Mr Kevin Driscoll & Mrs Joanne Driscoll

Elderthorpe Residential Home

Inspection report

230-232 Bradford Road
Shipley
West Yorkshire
BD18 3AN

Tel: 01274583375

Date of inspection visit:
16 August 2016

Date of publication:
14 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 16 August 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Elderthorpe Residential Home in August 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

Elderthorpe Residential Home is a care home which provides residential care for up to 26 people, including people living with dementia. There were 26 people living in the home at the time of this inspection.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe from harm. Staff were aware of the different types of abuse people might experience and of their responsibility for recognising and reporting signs of abuse. Full details of any incidents including safeguarding incidents were held and analysed on a regular basis to identify patterns or trends. Possible risks to the health and safety of people using the service were assessed and appropriate actions were taken to minimise any risks identified.

Robust staff recruitment processes were in place to ensure applicants were properly assessed as to their suitability for working with vulnerable people. There were enough staff to meet people's needs safely. The staff team were flexible which meant the service did not make use of agency staff therefore ensuring continuity of care for people using the service.

People were assisted to take their medication safely. The service had a good relationship with the supplying pharmacy and appropriate measures were in place for the supply, storage and administration of medication. The service had introduced a process for administering 'as required' medication which ensured there was always a sufficient therapeutic gap between administrations. Staff who administered medication had received training and had their competency to administer medication safely monitored on a regular basis.

Staff had been provided with ongoing training and support to assist them in performing their roles. Staff we spoke with told us they felt well supported and had the necessary skills needed to care for people effectively.

People using the service were asked for their consent to their care and treatment although we found 'best interests' decisions were not always formally recorded. We made a recommendation in relation to this.

People were assisted to maintain a balanced diet although systems in place to monitor people's food and fluid intake were not always completed consistently or in a timely manner. We highlighted this to the registered manager who told us this would be addressed with all staff members.

People were supported to maintain their independence and access support and treatment from external healthcare professionals.

Staff demonstrated a sensitive and caring manner in their interactions with people using the service. Care provided was person-centred, people were provided with choice about their care and treatment and their privacy and dignity was maintained.

People and their relatives were involved in care planning and were actively encouraged to share their views and opinions of the service. Care plans were reviewed and updated on a regular basis to reflect changes in people's needs. Feedback was sought from people, their relatives and staff about the quality of the service provided and action taken in response to people's comments.

The service had a range of systems in place to monitor and improve the effectiveness of the service although we found records were not kept of all checks performed. We made a recommendation in relation to this.

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 were protected from harm. Staff were aware of the signs and symptoms of abuse and their responsibility for recognising and reporting these.

Risks to people were assessed and appropriate measures taken to keep people safe from harm.

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

People were assisted to take their medication safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care and treatment was sought in line with appropriate legislation. Where best interest decisions had been made on a person's behalf these were not always formally recorded.

People were supported to meet their nutritional needs although the documentation completed in connection with this was not always fully completed.

People were care for by staff who received appropriate support in terms of training, supervision and appraisal.

Is the service caring?

Good

The service was caring.

Staff demonstrated a sensitive and caring manner in their interactions with people. Staff were very knowledgeable about the people they supported and were able to provide care to people in a way that met their individual needs.

People's privacy and dignity were respected.

People were treated as individuals and encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and reviewed on an on-going basis. Care provided was person-centred.

The service had an appropriate system in place for recording and responding to complaints.

People were asked for their feedback on the service and information provided by people was used to improve the care people received.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager who was aware of their role and responsibilities. People, relatives and staff spoke highly of the registered manager.

There was an open culture in the service that sought the views of people, relatives and staff.

Systems were in place to monitor and develop the effectiveness of the service and areas for improvement were addressed.

Elderthorpe Residential Home

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 16 August 2016 and was unannounced. This inspection was undertaken by 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 service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

During the inspection we toured the building and talked with four people who lived in the home and three relatives. We also spoke with staff including the registered manager, the deputy manager, a senior carer and two care workers. We reviewed a sample of four people's care records, three staff personnel files and other records relating to the management of the service. We also undertook general observations in communal areas and during lunchtime and spoke to two external healthcare professionals who visited the service on the day of the inspection.

