Bupa Care Homes Limited

Bakers Court Care Home

Inspection report

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London
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Date of inspection visit:
11 September 2017
12 September 2017
21 September 2017

Date of publication:
23 November 2017

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

This inspection took place on 11, 12 and 21 September 2017 and was unannounced. Bakers Court is a residential and nursing home which provides nursing and personal care for up to 78 people. The home is spread over three floors accessible by a lift. At the time of this inspection there were 66 people using the service. The ground floor was dedicated to people who needed nursing or residential care. The middle floor was for people who had mental health needs and the top floor was for people living with dementia. This was the first inspection of this service under the provider's new legal entity.

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

People thought the service was safe. Staff were knowledgeable about safeguarding and whistleblowing procedures. The provider had a recruitment system in place to ensure the suitability of staff working at the service. Staff were not always deployed effectively to ensure people's needs were always met. Risk assessments were carried out with management plans in place to enable people to receive safe care. There were safe medicines management systems in place. The provider had systems in place to reduce the risk of spread of infection.

Staff received appropriate support through supervisions, appraisals and training opportunities. Appropriate applications for Deprivation of Liberty Safeguards had been applied for and authorised. Staff were aware of the need to obtain consent before delivering care. People's dietary needs and preferences were met through a varied and nutritious menu. People also had access to healthcare professionals as needed to meet their day to day health needs.

People thought staff were caring. Staff were knowledgeable about how to develop caring relationships with people who used the service. People's privacy and dignity was respected. Staff had awareness of equality and diversity issues. People were encouraged to maintain their independence.

Care plans were detailed, showed people's preferences and people confirmed care was delivered in line with their preferences. Staff were knowledgeable about providing a personalised care service. A variety of activities were offered in line with people's preferences. People and relatives knew how to complain and the provider dealt with complaints in accordance with their policy. The provider also kept a record of compliments about the service.

People and relatives said they felt comfortable raising concerns with the registered manager. Feedback was sought from people who used the service through surveys and regular meetings. Staff had regular meetings to enable them to contribute to service development. The provider had a variety of quality assurance systems in place to identify areas for improvement.

We have made two recommendations around supporting people with specific health conditions and the deployment of staff. Further information is in the detailed findings below.

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 at the service. Appropriate recruitment checks were carried out for new staff and criminal record checks were up to date. There were enough staff rostered to meet people's needs but staff were not always effectively deployed and people told us they sometimes had to wait for staff attention.

Staff were knowledgeable about the procedure to follow if they suspected abuse. People had risk assessments in place to ensure risks were minimised and managed. The provider carried out regular building safety checks.

There were appropriate arrangements in place for the administration and management of medicines to ensure people received their medicines as prescribed. People were protected from the risk of infection.

Is the service effective?

Good

The service was effective. People and relatives told us staff provided effective care. Staff were supported with regular supervisions, training opportunities and appraisals.

The provider was aware of what was required of them to work within the legal framework of the Mental Capacity Act (2005). Deprivation of Liberty Safeguards applications were made appropriately. Staff were knowledgeable about the need to obtain consent from people who used the service before delivering care.

People were given choices of meals and drinks from a nutritional and varied menu. The service assisted people to liaise with healthcare professionals as required.

Is the service caring?

Good

The service was caring. People told us staff were caring. Staff were knowledgeable about people's needs.

The service had a system where people had a named nurse and a named care worker to oversee the care they received. We observed positive interactions between staff and people who used the service.

Staff demonstrated awareness about encouraging people to maintain their independence. People confirmed their privacy and dignity was respected and staff demonstrated they were knowledgeable about providing dignified care. Staff had awareness of equality and diversity issues.

Is the service responsive?

Good

The service was responsive. People told us staff provided care in line with their preferences. Staff were knowledgeable about providing a personalised care service. Care records were personalised and contained people's preferences.

There was a varied range of activities offered to people which included visiting entertainers and clothing sales.

People and relatives knew how to make a complaint if they were not happy with the service provided. Complaints were resolved in line with the provider's policy and to the satisfaction of the complainant. The provider kept a record of compliments.

Is the service well-led?

