said staff were kind and respectful in their approach. For example, “They are very helpful, always polite and kind and always knock before entering.” Staff discreetly guided people to help them find their way around the home and checked with them what level of help they needed. Staff knocked on doors before entering, which a person said they always did. Staff understood the importance of confidentiality and were respectful when they spoke about how they supported people living at the home. One person said, “All staff are lovely” and they would recommend the home to other people. Another person said, “The girls are very obliging.”

The environment of the two dining rooms supported people’s dignity with care being given to create an attractive setting with flowers, condiments, napkins and tablecloths. Staff were attentive during lunch, offering help in a manner which maintained people’s dignity. They supported people living with dementia in a considerate way, for example describing meals to them when they had difficulty completing the menu card independently and difficulty remembering what ingredients a meal might contain. Staff supported people’s friendships. They spoke respectfully about the support provided to ensure people living at the home could maintain relationships with partners living both at the home and outside of the home.

There were positive relationships between the registered manager, staff and people living at the home. For example, one person said, "I mentioned to X (the registered manager) that I had a birthday coming and it would be nice to have something different to chocolate and cakes. She knows I like salmon and organised a nice salmon hors d'oeuvre for the people on my table on my birthday.” It was clear from our discussions and observations that staff also knew when to adapt their approach in recognition of people’s individuality. For example, from gentle banter to a more formal approach. People said, “Everybody’s nice and staff are helpful” and “the girls are so kind and such fun.” Another person said there was “Fantastic care” and a fourth person commented “It's lovely, everybody so helpful to me.”

People visiting the home were reassured by the approach of staff towards them. They said their impressions were the staff were friendly and welcoming, while another person said the staff came across as “friendly and caring people.” During the inspection, people visited the home to help them make a decision about whether they wished to move there. The registered manager and staff welcomed them and listened to their queries and provided reassurance and information.

Staff spoke sensitively and compassionately about their responsibility to care for people at the end of their life with dignity and respect. They explained how changes were made to the rota, if necessary, so that a staff member could sit with the person so they were not alone. A relative thanked the registered manager for ensuring that the staff member was someone their relative ‘was so fond of’. Another relative commented that because of the skills of the staff their relative had been transformed from someone who was ‘frightened’ to someone who was ‘relaxed’.

The registered manager recognised the importance of providing staff with the right skills to support people who had end of life care needs. The service had taken part in a project run by Hospiscare and had received written feedback on their ‘highest quality’ care. Feedback included that the staff at Brandon House were attentive and went ‘the extra mile’ to help make people happy and feel well cared for. Further comments included the person centred approach by staff, which was ‘always caring and respectful.’ Staff recognised the support families needed during a person’s end of life care; feedback from relatives showed how much this approach was valued. Relatives repeatedly praised the staff for their care and kindness.

Good

Is the service responsive?

Our findings

The home's complaints information was not on display; the registered manager assured us this was normally kept near the visitors' signing in book but it could not be found during our inspection. They said they would rectify this matter as they recognised this information needed to be available to visitors to the home. Staff said people had a copy of the complaints policy in their room as part of the service user guide. A staff member was clear about how to respond to complaints in a timely manner and to refer to the management team. They also knew where to find the home's complaints policy.

People said they had no reason to complain but felt confident they could if they needed to. For example, "If I had any concerns I would talk to X [registered manager]. When I want something done she does it quickly". Another person said, "I've no complaints; I'd tell you if I had." They were unclear how to complain but said a family member would help them. A third person said if they had any concerns, "I would talk to someone at reception" and a fourth person said they would go to the registered manager. The registered manager said they had not received any formal complaints in the last twelve months.

People told us how they had moved to the home; one person described how they had visited first and compared it with other services. We discussed with the registered manager how they recorded information from these visits to become part of their pre-admission assessment as the care files we checked did not contain this information. Following this discussion, they adjusted when this initial assessment was recorded so that it contributed to an assessment completed on the day the person moved to the home.

Written assessments were in place to help the registered manager make sure they could meet the needs of people. People said staff knew what was important to them, for example their personal routines and how they liked to be assisted. Staff members demonstrated this knowledge when we spoke with them about how they supported people in a person centred manner.

Care plans are a tool used to inform and direct staff about people's health and social care needs.

People's care records were up to date, reviewed and personalised, including people's likes and dislikes. Discussions with people about their care were well documented and were signed by people living at the home. People received personalised care and support specific to their needs and preferences. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. A person showed us the equipment in their room to help prevent damage to their skin; they understood the risks to their health and why the equipment was in place. Changes in people's health were monitored and the registered manager ensured people moving to the home were visited by health professionals to assess health complications.