Good

Is the service safe?

Our findings

Relatives we talked with told us they felt their family members were safe at the home. Their comments included, "My [family member] is definitely safe", "There's always plenty of staff on duty", "My [family member] wasn't safe when they lived at home; they're safe here", and, "They've put equipment in place to make sure [family member] is safe in bed."

The service had a safeguarding policy and procedure in place. These documents provided details of the provider's responsibility for recognising and reporting abuse. Guidance was provided to staff on the different types of abuse and the signs and symptoms people being abused may display. Staff we spoke with were aware of their responsibilities for recognising and reporting any concerns or suspicions of abuse and had received training in relation to safeguarding.

We asked to review the service's safeguarding records. We found records held in relation to all incidents including safeguarding incidents and accidents were detailed and provided information about the action taken by the service. An overall log was maintained which provided high level overviews of all incidents. Monthly reviews and audits of all incidents were undertaken by the registered manager and we saw evidence appropriate action was being taken to reduce and minimise risks to people using the service and protect them from harm.

We reviewed a copy of the 'service user guide' following the inspection. The guide provided information to people about what they should expect from living at the home and how their rights would be protected. However, we found it did not provide guidance to people about the action they could take if they felt their rights were not being protected. The home's complaints procedure had contact details for the local authority commissioning team, but we felt it would be helpful to have more contact details for other agencies. We discussed this with the registered manager following the inspection who agreed the guide would be updated to included additional information for people using the service.

The service also had a whistleblowing policy and procedure in place and staff we spoke with were aware of this. Information about the whistleblowing policy and procedure was on display in the home for staff members to refer to. Staff we spoke with told us they would feel confident raising any concerns with the manager or with other relevant agencies if they had any concerns.

We reviewed the service's risk assessment folders. These contained individual risk assessments based on different areas of the building as well as tasks undertaken by staff, for example medication administration. There was evidence risk assessments were reviewed and updated and actions were taken to minimise risks were clearly recorded.

A range of risk assessments had been completed in relation to people's personal safety during their care delivery. Detailed measures were in place to guide staff on addressing risks such as moving and handling, falls, and behaviours which could be harmful. During our visit we observed that staff assisted people safely, for example when giving support to transfer to and from wheelchairs.

We were informed the service had a business contingency plan in place but found this did not cover what action was to be taken if the home became uninhabitable for example as a result of a fire. We highlighted this to the registered manager during the inspection. The owner took immediate action to resolve this by contacting the local authority in order to establish arrangements which could be put in place to mitigate this potential risk.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment to ensure its safety for use.

We spoke with the registered manager about staffing levels. We were advised staffing levels were based on the number of people using the service and the level of support they required. The registered manager told us staffing levels had recently been reviewed following feedback from staff. Changes had been made to the allocation of tasks for staff to account for an increase in people's needs. Staff rotas were produced a number of weeks in advance by the deputy manager and were displayed on one of the staff noticeboards within the home for staff to refer to.

We asked the registered manager about the arrangements for emergencies and out of hours cover. We were told the registered manager and the deputy manager were on call on an alternating basis overnight and staff members we spoke with confirmed this. The registered manager told us the home did not use agency staff but that emergencies, sickness and leave were all covered by the existing staff team who were very flexible.

During our visit we observed there were enough staff on duty to safely meet people's needs. We saw call bells were responded to promptly and where people required two to one support this was received.

We looked at how the services ensured that staff were recruited safely. We reviewed the staff files for three members of staff who had been recruited by the service in the last three years. We found potential staff members completed an application form which covered their full employment history as well as their qualifications and experience relevant to the role for which they were applying. We saw evidence two references were sought for all potential staff members and appropriate checks were undertaken with the Disclosure and Barring Service (DBS) to establish whether staff members had a criminal record. Checks were also undertaken to confirm staff member's right to work in the UK and their medical fitness to perform the role was also checked.

We looked at the management of medication. We found systems were in place for the ordering, storage, administration and disposal of medication. We observed the lunchtime medication round and spoke to one of the senior care workers about medication administration. The senior care worker told us the home had a good relationship with the supplying pharmacy and that they had come in to the service on a number of occasions to provide additional training and support to staff.

