Methodist Homes

Brookfield

Inspection report

Little Bury
Oxford
Oxfordshire
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on 8 March 2017. The inspection was unannounced.

Brookfield Nursing Home is registered to accommodate persons who require nursing or personal care. The home offers care for up to 66 people. At the time of our inspection there were 59 people living at the Home. Brookfield supports older people who have nursing needs and people who are living with dementia.

At a previous inspection on 20 January 2016 we found the provider had not taken reasonable steps to ensure the administration of medicines were managed properly. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We also found that the provider had not acted in accordance with the principles of the MCA and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found that the home had made significant improvements to address the areas of concern and bring the service up to the required standards.

The service did not have 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. However, we saw evidence that the service was in the final stages of recruiting to this position.

People received their medicines as prescribed. Staff administering medicines checked each person's identity and explained what was happening before giving people their medicine. Medicines were stored securely and in line with manufacturer's guidance.

People were supported by staff who had been trained in the MCA and applied it's principles in their work. Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager). Staff spoke positively about the support they received from their seniors and the provider.

There were sufficient staff to meet people's needs. Staff were not rushed in their duties and had time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

People told us they were safe. People were supported by staff who could explain what constitutes abuse and what to do in the event of suspecting abuse. Staff had completed safeguarding training and understood their responsibilities.

People had sufficient to eat and drink. Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff who clearly understood the dietary needs of the people they were catering for.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed. Staff were kind and respectful and treated people with dignity and respect.

The service sought people's views and opinions. Relatives told us they were confident they would be listened to and action would be taken if they raised a concern.

The manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements. Following our last inspection the service had submitted an action plan outlining what actions they would take to address the improvements needed following a previous inspection. This had been submitted to the Care Quality Commission as required. During our inspection we saw that the actions in the plan had been completed.

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.

People told us they felt safe. Staff understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse.

There were sufficient staff on duty to meet people's needs.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were supported by staff who had been trained in the MCA and applied it's principles in their work.

People had sufficient to eat and drink and were supported to maintain good health.

The service worked with other health professionals to ensure people's physical health needs were met.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.
People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

Is the service responsive?

Good

The service was responsive.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed.

People's needs were assessed to ensure they received personalised care.

There was a range of activities for people to engage with.

Is the service well-led?

Good

The service was well led.

The provider's values were displayed throughout the home. The leadership team and staff displayed these values in their work.

The manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

Accidents and incidents were recorded and investigated.

Brookfield

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 checked 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.

This inspection took place on 8 March 2017and was unannounced. The inspection was carried out by three inspectors and an expert by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, 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 previous inspection reports, the action plan that was sent to us following the last inspection and notifications we had received. A notification is information about important events which the provider is required to tell us about in law. Prior to the inspection we spoke with commissioners of the home to get their views on how the service is run.

We spoke with seven people, six relatives, four care staff, three nurses, the administrator, the chef, the Chaplin, the registered manager and the operations manager. We reviewed eight people's care files, three staff records and records relating to the management of the home.

We used 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.

Good

Is the service safe?

Our findings

At a previous inspection on 20 January 2016 we found the provider had not taken reasonable steps to ensure the administration of medicines was managed properly. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found that people received their medicine as prescribed and the service had safe medicine administration systems in place. We observed staff administered medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given. One person we spoke with told us, "The nurses always bring me my medicines". During our conversation with this person a nurse came into the lounge and explained to the person that they had the person's morning medicine and gave them their medicines.

Another person refused their medicine. Staff spoke with this person and explained what the medicine was for and why it was important to take the medicine. As a result the person took their medicine. We observed staff speaking with this person in a warm and gentle manner whilst maintaining a clear focus on the person finishing their medicine. The staff member administering the medicine told us "People need time, these things can't be rushed".

Medicines administered 'as and when required' included protocols providing guidance for staff about when the medication should be used. Staff had an understanding of the protocols and how to use them. Staff were trained to administer medicine and their competency was regularly checked by the provider. One member of staff told us "We have medicines training yearly". Medicines were stored securely and in line with manufacturer's guidance. Controlled drugs were managed safely.

People told us they felt safe living at the service. Comments included: "Yes I am happy and feel safe", "So long as I am looked after I feel safe." I also feel safe, as I cannot get lost here", "I have a (pendant alarm) which I wear round my neck and this makes me feel safe" and "I feel secure and safe".