Good

The service was well led. There was a registered manager at the service. People and relatives felt comfortable speaking with the registered manager about concerns. Staff spoke positively about the support they received from the registered manager.

The provider had a system of obtaining feedback about the quality of the service through a feedback survey and regular meetings with people who used the service and relatives.

The provider held regular meetings with staff to keep them updated on service developments. There were various audit systems in place to regularly check the quality of the service provided and issues identified were dealt with appropriately.

Bakers Court 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.

This inspection took place on 11, 12 and 21 September 2017 and was unannounced. The inspection was carried out by two inspectors and an expert-by-experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector and a specialist nurse advisor visited on the second day and one inspector on the third day. A specialist advisor is a person who has professional experience in caring for people who use this type of service. Bakers Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Before the inspection, we looked at the evidence we already held about the service including the Provider Information Return (PIR). This is a form in which we ask the provider some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications that the provider had sent us since registering under the new entity. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to obtain their views about the service.

During the inspection we spoke with 14 staff including the registered manager, deputy manager, two unit managers, three nurses, two senior care staff, two care staff, an activity co-ordinator, the chef and the maintenance person. We also spoke with five people who used the service, three relatives and a visiting health professional. We observed care and support in communal areas and 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. We reviewed 11 people's care records including risk assessments and care plans and six staff files including recruitment, training and supervision. We also looked at records relating to how the home was managed including medicines, policies and procedures, building safety and quality assurance documentation.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. Comments included, "I feel safe", "Yes. At home I was all alone. Here I have people around me", "Safe because I have people around me", "Yes, I don't know why, it just feels safe. There are familiar faces."

There was a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, we found staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and written references. We also saw staff had criminal records checks carried out to confirm they were suitable to work with people.

The service also had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK and ensures nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards. This meant a safe recruitment procedure was in place.

People told us they sometimes had to wait for their needs to be met. One person told us, "Sometimes the staff are short, more so in the dining room. You ask for something you can wait a while and still no one comes. There is only one carer." Another person said, "There should be another two on duty. Everyone wants to go to the toilet and we have to wait." A relative told us, "Not always. Some days too tight, the carers are exhausted."

One staff member told us, "We get busy sometimes, but we have enough staff." We reviewed the staff rota which showed there were six nurses and 12 care workers divided across the three units during the day and one nurse and two care workers on each unit at night. We saw call bells were not always answered in a timely manner and there were times when people were on their own in lounge areas or bedrooms. However at these times, staff were observed gathered together in another section of the units who were not busy supporting people who were using the service. This meant staff were not being effectively deployed to ensure people's needs were consistently met when needed.

The registered manager told us they had a number of staff vacancies and were in the process of recruiting new staff. This meant the service was relying on the use of agency staff to ensure there were enough staff working. Records showed the service used a tool to assess the dependency level of each person who used the service and decide on the staffing levels. The registered manager told us that they also assisted on the units when staff called in sick and could not work. The registered manager told us they would observe how staff were deployed on each unit and would discuss with the unit managers the effective deployment of staff to ensure people received care in a timely manner.

We recommend the provider seeks advice and guidance from a reputable source about staffing levels and deployment of staff to ensure the needs of people who use the service are met.

Staff were knowledgeable about safeguarding and whistleblowing procedures. One staff member told us, "If

you see something which is not right, you need to report it to the manager, to safeguarding, the police or to you, CQC." Another staff member said, "We call it 'speak up'. I will investigate it, report it to the manager, inform CQC and maybe the police and safeguarding." A third staff member told us, "Any harm done to [a person using the service] must be reported. Have to report it immediately to my line manager, the home manager, safeguarding, the social worker or the CQC."

Records showed staff received training and regular updates on safeguarding adults. The service had comprehensive policies on safeguarding and whistleblowing which gave clear guidance to staff on the actions they must take if they suspected abuse. Records also showed the provider notified the local authority and CQC when there was a safeguarding incident. This meant the provider had systems in place to safeguard people from the risk of harm or abuse.