During the medication round, the staff member observed good hygiene practice, using disposable gloves and changing these between each administration. The staff member got down to people's level, explained what their medication was for and offered them a drink to assist them in taking their medication. Where people were prescribed pain relief on an 'as required' basis we observed the staff member asking people whether they were in pain and if so whether they required pain relief. The service received pre-printed Medication Administration Records (MARs) from the supplying pharmacy and these were clearly labelled with the time of administration. The service also used a colour coded dispensing system to assist staff in

identifying what time each person using the service required their medication to be administered. All MARs we observed were clearly signed by staff to confirm when medication had been administered. Where medication was refused this was also clearly documented on the person's MAR. Additional records were also kept for medication which required a specified therapeutic gap between administrations to ensure people were only receiving these once a sufficient gap had elapsed. We found gaps in the topical medication administration record for one person using the service which we highlighted to the manager and the deputy manager.

Medicines were stored securely in locked trolleys and the service also had a separate medication storage room as well as a medication fridge. Temperature checks of both the medication fridge and medication storage room were performed on a daily basis and records indicated these were within safe limits.

Records showed senior staff members had received medication training and were also the subject of regular observations to ensure their on-going competency in the safe administration of medication. We found records held in relation to these observations were detailed and feedback was provided to staff covering both the administration itself and their interaction and care of people using the service.

Requires Improvement

Is the service effective?

Our findings

People told us the care they received was effective and they were supported to access other health care professionals. A person we talked with told us, "The district nurse comes to dress my legs", and a relative commented, "My [family member] gets good health care here." A person who was being cared for in bed looked, and told us that they were comfortable.

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).

Communication needs and the person's capacity to make decisions about their care had been assessed. Information was also obtained about any representatives with legal status, such as lasting power of attorney, to make decisions on the person's behalf. Care documentation included space for the person, or their representative, to sign, giving their agreement to the care planned. Where possible, people also gave written consent to their care and treatment and to being photographed for specific purposes.

Formal processes had been followed for DoLS applications to be made to ensure that people received the care they needed. The management also liaised with the local authority, for example in arranging a mental capacity assessment for a person who had wished to return to their own home. Whilst the service mainly worked within the principles of the MCA, we noted that a decision for a person to be given their medicines covertly (disguised in food or drinks) had not been formalised. It was evident that relevant professionals were consulted, though a mental capacity assessment and decision in the person's best interests had not been completed. We recommended the service review its processes and procedures in relation to recording best interest decisions.

New staff undertook induction training to prepare them for their roles and their competency was checked by the registered manager or deputy manager. The registered manager told us that any new, inexperienced staff would be expected to complete the 'Care Certificate'. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

Training provision was a mix of face-to-face and e-learning courses and staff had access to the home's computer system to complete online training. A matrix was kept with an overview of mandatory and other safe working practices training that had been undertaken. This showed the staff team had completed the necessary training courses and that refresher training was arranged where needed. Other training topics, relevant to the needs of the people living at the home were provided. These included person-centred care,

privacy and dignity, caring for people with dementia, challenging behaviour, mental capacity law, and end of life care. A number of staff had also either completed or were currently studying for health and social care qualifications.

The registered manager and deputy manager provided frequent, often monthly, individual supervisions to care staff. These were routinely focused on different aspects of practice, such as care planning, dignity, nutrition, and medicines procedures. Annual appraisals to review each staff member's performance were also carried out.

The service did not condone the use of excessive control or restraint when supporting people with challenging or distressed behaviours. Behavioural assessments were carried out and specialist support from external professionals was sought when needed. Care was planned emphasising the use of distraction techniques and eliminating possible underlying causes, such as the person being in pain or having an infection.

Assessments of people's nutrition were completed, including body mass index, dietary preferences, frequency of weighing and any support required with eating and drinking. Information about people's requirements was passed onto the catering staff and kept in the kitchen. Details included individual's preferred foods, portion sizes, special diets and any people who had experienced weight loss. The registered manager told us people were given food and drinks which had routinely been fortified to add calorific content.

Although care was appropriately planned for people who were nutritionally at risk, the monitoring of food and fluid intake was inconsistent and not completed in a timely way. There were numerous gaps to intake records, snacks at suppertime were rarely recorded, and food taken at lunchtime on the day had not been documented by mid-afternoon. This matter was raised with the management who assured us they would follow this up with staff.