Relatives told us they felt their family members were safe. One relative told us, "We feel that she is safe, especially now that she wears an alarm pendant around her neck". Another relative told us "My husband has been here two years. He has (medical condition). Although I never wanted him to go into a home I can relax and know that he feels happy and safe here. And so do I. It is not like an institution. It is his home".

Staff were aware of types and signs of possible abuse. Staff had completed safeguarding training and understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse. Staff told us that if they had any concerns then they would report them to the manager. Staff comments included "Types of abuse include physical, sexual, financial and psychological", "Signs of abuse can be bruises, withdrawn, fearful and not engaging in activities. I would report concerns to the nurse or the manager", "Any concerns we report to the manager and the safeguarding team" and "The first thing I would do is report it to my manager or deputy manager". Staff were also aware they could report externally if

needed. One staff member told us "I would go to the police and CQC (Care Quality Commission)".

People's care plans contained risk assessments which included risks associated with; moving and handling, choking, pressure damage, falls, personal care and environment risks. Where risks were identified plans were in place to identify how risks would be managed. For example, some people had restricted mobility. Peoples care records gave guidance for staff on how to support them effectively whilst moving around the home. Throughout our inspection we observed staff following this guidance.

People who were at high risk of pressure damage had accurate and up to date repositioning charts in place and were supported by staff who were aware of these risks and what action to take as a result. The service had also sought advice and guidance from the tissue viability team. This included the use of pressure relieving equipment.

People who were assessed as being at risk of malnutrition had accurate and up to date Malnutrition Universal Screening Tools (MUST) in place and were supported by staff who were aware of these risks and what action to take as a result.

We spoke with staff and relatives who gave a varied response about staffing levels. Comments included "I think we have enough staff", "Staffing varies. There are times when we don't have enough staff but rarely use agency. We cover staff shortages with our own staff", "Sometimes I feel there is not enough staff for personal care", "I think we have enough staff" and "The staff are busy are (sometimes) there is not always enough (staff)". However, we observed, and staffing rotas confirmed, there were sufficient staff to meet people's needs. The manager used a 'dependency tool' when carrying out initial assessments on peoples care needs. This enabled the manager to calculate the right ratio of staff against people's needs. We saw that this was reviewed regular by the management team. There were ten care workers and four nurses on duty to support 59 people. During the day we observed staff having time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. One member of staff told us, "I had to wait for (DBS) to come back before I started".

People were protected from the risk of infection. The premises and the equipment were clean, and staff followed the provider's infection control policy to prevent and manage potential risks of infection. Equipment used to support people's care, for example, wheelchairs and hoists had been serviced in line with national recommendations. Protective equipment such as aprons and gloves were available and used by staff.

Good

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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.

At the previous inspection on 20 January 2016 we found the provider had not acting in accordance with the principles of the MCA and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found that the home had made significant improvements to address the areas of concern and bring the service up to the required standards. For example, one person was being given their medicines covertly (medicine which is put in food or drink without the person knowing). Records confirmed that mental capacity and covert administration assessments had been completed and were reviewed regularly by the home. We noted that the person's family, G.P and community pharmacist had been involved in 'best interest' meeting to ensure that the decision to carry out covert medication was in the person's best interests.

Another person's care record highlighted that they lacked capacity to take particular decisions in areas that related to their personal care and accommodation. This person's care records demonstrated that a mental capacity assessment had been carried out and that the person's family had been involved in a meeting. This demonstrated that the service had involved relatives in identifying the least restrictive options that were in the person's best interests.

People were supported by staff who had been trained in the MCA and applied it's principles in their work. All nurses we spoke with had a good understanding of the Act. Comments included "MCA includes ability to support people to make decisions about their day to day things", "Mental capacity assessments are taken individually for time specific events" and "MCA is about the ability to make safe decisions". Care staff we spoke with told us they would report any concerns they had in a person's capacity to their manager or the nurses on duty. One staff member said "I would report it to one of the nurses". The service sought people's or their legal representative's consent. We saw documents in care plans evidencing that consent to care and being photographed had been gained.

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 home was meeting the requirements of DoLS. At the time of our inspection the service had made DoLS applications for 47 people.

Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to

one meetings with their manager) and yearly appraisals. Staff told us they felt supported by their seniors. Comments included; "We have supervisions every three months and we talk about areas of improvement and if we are happy with work and training opportunities", "I find supervisions useful. We have targets to meet between supervisions", "We have appraisals every year and we receive performance feedback", "If I was unsure, I would go to my senior and she will always help. It's nice to be able to have someone who is reassuring" and "I feel supported by my manager".

