Highlands Care Home Limited

Highlands Care Home

Inspection report

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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

Say when the inspection took place and whether the inspection was announced or unannounced. Where relevant, describe any breaches of legal requirements at your last inspection, and if so whether improvements have been made to meet the relevant requirement(s).

Provide a brief overview of the service (e.g. Type of care provided, size, facilities, number of people using it, whether there is or should be a registered manager etc).

N.B. If there is or should be a registered manager include this statement to describe what a registered manager is:

'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.'

Give a summary of your findings for the service, highlighting what the service does well and drawing attention to areas where improvements could be made. Where a breach of regulation has been identified, summarise, in plain English, how the provider was not meeting the requirements of the law and state 'You can see what action we told the provider to take at the back of the full version of the report.' Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

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 benefitted from well maintained and equipped accommodation.

People were protected from the risk of harm or abuse.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Good

The service was effective.

People and/or their representatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

Staff knew how to ensure people's human and legal rights were protected.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

People and/or their representatives were confident their wishes related to end of life care would be followed.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which was responsive to their changing needs and now included their social and leisure needs.

People made choices about aspects of their day to day lives. People and/or their representatives were involved in planning and reviewing their care.

People and/or their representatives shared their views on the care they received and on the home more generally.

People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Good

The service was well led.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

The service took account of good practice guidelines and sought timely advice from relevant health professionals and used various resources to improve care.

There was an honest and open culture within the staff team who felt well supported.

People benefitted from a well organised home with clear lines of accountability and responsibility within the management team.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Highlands Care 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 checked 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. We also wanted to check that the improvements required following our inspection in May 2015 had been met. We had received a satisfactory action plan from the manager at the time and during this inspection we found all areas had been fully addressed.

This inspection took place on 15 August 2016. This was an unannounced inspection and was carried out by an adult social care inspector.

We reviewed previous inspection reports before the inspection and the information we held about the home. The provider had not completed a provider information return (PIR) as we had not requested one.

At the time of this inspection there were 22 people living at the home. During the day we spent time with 12 people who lived at the home and two relatives. We also spoke with the manager, head of care, senior care worker and three care staff. We looked at a sample of records relating to the running of the home, including three relating to the care of individuals.

Good

Is the service safe?

Our findings

The service was safe. At the last inspection in May 2015 we rated the service as 'requiring improvement' in the areas of safe. This was because the accommodation in the lower ground and first floors required considerable attention, storage areas were not safe and people did not all have adequate comforts in their rooms. Most people at the home spent their time in the communal areas, two large lounges and an adjoining kitchen/dining area. These had been re-furbished and were clean, comfortable and well furnished with attractive décor. Since the last inspection there had been considerable investment in ensuring the accommodation on the lower ground and first floor were clean, well maintained and welcoming.

The manager had included a bedroom audit into the service improvement plan and regularly checked people had everything they needed in their rooms. Rooms were bright and airy, many having been re-painted along with the corridor areas to make them brighter. People had fresh, new laundry and bedding, new bedside lights and curtains. We could see that people's rooms and possessions were valued and cared for, the manager also checked people's clocks showed the correct time. Staff helped people and their families to decorate and add personal touches as they wished. Areas used for storage had been organised and locked.

One person said, "It's a lovely place. I like being here." The new, plain flooring throughout the ground floor helped to promote a flow around the home especially for people living with dementia who may find patterned floors confusing. A lounge door had been re-opened to further enable people to walk freely around the ground floor in a circle, which is good practice for people living with dementia and avoids 'dead ends'. Other people were not able to respond directly about their experiences due to living with dementia but appeared happy and comfortable with staff and each other.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them. Staff had received training in safeguarding adults. They completed a workbook after watching a training DVD and this was assessed by the manager. They had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The manager had informed us of any safeguarding incidents and these had been dealt with appropriately involving the local safeguarding team.

Relatives said they felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any; they felt they would be listened to and action would be taken to address any issues raised.

Staff encouraged and supported people to maintain their independence. Most people were unable to mobilise without prompting or staff assistance. Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help. There were risk assessments which identified risks and the control measures to minimise risk. The balance between people's safety and their freedom was well managed. For example, one care plan noted that one person was becoming less able to

use a zimmer frame without promoting from staff. They used gentle persuasion to show the person how to hold the frame. Care staff ensured they prompted people to dress themselves and assisted with sequential dressing. People were wearing appropriate clothes for the weather. On the day of this inspection it was very hot. The manager reminded staff to ensure people had regular drinks, ice lollies and that rooms were kept cool to keep them safe from overheating.