Catering staff worked to a four week cycle of menus that was varied and offered choices of food at breakfast, lunch and teatime. We noted there were no details of snacks provided for suppers. People were asked to choose their meals in advance and we were told enough of each dish was prepared should anyone change their mind. Alternatives to the menu could also be readily provided. In the dining room, menus were written up on a board and there was laminated information to promote the availability of different hot and cold drinks. We observed that people were offered a range of drinks throughout the day. The people we spoke with told us they enjoyed the food. One person commented that they were prescribed nutritional supplement drinks and were able to choose the particular flavours they liked.

Information was maintained about people's medical history and any changes in their physical and mental health. The registered manager told us people received ongoing support from local GP practices, regular health reviews by nurse practitioners and were referred to other services as necessary.

A visiting health care professional described good communication with staff at the home. They told us that prompt referrals were made for their input and advice regarding people's treatment was followed.

Care records confirmed that people accessed the support of health care professionals including GP's, district nurses, physiotherapy, optical and podiatry services. Details of any hospital admissions and treatment were also documented. Information packs had been developed summarising the person's care needs in the event of being admitted to hospital, to enable their care to be properly co-ordinated.

People's wishes about their future care and treatment, including resuscitation were known and recorded. Arrangements were in place for GPs to carry out fortnightly reviews with people receiving palliative care. The home had recently achieved the Gold Standards Framework (GSF), an initiative that aimed to improve the quality, co-ordination and outcomes of care for people at the end of their lives.

Good

Is the service caring?

Our findings

People and relatives told us the service was caring. A person staying for respite care at the home told us, "I enjoy coming here. I know most of the staff and have a rapport with them." Other people's comments included, "Everybody is wonderful to me", and, "I get on well with the staff, they're all very nice. I'm happy here." A relative we talked with told us they had been impressed with the home when looking for a care facility for their family member. They said they were given sufficient information about what to expect from the service and liked the fact the home was 'family run'. The relative said, "The staff are caring and friendly and it's good that the owners are on-site." Another relative told us, "The staff are very pleasant." A third relative commented that they were generally happy with the care their family member received.

We noted a warm, inclusive atmosphere in the home. We observed staff were polite, friendly, patient and caring in their approach to people and their relatives. We observed staff carried out their tasks in an unhurried manner. Relationships between staff and people in the home were clearly based on mutual respect and affection. Staff and people appeared at ease in each other's company and smiled and interacted freely.

We saw memory boxes on display outside of people's rooms. One staff member told us how they had used the information contained within these memory boxes to start conversation and build relationships with people when they first began their employment at the home. Staff we spoke with were knowledgeable about the people they cared for and were able to provided information about people's likes and dislikes and their life histories.

The care environment was homely, personalised and had signage to help people find their way around and recognise different rooms. There were colourful and interesting themed seaside and woodland areas which staff told us were often used to help engage and reminisce with people. There were plans in place to update the décor in a bathroom to tropical reef theme.

The deputy manager told us the addition of a new kitten to the home had been a source of interest and had helped calm people displaying signs of anxiety.

People were provided with a 'service user guide' when they joined the service. This provided people with detailed information about the service and what to expect. A range of information was also displayed in the home for people and their relatives to refer to. This included details of how to make a complaint, details of social activities, dates of the next resident and relatives meetings and copies of the latest survey results. A noticeboard in the main entrance of the home also contained pictures of staff members and their job titles for people to refer to. A further board indicated which staff members were on duty at the time. This meant people and their relatives always knew who was available to support them.

Information about independent advocacy services was also made available in the 'service user guide', and we were told had been used in the past. Where people were unable to express their views, relatives told us they advocated on their behalf. For instance, one relative confirmed their involvement in important

decisions and said their family member was able to make day-to-day choices about their care. Another relative said they visited regularly and were kept updated about their family member's welfare. They also told us they had read and signed care plans and attended care review meetings to represent their family member's views.

There was a relaxed atmosphere in the home with flexible routines. For example, some people chose to get up later in the morning and were given a late breakfast. Staff passing through the dining room acknowledged and greeted people in a cheerful way. We saw that staff had cut up the cooked breakfast for a person before serving their food, so they could eat independently. There was no rush throughout the morning and the person stayed in the area after their meal, reading the newspaper and easing into the day.