New staff were supported to complete an induction programme before working on their own. This included training for their role and shadowing an experienced member of staff. Staff told us, "Induction included shadowing for two weeks", "Induction was very good and effective", "I had a buddy to support me during earlier days after induction" and "Training includes e-learning and face to face training"

Records confirmed people were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff completed training which included safeguarding, MCA, food and fluids, moving and handling, infection control, first aid, medication, dementia and wound management. One staff member told us, "Training is available to us and we can request extra training". Another staff member said "I have learnt a lot from the training. Especially the manual handling training".

Staff told us and records confirmed that staff had access to further training and development opportunities. For example, one nurse told us, "Training is available to us. I requested ear syringing and phlebotomy training and the provider is arranging it".

Another member of staff told us "I have been working here for five years after I completed a Health and Social Care course. And I love it here. As well as working in (department) they have sent me on a dementia awareness course, which I wanted to do, as I wanted to know more about dementia and how I can relate and understand these types of residents".

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. We observed staff gaining consent to ensure that people had agreed to support being provided.

People told us they enjoyed the food provided by the home. Comments included "I like the food. I like it all", "The food is very good. I am a tea man. I had egg, bacon and sausages for breakfast", "I love the food. The ham is my favourite", "The food is nice here", "The food is always good" and "You can't knock the grub here". We found that people with specific health problems such as diabetes had the correct guidance in place for staff to deliver effective treatment. Records confirmed that staff followed this guidance.

People were offered a choice of meals three times a day from the menu. Staff advised us that if people did not like the choices available an alternative would be provided. At lunch time we observed that a person had changed their mind and asked for something different. Care staff responded to this and brought the person a meal of their choosing. We spoke with this person's relative who told us, "They cook simple food and to her wishes. Today she is having an omelette which she asked for". We observed that the food looked wholesome and appetising. Snacks were available for people to have in between meal times.

People who needed assistance with eating and drinking were supported to have meals in a dignified way by attentive staff. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace that matched the needs of the people they were supporting. We observed a staff member supporting a person with their lunch time meal. Throughout the interaction the staff member maintain conversation with the person and encouraged them appropriately when needing to. A relative told

us, "I support most meal times. That is my choice. It is what I can still do for him. But if I am going out, I know that the staff will look after him well".

Menus were displayed in the homes dining area and staff assisted people with their choices. During our observation of the lunch time meal we noted that people were offered a choice of drinks throughout. People had access to and were offered drinks throughout the day. Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff who clearly understood the dietary needs of the people they were catering for.

People had regular access to healthcare professionals such as, G.P's, occupational therapists, dieticians, physiotherapists and other professionals from the care home support team. Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments. For example, where people had been identified as having swallowing difficulties referrals had been made to Speech and Language Therapy (SALT). Care plans contained details of recommendations made by SALT and we saw staff were following the recommendations.

Good

Is the service caring?

Our findings

People were complimentary about the staff and told us staff were caring. People's comments included; "The carers are kind", "I find the staff are very nice", "The staff are a good laugh which I like", "They are a lovely lot of girls", "They look after me and are friendly. The carers are nice" and "I get on with all the staff. I have no favourites". One relative told us "The nurses are all amazing". Another relative told us "We choose this place and we would choose it again. The best choice".

Staff told us they enjoyed working at the service. Comments included: "I love this job. I like caring", "I treat people like I would like to be treated", "It's lovely working here", "We treat residents like family" and "I love working here. The residents are great".

Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people and reassure them, always making sure people were comfortable and had everything they needed before moving away. For example, one person needed to go to the toilet. Staff knelt down to this person's eye level and asked them discreetly which bathroom they would like to use. When the person and staff returned, the staff member asked them if they wanted a cup of tea. The person declined and staff respected the person's wishes.

Staff told us they respected people's privacy and dignity. They said, "We knock on people's doors and wait for permission. We close doors and explain procedures" and "During personal care we cover residents with towels. We draw curtains and doors for privacy".

We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. People's friends and relatives could visit whenever they wanted to. People were able to meet their relatives in the communal areas or in the privacy of their rooms. One relative told us, "I can come anytime I like". Another relative told us, "Visiting times are open and no limit of numbers. We can also take her out when we want to".

Relatives told us they felt involved in people's care. One relative told us, "I am involved with his care plan and end of Life care. The staff are very helpful". Another relative said, "I am involved with her Care".