Risk assessments and actions for staff to take were included for risk of pressure area skin damage, falls and nutrition. Where people required pressure relieving equipment to maintain their skin integrity, staff ensured cushions, for example, were moved with the person when they moved. No-one at the home had any pressure damage. One moving and handling risk assessment detailed that the person needed to wear hip protectors and appropriate footwear, which they were. Also where people were at risk of recurrent urine infections which could affect their safety such as mobility, dementia and cognition, staff were vigilant in sending samples off for testing and ensuring the person had appropriate treatment to keep them safe.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. Staffing numbers were determined by using a dependency tool, although these remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. There was no-one with particularly increased needs or receiving care in bed during this inspection. We saw that people received care and support in a timely manner. During our inspection there were four care workers, the head of care, a senior care worker and the manager, a cook, housekeeper and laundry assistant. Staff were attentive to people's needs. For example, one person became unwell in the lounge and staff discreetly assisted them.

All staff who gave medicines were trained and had their competency assessed before they were able to do so. Medication administration records detailed when the medicines administered or refused. Medicines entering the home from the local dispensing pharmacy were recorded when received. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. The care worker stayed with one person whilst they took their medication at their own pace.

Medicines were thoroughly audited by the manager and there had been an external audit by the local pharmacy provider. A medicine fridge was available for medicines which needed to be stored at a low temperature such as eye drops. Some medicines which required additional secure storage and recording systems were used in the home. We saw that these were stored and records kept in line with relevant legislation. The stock levels of these medicines were checked by two staff members at least twice each day. We checked some people's stock levels during our inspection and found these tallied with the records completed by staff.

Good

Is the service effective?

Our findings

There was a stable staff team at the home who had a good knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. Relatives spoke positively of the staff who worked in the home. Comments about staff included, "They know what they are doing, I've no concerns about that at all."

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care and were encouraged to develop. There was a programme to make sure staff training was kept up to date. Where there were gaps, training had been booked. Mandatory training included safeguarding, manual handling, fire, infection control, health and safety and food hygiene. The manager also sought additional resources and training which may be relevant to people's current needs. For example, resources from Bournemouth University had been used to support eating and drinking for people living with dementia. This had resulted in menu changes and a reduction in the use of laxatives being prescribed by the GP and a move towards more natural methods.

Policies and procedures were accessible to staff. The home also invited students of Health and Social Care from the local college to undertake 12 week placements at the home and worked with their tutors who visited. There was a clear induction programme for new staff in line with nationally recommended standards. This included working with more experienced staff for a period until each new staff member felt confident to work independently. This time varied with each individual. For example, one new staff member was not making as much progress as they should and the manager was working with them to ensure they addressed any issues during their probation period. All staff had received the Care Code of Conduct for Healthcare. This is national guidance which sets the standard of conduct expected of all healthcare support workers. Other training included end of life care and the home now used the Care Certificate documentation. These are nationally recognised resources which give guidance in how to achieve a good standard of care in a range of topics. Nearly all staff had received training in dementia awareness and more was planned. Changes in dementia care were on-going. For example, the manager had introduced 'Twiddle Muffs'. These were knitted items used to promote sensory stimulation for people living with dementia. The manager had left print outs of the knitting pattern and a group of relatives had brought finished items in. Staff said they liked working at the home and felt they could say if there was an area of training they were interested in.

Staff received regular one to one supervision sessions. This enabled staff to discuss career and training needs, any issues and for the manager to assess competency using a set format. One supervision record showed how an area for improvement had been highlighted and was being monitored to ensure the care given was effective and safe.

People had access to health care professionals to meet their specific needs. Records showed people attended appointments with GPs, dentists, chiropodists, district nurses and speech and language therapists. People said staff made sure they saw the relevant professional if they were unwell. Staff were allocated tasks

at a handover meeting before a shift to ensure people's specific needs were met consistently. One person had decided they did not want to follow advice about their medical condition so staff regularly monitored their view and made sure their GP was aware.