A person we talked with confirmed they made choices in daily living. They told us they had a key to their bedroom, chose when to get up and go to bed and how they spent their days.

Staff we spoke with were aware of the need to involve people in their care and we observed people being offered choice throughout the inspection. Staff members we spoke with explained how they would offer people choice in terms of what they wanted to wear, eat and how they would like to spend their day. We observed staff knew the people they were caring for well and were able to assist them in making everyday decisions.

Staff we spoke with were also aware of the need to maintain people's privacy and dignity and were able to give examples of how they would do this. During the inspection we observed good practice. For example the deputy manager supported a person to take a drink from a lidded cup, kneeling to eye level, and encouraging them to drink. On another occasion, we saw a staff member help a person with a physical disability so they were comfortably repositioned before supporting them with food and drinks. However, we noted that lunchtime was somewhat disorganised and a lack of preparation led to some people's dignity being compromised. For example, specialist, coloured crockery to help people see their food and eat independently was stored in the kitchen but not used at the meal. No condiments were made available, hot and cold drinks were served at the same time, and there was delay in some people being served the next course. The issues we noted during lunchtime were brought to the attention of the registered manager and deputy manager as learning points.

We found the service had received a nationally recognised award for the care provided to people at the end of their lives. The homes' recent Gold Standards Framework (GSF) award had required that the registered manager had ensured the home met strict criteria to ensure that people in the home received positive outcomes and experiences at the end of their lives. We saw this was something the service had been working towards over a period of time. The service had created additional facilities for people and their relatives as part of the work it had undertaken towards this award. For example the creation of a private lounge for people's relatives to use.

Good

Is the service responsive?

Our findings

One person we talked with showed us they had the call system within reach to summon assistance from staff when needed. They told us, "The staff are always checking on me, making sure I'm alright and if I need anything." A relative commented, "They (staff) keep me well informed and I feel that [family member] is well looked after here. I'd complain if I was unhappy." Another relative said they would also make a complaint if necessary, though felt there had been nothing to warrant doing so.

The registered manager gave us examples of how the service had responded to the needs of people living at the home. They told us, for instance, about night staff wearing dressing gowns to give a visual cue and help orientate people who might be confused about the time. Staff had also recognised the importance that a person placed on having a very structured routine, including the consistency of food they chose to eat. This was catered for and the person was also supported to go to the local supermarket to choose items.

People's care needs were assessed before they moved into the home and information was obtained from social workers and relatives. Individualised care plans for meeting identified needs had been devised. The care plans we examined described how the person preferred their care to be given, their independent skills and the extent of support that staff would provide. They addressed all aspects of physical and emotional welfare and the personal care each person required.

Assessments were routinely reviewed to ensure they reflected current needs and care plans were evaluated monthly to keep checks on whether they remained appropriate. Where applicable, any changes in needs led to care being adjusted. For instance, additional support with maintaining skin integrity had been built into a person's care plan and pressure-relieving equipment had been provided for their comfort.

Records were kept of people's on-going care, with staff from each shift making entries which accounted for the personal care provided and reported on the person's well-being. Where a person was cared for in bed, further records and charts were completed to monitor their care including positional changes, fluid intake and pain management.

Wherever possible, people were consulted each month about the care they received and their comments were recorded. Family communication records were kept, demonstrating that staff kept relatives informed of their family member's welfare, including their health and any accidents that occurred. This was confirmed during our visit where we heard the deputy manager telephoning a relative to inform them of their family member having had a fall, and reassuring them that no injury had been sustained. There was also evidence in care records of formal reviews of care having taken place which relatives had attended.

Profiles about the person's background, preferences, routines and interests had been compiled, which relatives had often contributed to. This helped staff to understand the person as a unique individual and provide care according to their wishes. Each person's care plan also made staff aware of their social needs and the activities they enjoyed.

A weekly programme was drawn up that informed people about the social activities provided in the home. The current programme depicted arts and crafts sessions, games, hairdressing and pampering, baking, bingo, film and music afternoons, a quiz, chair aerobics, reminiscence, and a church service. Visiting musical and theatrical entertainment was also arranged throughout the year. Photographs of events and activities were displayed around the home though no records were kept to show what people had participated in.