Staff knew people's individual communication skills, abilities and preferences. Care plans contained information and guidance on how best to communicate with people who had limitations to their communication. For example, one person's record said, 'take time to allow [person] to respond. Ask yes or no questions'. We saw staff communicating with this person and offering only yes or no questions to consider. The person was smiling, relaxed and clearly comfortable with staff.

People's independence was promoted. We saw people using mobile call bells whilst in the communal areas. This allowed them to do what they chose knowing they could call for staff for help if needed. People's care plans guided staff on promoting independence. For example, one person's care plan stated 'able to wash face and needs prompting with brushing hair and teeth'. Staff told us they followed this guidance.

Staff told us how they supported people to do as much as they could for themselves and recognised the importance of promoting peoples independence. One staff member we spoke with highlighted how promoting independence would prevent a rapid decline in people's health and wellbeing.

We saw staff call out to people if their room doors were open before they walked in, or knocked on doors that were closed. For example, we observed a staff member knocking on a person door before entering. When the staff member entered the room they said in a joyful tone, "Good morning [person], how are you today. Have you had a good breakfast".

People's wishes relating to 'end of life' care were recorded and respected. Advanced care plans recorded people's preferences and wishes. For example, whether people wished to be buried or cremated, funeral and family arrangements. Staff we spoke with were aware of these wishes and told us people's preferences were always respected. One staff member said, "During end of life we keep residents comfortable and without pain. We make them not feel alone and maintain oral hygiene. We support the family and keep them informed of changes". Another staff member told us "We do the best for the time they have and make them comfortable".

Staff understood and respected confidentiality. Staff comments included; "We speak in private when discussing about residents", "We never leave care plans in plain sight" and "We don't talk about residents in corridors and we keep our voices down". We observed staff respecting people's confidentiality.

Good

Is the service responsive?

Our findings

Relatives told us that the service was responsive to people's needs. One relative told us, "They sent him to hospital when he became very ill and the hospital said that this quick action was the best care for my husband". Another relative said, "If there is a medical problem then I will talk to the nurses. If it is not medical then I will talk to the manager. They always respond".

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. People had contributed to assessments. Staff were responsive to people's changing needs. We noted the service had responded to one person's changing needs surrounding a medical condition. Following this change in need the home arranged for a G.P to visit the person. The result of this was that the service then put in place a 'short term care plan' that was specific to the person's condition. The impact of this was that the person's quality of life improved.

Care plans contained details of people's preferences, likes and dislikes. For example, care plans contained person specific information that captured people's military histories, previous employment, people's favourite music and favourite past times. Staff we spoke with were knowledgeable about the person centred information within people's care records. For example, one member of staff told us about a person's military history. The information shared with us by the staff member matched the information within the person's care plan. During our inspection we observed another member of staff engaging in conversation with this person about their history and things that were clearly important to them.

Another person's needs changed in relation to pressure sores. Staff sought specialist guidance and the person was being nursed on a pressure mattress. The person's care plan and pressure risk assessment was updated to reflect the changes. Relatives told us the service was responsive to people's changing needs. Comments included; "The nursing staff have been wonderful. They have met all his health needs as they have changed", "They phone me if they need to call the GP and keep me informed", "They informed me when she needed protective footwear" and "The staff have got him a special wheelchair to make his legs more comfy and he can lie back in". During our inspection we observed an afternoon staff meeting and it was evident that people's changing needs were being discussed.

People told us that they received person centred care. One person told us, "I like gardening. I know the electrical man well and we chat about electrics and he brings me my newspaper every day. People talk to me about my travels". Another person told us, "I am Polish and some of the staff speak Polish to me which I like". We spoke with this person's relative and they told us, "Several staff are Polish like mum and they will talk to her in Polish, which I think is lovely". Another person's relative told us, "Mum has regular staff which is good as they know her well".

Staff we spoke with clearly understood the importance of delivering person centred care. One staff member told us, "We encourage person centred care. We use life stories to give effective person centred care". Another staff member told us, "I have got to know the likes, background life and work history of the residents. Several residents like singing. One lady when I first met her, she never spoke when I was holding a

session. I looked at her Care Plan and read that she had been (previous employment). I then over the next few meetings asked her favourite hymn and she gradually started talking about (her previous employment) and her interests".