During our inspection a hospice nurse from the local hospice visited as requested by the home through the GP. Staff updated the care plan following the visit and were assured they were doing all the right things to make the person, who was living with dementia, comfortable. The manager said how important it was not to forget that people living with dementia may have physical needs too. They particularly focussed on managing pain relief. The home used a nationally recognised pain tool to regularly monitor how people were and ensured they had adequate pain control. For example, when a person had fallen or suffered a skin tear, the pain score tool was always completed and pain relief given appropriately. This demonstrated the staff were involving outside professionals and taking appropriate action to make sure people's needs were met.

Most people who lived in the home were not able to choose what care or treatment they received. The manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Throughout the day staff demonstrated that they were familiar with people's likes and dislikes and provided support according to individual wishes. For example, one person liked to help out with kitchen chores and staff facilitated this safely.

People can only be deprived of their liberty to receive care and treatment which is in their best interest and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). The majority of people required some restrictions to be in place to keep them safe. The manager had made appropriate applications to the local authority to deprive people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the MCA. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and the people's advocates. Staff were aware of the implications for people's care.

The provider and manager kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. For example, decisions about use of restrictions such as bed rails and pressure alert mats had been made in people's best interests with their representative.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Care plans included nationally recognised nutritional assessment tools to ensure staff knew who was at high risk and what action to take. Staff told us, and the person's care records showed, that appropriate professionals had been contacted to make sure people received effective treatment. For example, staff had recognised that one person was not as well. They had been referred to the speech and language therapist and now received a pre-mashed diet to ensure they were not at risk of choking.

Everyone we spoke with was happy with the food and drinks provided in the home. Comments included, "I like the food, can't complain" and "Yes, I have no worries there." Relatives said they were happy with the

food and that they could be included too. We observed the lunchtime meal being served in the dining room. People sat at tables which were nicely laid and each had condiments for people to use. People chose meals in advance and were offered a choice of two meals on the day. A picture of the food was displayed on the dining room door. The home used an external caterer but assessed each meal and supplemented these with more home made items such as roast potatoes, home made cakes and desserts. We discussed the need for a more visible list of people's dietary requirements was available in the kitchen and the area where the food was dished up from the hot trolley to minimise risk. The manager said they would make sure they checked there was one with the cook who was off duty at the time. Staff all knew who was on what diet. Throughout lunch people were treated with respect and dignity. People were offered their choice of drinks. They were not rushed but food was served in a timely way. There was friendly banter between people. This helped to make lunchtime a pleasant, sociable event.

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home, including the garden and people had individual walking aids, wheelchairs or adapted seating to support their mobility.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff had good knowledge of each person and spoke about people in a compassionate, caring way. For example, one person had very limited comprehension. We saw staff trying to engage with them using gentle touch. Staff interacted well with people, touching, reassuring and complimenting people as they passed. One relative said, "They are lovely girls. I can't fault them. They always look after people nicely. People we spoke with said they thought all the staff were caring saying, "I Like the staff" and "Yes I'm ok they are all nice." There was evidence that relatives felt they could have a meaningful relationship with the staff at the home. For example, two relatives had completed a fundraising event for the home and another relative whose loved one had died some time ago continued to enjoy spending time at the home with staff who knew them.

Throughout the day we saw staff interacting with people in a caring and professional way. There was a good rapport between people; they chatted happily between themselves and with staff. Some people liked to use the smaller lounge where people were more able to chat. Staff ensured they checked the television showed people's preferences correctly and asked people if they would like a drink or an ice lolly.

When staff assisted people they explained what they were doing first and reassured people. One person liked to have a lie down at a certain time, staff knew to leave them in peace and visit them later. The manager said, "The girls know what [person's name] wants by their body language. Sometimes they are tired or feeling down."

The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly to maintain their continence. One person had not been managing their continence well so the manager had ensured their room was re-decorated to take this issue into account and minimise odour. The manager had made a new continence storage room which ensured these items were not on show in people's rooms to help maintain dignity.

Staff supported people who were in pain or anxious in a sensitive and discreet way. This included thinking about whether there may be a physical reason why someone was not behaving in their usual way. One record showed the manager had recognised someone seemed depressed. They had referred them to the GP and staff were monitoring their moods. Staff joined in with an external activity to ensure people with less skills could join in so they were included.