Staff accompanied people to go out into the local community, for walks, to the park and shops. Whilst organised group outings had not been popular to date, we saw these were discussed at the last 'resident meeting', where people were asked for suggestions on where they would like to go.

The complaints procedure was accessible to people living at the home and their representatives. None of the people we talked with expressed any concerns about their care or the service in general. A visiting professional told us they had no concerns about the care provided at the home.

Complaints made over the past year, no matter how minor, had been appropriately responded to and investigated. Follow up action had been taken, where applicable, including spot checks and reinforcing care practice standards with staff. The management had, on occasions, supported people in making complaints about other services they had received. A number of compliments and thank you letters had also been received from relatives and external professionals.

Good

Is the service well-led?

Our findings

People and relatives we spoke with told us the service was well-led. One relative we talked with told us, "I've completed surveys. I'm satisfied that the home is well-managed." Another relative commented, "The manager is approachable. I feel I can talk to her."

The service had a registered manager in post who was aware of their role and responsibilities. The registered manager was supported in their role by the deputy manager and support was also provided by the senior care workers. We were informed the registered manager and deputy manager staggered their working hours to increase the period over which direct management cover was provided. Outside of these hours, they also took turns providing on call cover and staff we spoke with confirmed this.

We found the service had a person-centred, open, inclusive, empowering culture. The 'service user guide' encouraged people to be involved in the running of the service. It also detailed the service's resident charter which clearly documented what people could expect from living in the home. It also stipulated that people should be 'encouraged to complain about any deficit in the quality of care in the home'.

The registered manager told us when the service had been refurbished they had taken the decision to locate the manager's office next to the front door. The registered manager explained this meant they were more accessible to people and their relatives and could closely monitor what was going on in the service. The pharmacist spoke highly of both the registered manager and the deputy manager and their hands on approach with the service. People and relatives we spoke with were complimentary about the management of the service and felt able to approach staff if they had any concerns.

The service used quality assurance surveys to obtain feedback from people, their relatives and staff about the service. Notices were on display in the service of the results from the survey completed in April 2016. These provided an overview of the results and the actions taken by the service to address areas where an average or adequate response had been received. For example, where comments had been received about dust in the en-suite area the service had informed domestic staff of this and action had been taken to immediately rectify the situation.

We asked the registered manager about the duty of candour. The registered manager confirmed they had introduced a policy and procedure in connection with this and they were aware of their roles and responsibilities under this.

Records we reviewed indicated the service held regular staff meetings. We found there was a clear record of the topics discussed during these meetings with staff being praised for good work, encouraged to report concerns and being reminded of expected standards. Meetings were also used as an opportunity to update staff for example in relation to the service's work towards the Gold Standards Framework or to discuss changes in people's circumstances.

The provider had a range of systems in place for checking the quality of the service. We saw the registered

manager and deputy manager regularly conducted spot checks, including at weekends and during the night, to ensure staff adhered to the expected standards of care practice. We saw these checks were well recorded and had included reviewing the atmosphere in the home, people's appearances, staff carrying out their duties and the level of interaction. The service also used a variety of other methods to check the quality of the service, which included; reviews of people's care plans, meetings with people, their relatives and staff as well as the completion of internal audits.

We saw evidence that where areas for improvement were identified action was taken to resolve these. We did however note that records were not always kept of all checks and audits performed. For example the deputy manager informed us they regularly audited people's MARs. We saw evidence of this in the medication competency and supervision records held for staff. However, the deputy manager confirmed they did not record the audits they performed on the MAR charts. We recommended the service ensure all audits and checks performed were recorded and clear records kept of actions taken.

Prior to the inspection we were informed by the local authority that they had asked the home to complete a number of actions. One of these included three yearly checks of staff DBS certificates. At the time of the inspection we saw evidence the service had introduced a process for conducting these checks and was making good progress to ensure these had been undertaken for all staff members.

We saw evidence checks of the quality of the service were also performed by external organisations. For example the service had been inspected by the Food Standards Agency and had also been the subject of an infection control inspection. The service had taken action to address areas for improvement identified during both of these inspections.