The activities co-ordinator described their role to us, which included working at weekends. They were passionate about the importance of providing a range of activities to meet the individual needs of people, some of whom were living with dementia. They took time to get to know people individually and met with people when they first moved to the home. Their records were well kept and up to date, which showed the variety of activities on offer, including poetry, cards, a cinema club, a knitting group and quizzes. A person commented positively on the wide range of exercise classes including yoga, chair based exercises, balance exercises and a dance session.

An informative weekly newsletter was provided to each person to update them on events in the home. Records showed that the activities co-ordinator spent time on an individual basis with some people who preferred to stay in their room. A shop was also run within the home to enable people to buy toiletries and sweets. People discussed the activities in the home; we saw people participating in activities and care staff made sure people were aware of what events were planned for the day. One person said the activities co-ordinator "holds this place together" and said, "I wouldn't want to be anywhere else."

Good

Is the service well-led?

Our findings

People at the home knew who the registered manager was; several people were impressed she had met with them to show them around and met with them when they had moved in. For example, "X [registered manager] came to see me soon as I arrived, it's a good sign." People were positive about the running of the home and quality of the care. For example, "We think we're being well looked after, we think the staff try hard", "Living here is fine, if you got to live anywhere it's good, we are well looked after" and "It's lovely, everybody so helpful to me." From her discussions with us, the registered manager clearly knew people as individuals and recognised the importance of knowing people's social history and the role of people that were important to them. People had the opportunity to comment on the running of the home through surveys which covered different aspects of their care, such as food and the skills of the staff group.

The registered manager managed both Brandon House and Sheridan House; she was supporting two staff to develop their management skills to support her at Brandon House. There was a commitment to providing quality care in a safe and well-maintained environment. For example, audits ensured equipment was safe and maintenance around the home was carried out routinely. These audits were up to date and staff knew to report maintenance issues. Staff response times to call bells were monitored to check people received a safe and responsive service.

There were systems in place to enable staff to feedback on the skills of their colleagues to ensure all staff were supported with the right level of training. The registered manager said they observed staff practice, which was confirmed by moving and handling and medication competency assessments. Staff demonstrated their willingness to learn and try new ways of working to benefit the people they supported. This helped to promote the ethos of the service which was one of on-going improvement. Staff were kept informed in a variety of ways, including handovers, supervision and staff meetings.

The registered manager was open to learning from events, for example creating a new system to help care staff clearly identify when people had risks to their health and well-being. This change was shared with staff in a team meeting. Team meeting minutes also demonstrated how the registered manager encouraged staff to learn from events and to support staff during sad times, after people had died. Working in partnership with agencies meant staff had the opportunity to learn new skills and consolidate their existing knowledge, such end of life care.

Staff were motivated to provide a good standard of care; they recognised the importance of person centred care and promoting choice showing the provider promoted a positive culture in the home. This was demonstrated throughout the inspection. Staff told us there were staff meetings, and minutes showed these were well attended. Staff spoke about the positive team work within the home, which was across job roles such as cleaning, caring, catering and activities. A staff member said there was a "brilliant atmosphere" and that you could go to the registered manager "for anything, she's that sort of person." People living at the home spoke positively about all staff with different roles. For example, a person praised the role of the maintenance person saying they were friendly and helpful, and told us they appreciated the company and approach of the staff who cleaned their room.

Auditing processes had not identified some areas for improvement such as infection control in the laundry and some aspects of medicines management. Notifications of incidents in the home had been sent to the Care Quality Commission (CQC) but these had not covered all notifiable events, and this had not been identified by the provider in their quality assurance audits. Once this discrepancy was identified during the inspection these two notifications were completed retrospectively and sent to CQC. During the inspection, we discussed notifiable incidents that linked to people's safety with the registered manager, and looked at records. We were reassured by the action they had taken in response to these incidents.

The registered manager told us a new role had been created to manage training updates and training records in recognition that this was an area for improvement. It was difficult to audit the staff training records and the management of training updates as there was no overview of staff training. For example, training certificates showed the previous moving and handling trainers' practice had not been updated. Since this inspection, the registered manager said training had been arranged for a number of staff to be 'train the trainers' in moving and handling to ensure staff were receiving up to date in house training. Other members of the management team were also

Good

Is the service well-led?

beginning to manage supervision sessions, which had previously not been consistently managed and recorded. Therefore steps were in place to improve the support for staff.