Most people were not able to tell us about their choices directly due to their dementia. Care plans contained people's preferences which gave staff a basis to work with. Staff said they could update care plans as they learnt more about people.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. The manager had asked relatives/representatives about people's end of life preferences which were recorded. This was done sensitively and at a time to suit people. For example, one relative found the conversation upsetting so staff had recorded to follow this up when the relative felt able to. There was

information which showed the manager had discussed with people if they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions.

The manager said they had compiled a file 'For End of Life Care' to ensure that staff recognised and communicated clearly, decisions are made and actions taken in accordance with the persons needs and wishes. They were aware of national guidance called 'One Chance to Get it Right'. They said staff had sensitive communication between staff and the person at the end of their life, and those identified as important to them. They saw the needs of families and others identified as important to the people as important and actively explored, respected and met their wishes as far as possible. An individual plan of care was drawn up ,which included food and drink, symptom control and psychological, social and spiritual support.

Good

Is the service responsive?

Our findings

We found there had been improvements in managing how people's social and leisure needs were met, especially for those people living with dementia. Care plans contained detailed information about the things people had previously enjoyed. Each care file had a 'This is Me' document. This is a form used by the Alzheimer's Society to encourage people and their families to record personal information about people's backgrounds and experiences, likes and dislikes. This enables staff to provide a more person centred approach to care delivery as they are able to get to know people despite their dementia. Some families had completed the forms and in other cases staff had tried to find out and document people's preferences on an on-going basis. For example, one person had been a gardener and liked cars. Staff were able to talk to the person about this despite a lack of response they still tried. Each person's door displayed a picture of something that was related to them such as flowers or a place. This helped people identify their rooms and make them comfortable in the homely environment.

Due to people spending most of the day in the communal areas, they were able to interact with staff and watch what was going on so there was a low risk of isolation. The manager had employed an activity co-ordinator five days a week and was taking on a further activity assistant in September who had a degree in art therapy. The activity co-ordinator did structured and spontaneous activities with people. The manager was also monitoring how this was going and that people were enabled to receive appropriate stimulation and engagement that met their individual needs. The manager was also monitoring how staff were also involved in meeting those needs when the activity co-ordinator was not on shift, for example at the weekends. There were now more resources for staff to use to engage with people. For example, nationally published research had shown that the use of dolls and soft toys could be useful for people living with dementia and these were available as well as pens and paper, magazines and books.

During our inspection the manager was trialling a sitting yoga session with people. People were clearly enjoying the event. We saw staff sitting with people and ensuring they had contact with people despite the limitations of living with dementia.People had enjoyed time in the garden, and the manager said several people had planted seeds and these had been put into raised beds so they could watch them grow. Cake making had taken place and was made more enjoyable as people got to eat the produce they had contributed to. The manager said and records showed people had engaged in craft making, reminiscence sessions, book readings, one to one sessions, dominoes, gentle exercise, puzzles, film afternoons, cards and music sessions. Some more able people had been able to go for a walk in the local community, go to a fete and open air music in the park. Other people had been able to attend church with their loved ones and the manager was looking at how to enable this to continue for one person whose mobility had decreased. One relative said, "Yes there are things going on. I was able to play the organ here at Christmas and the staff are lovely and encourage us to visit and take part in things."

Records contained information about people's wellbeing such as behaviour and mental health which could affect their wellbeing and what they had done that day. For example, one person was being monitored because of their low mood and some people who liked to move around freely were able to do so with staff support when they wanted. This showed the manager had responded to the requirements made during the

past inspection to ensure people's needs were met in relation to stimulation and engagement.

People received care and support that was responsive to their personal care needs because staff had good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone. People were involved in discussing their needs and wishes if they were able and people's relatives also contributed.

During the inspection we read four people's care records. The new computer format was working well and care plans were detailed. All were personal to the individual which meant staff had details about each person's specific needs and how they liked to be supported. Information relating to how their personal care needs were met was followed by staff including social and leisure information. Staff updated the care plans using electronic tablets which they could use in the communal areas and complete with people in a timely way.

Staff at the home responded to people's changing needs. For example, staff recognised when a person required a liquid form of medication and when another person was not so well. The daily records were excellent and gave clear information about how people were so that staff on each shift would know what was happening. Some short term issues were noted in the daily records which meant they could get 'lost' within the text. We discussed this with the manager who agreed a separate care plan for these would make the information more easily accessible and reduce the risk of information not being acted on in a timely way. However, we saw that the staff were very responsive to changes in need and referred people to appropriate health professional in a timely way. For example, in relation to chiropody, eye care and to the district nurses or GP.