People had access to activities which included sewing, armchair exercises, board games, reminiscence therapy and music therapy. We saw people participating in music therapy. The people involved were clearly enjoying the activity. People who wished to remain in the privacy of their own rooms were protected from the risk of social isolation. For example, we observed staff reading a person's favourite book to them in their own room. Relatives told us that people were encouraged to avoid social isolation. Comments included; "Mum is settled here, even if she says she does not want to join in, the staff encourage her with activities. She likes the music therapy sessions. She likes to watch all that is going on", "The activities person comes to do one to one chats with mum as she can't get out of her bed" and "[Person] loves singing and doing crafts".

We observed that the home had an onsite chapel. Chapel services were regularly provided for people to attend and care records highlighted people's faiths and religious practices. This meant that people could practice their faiths in a way they wished. We spoke with the homes Chaplin about different faith needs that people may have. They told us "I work here three days a week as part chaplain and part friend, if the residents need care from another faith I will find the person for them". People told us that they were supported to follow their faith in the way that they like to.

People knew how to make a complaint and information on how to complain was available in the home. One person told us, "I would tell the manager if I wasn't happy". A relative told us, "We are happy for her to be here. It is nice to see Mum so happy here. We have no complaints". Records showed there had been five complaints since our last inspection. These had been dealt with in line with the provider's complaint procedure.

The home sought people's views and opinions through regular residents and relatives meetings. We noted that people had asked for more meaningful activities for people who wished to remain in their rooms. As a result the home had also developed a mobile manicure trolley so that people who wished to stay in their own rooms could also access this activity. We noted that feedback from people and their relatives had been positive about the change.

Good

Is the service well-led?

Our findings

The service did not have 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. However, we saw evidence that the service was in the final stages of recruiting to this position. In the absence of a registered manager the home was being managed by a senior area manager who was present at the location five days a week.

Staff spoke positively about the manager. Comments included; Manager is fair with everyone", "Manager is the best. You do something wrong, she will support you", "Manager is amazing and hugely supportive" and "Residents love [manager]". A commissioner for the service told us "[Manager] has absolutely ensured that a quality staff team have been employed. She has turned the entire culture of the home around".

The provider's values were displayed throughout the home. These were, respect, dignity, the best we can be, open and fair and body, mind and spirit. We observed the leadership team and staff displaying these values in their work. One staff member we spoke with was able to describe what these values meant for them and how they aligned the values to their day to day work. Throughout our inspection there was a positive and open culture in the home and the manager was available and approachable. People knew who the manager was and we saw people and staff approach and talk with them in an open and trusting manner.

Regular audits were conducted to monitor the quality of service. These were carried out by the manager and the provider. Audits covered all aspects of care including, care plans, risk assessments, infection control, environmental audits, activities and medication. Information was analysed and action plans created to allow the registered manager to improve the service. For example, following a recent audit of care plans the manager had identified inconsistencies that were not aligned to an audit of risk assessments. As a result staff were supported to revisit people's care records and update them to reflect people's current needs.

Another audit had identified areas of improvement in relation to the activities provided at the home. As a result the manager was taking steps to address this by revisiting the activities to ensure that they were meaningful to everyone at the home. The manager told us "We need to make sure that all the activities are about social engagement and interaction". This demonstrated that the home was continually looking to improve.

The manager was also implementing a role within the home for a "Dementia facilitator". This involved, training a staff member who would then be able to train other staff in the home and be a point of reference for staff on dementia matters. The home was working with a leading national university in dementia care to implement this.

The provider had a robust quality monitoring system in place. We saw evidence that the provider regularly sent an internal quality auditor to carry out unannounced visits at the home. Following the visits a report was generated and sent to the manager. The manager then used the report to create an action plan.

Following this an internal quality auditor would return to assess whether the actions have been completed. We saw that the service was taking appropriate actions in addressing areas of the latest report.

Accidents and incidents were recorded and investigated. The manager used information from the investigations to improve the service. For example, following a number of incidents that involved a person falling during personal care, the manager conducted an investigation. The manager highlighted different times of the day in which this person was more prone to falling. The manager then used this information to make the appropriate referrals to other healthcare professionals. The manager told us, "We look at trends. Is there any way we can minimise the risk. We can do this by looking at particular times of the day, the person's mood and state".

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One member of staff told us, "If I felt I wasn't being listened to then I would whistle blow".

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist, occupational therapists, chiropodists and professionals from the care home support team. We contacted one healthcare professional prior to the inspection and they told us "Our relationship is growing from strength to strength".