Staff used clear body maps to monitor people's skin and to show why and where topical creams were required. Some body maps needed updating to inform when issues were no longer current, for example when a bruise or skin tear had healed. The manager said they would ensure this was done.

Most people were unable to be directly involved in their care planning but the manager met with each person and/or the person's representative to discuss the care plans. A copy of the care plan was then sent to the representative if they were happy to be involved. There were regular reviews of people's health. Each person had a 'hospital passport'. This documented a summary of people's important care needs so that if they went to hospital, staff there would know how to care for them if they were living with dementia for example.

People and their representatives said they would not hesitate in speaking with staff if they had any concerns. People and their representatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. Formal complaints had been dealt with appropriately. There had been no formal complaints for the last 12 months. Issues were taken seriously and responded to in line with the provider's policy.

Good

Is the service well-led?

Our findings

There was a management structure in the home which provided clear lines of responsibility and accountability. The manager had been in post since January 2015 and was currently going through the registration process with CQC. There had been a delay due to issues with the previous manager which were now completed.

Since the last inspection where we found some issues had been recognised but not dealt with in a timely way, the manager had been working with the local authority quality and improvement team to address the shortfalls. They had been able to access some useful information including a more thorough way of managing quality assurance. The new service improvement plan was an on-going working document and was working well to highlight any issues so they could be addressed in a timely way. For example, activity information was now accessible in people's care plans so all staff could find it easily. Headings included management of absence, agency use, staffing levels, handover spot checks, medication audits and observations of daily life. For example, the manager noted how staff provided drinks and gave people time to drink them. They also noted that people did not eat mushy peas so the menu was changed to garden peas.

The manager was supported by a knowledgeable 'head of care'. The provider was not involved in the day to day running of the home but was supportive and accessible. The manager said the provider had been pro-active in addressing the areas of concern raised at the last inspection and the manager was able to raise any issues they identified knowing they would be dealt with. The manager was able to receive support and advice from the manager of another care home owned by the provider, and they had contact on a regular basis to discuss management issues.

The manager and senior care worker were available throughout the inspection (the manager was not working that day but came in to see us). We observed they took an active role in the running of the home and had a good knowledge of the people who used the service, relatives and the staff. People appeared very comfortable and relaxed with the management team. One relative told us how lovely the manager was. We saw members of the management team chatting and laughing with people who lived at the home and making themselves available to personal and professional visitors. For example, they spent time with the hospice nurses discussing a person's care in private. Staff told us, and duty rotas seen confirmed, there was always a senior care worker on each shift. Staff said there was always a more senior person available for advice and support.

All of the people spoken with during the inspection described the management of the home as open and approachable. The manager showed enthusiasm in wanting to provide the best level of care possible. Staff had adopted the same ethos and enthusiasm and this showed in the way that they cared for people. One staff member said "It's nice here. We work as a family and the manager looks after us too." The manager said the home was the happiest one they had been in and they owed it to people, staff and the provider to do a good job. We heard examples of how they had supported staff with personal issues as well as the provider, to ensure staff were happy in their job and felt they could come to them with any worries. Some staff at the

last inspection no longer worked at the home and we could see from records that staff competency was monitored to ensure the staff employed were of a good quality and provided good care.

The manager had an open door policy and they were available to relatives, people using the service and health professionals. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area including college tutors in health and social care. For example, recent training by a university had resulted in improvements to care by reviewing each person's medication prescription with the GP to discontinue medication where possible. The manager enjoyed attending the local provider engagement network and showed us what they had learnt to put into practice at Highlands. This had included using a new tool to assess pain, especially relating this to an after falls assessment.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care including medication audits, care plans audits and falls.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. For example, where people had fallen risk assessments were reviewed and preventative measures taken. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

There were systems in place to share information and seek people's views about the running of the home. A recent quality assurance survey was on-going and the manager was analysing the results which were positive so far. The service did not currently have a residents meeting due to the level of people living with a profound dementia. The manager saw each person's relative regularly and when care reviews were carried out. This enabled the home to monitor people's satisfaction with the service provided and ensure any changes made were in line with people's wishes and needs. The manager said they were hoping to start a new newsletter to inform people of events and happenings at the home. The home had notified the Care Quality Commission of all significant events which have occurred in line with their
legal responsibilities.