People had individualised risk assessments that gave guidance to staff on minimising risks while supporting people to regain their confidence. Risk assessments included moving and handling, mobility and falls, skin integrity and bedrails. Moving and handling care plans gave guidance to staff on equipment to be used with the person and detailed the equipment to be used for each type of transfer. For example, one person's moving and handling risk assessment stated, "Needs sliding sheet and assistance of two staff to change his position. Opera hoist with large sling to transfer from bed to chair and from chair to bed. Mobilises in a wheelchair with the assistance of two staff."

However we noted that people with diabetes did not have guidelines to inform staff of symptoms to look for in the event that somebody was experiencing hypoglycaemia [low blood sugar] or hyperglycaemia [high blood sugar]. The registered manager and the deputy manager told us they would take action on this.

We recommend that the provider seeks guidance and advice from a reputable source about caring for people who have specific health conditions in order to provide the right support and minimise risks.

We saw building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, annual testing of portable electrical appliances was done on 17 July 2017 and the five year electrical installation check was done on15 August 2017. The maintenance person told us they carried out monthly checks of the carbon monoxide alarms and weekly checks of the fire alarms and fire doors. Records confirmed these checks were up to date.

The provider had a comprehensive medicines policy which gave clear guidance to staff about the storage and administration of medicines including monitoring people who self-administered their medicines. Medicines were stored appropriately in locked trolleys stored in a locked room. Records showed that the temperature at which medicines were stored was monitored including those that required refrigeration and these were up to date and correct.

Medicine administration record (MAR) sheets for medicines taken daily were completed correctly with no gaps. There were also appropriate arrangements in place for the receipt and disposal of all medicines. Some prescription medicines are controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had systems in place to ensure controlled drugs were stored appropriately and correctly accounted for.

People who required "pro re nata" (PRN) medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. PRN medicines that were not supplied in blister packs were in date and clearly labelled. People who required their medicines to be given covertly had guidelines on how to safely administer the medicine and signed agreement by the GP. Covert medicines are

those that need to be given in a disguised format because the person lacks the capacity to understand why the medicine is needed. The above meant that people received their medicines as they required them and as prescribed.

The provider had an infection control policy which gave guidance to staff on the steps they should take to prevent the spread of infection. We saw staff wore gloves and aprons before giving care and changed these before giving care to the next person. This meant people were protected from the risk of infection.

Good

Is the service effective?

Our findings

People and relatives told us staff provided effective care. Comments from people included, "It is top notch. All of them who look after me are top notch", "I am happy the way they look after me" and "All the staff are good." A relative told us, "It is the only home I have been to that does not smell of wee or food."

Staff told us they found the training they received useful. One staff member told us, "I have been given a good induction and handover, and I am clear about my role." Another staff member said, "Some people can be challenging to us and other people but we are trained to de-escalate these situations." A third staff member told us, "Yes, of course it is useful. We need to update our knowledge."

Training records confirmed staff had received appropriate induction training when they began employment at the service. Nursing staff had a competency assessment before administering medicines without supervision. Records also confirmed that staff were required to complete core training such as nutrition and hydration, fire safety, infection control and dementia. The training matrix was colour coded and dated to enable managers to see when staff were due refresher training.

Staff told us they had regular supervisions and appraisals. Records showed topics discussed in supervisions included, documentation, consent, choices, moving and handling, infection control, end of life care plans and training. Appraisals included an evaluation of the staff member's performance over the previous year and outcomes they agreed to work towards for the forthcoming year.

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

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection, 16 people had DoLS authorisations in place because the individuals needed a level of supervision that may amount to their deprivation of liberty. For example the main door to the building, the lifts to each floor and the entrance door to each unit had a key code lock. People who were assessed as having capacity had access to the code for their unit and the lift. The service was awaiting the outcome of 23 further applications. Care records showed assessments and decision making processes had been followed correctly.

Care plans included a consent form allowing staff to provide care, share relevant information with health professionals and use photographs to document or track care. The consent form was signed by the person

who received the service when they had the capacity to give consent. Records documented when a person lacked the capacity to give signed consent.

Staff were knowledgeable about the need to obtain consent before giving care. One staff member told us, "Before you approach them, you need to ask them and explain to them before giving them care." Another staff member said, "We ask them. If they say no, we will come back to try again later." A third staff member told us, "Don't make decisions for them. You have to seek their consent and it has to be their own choice."

People had mixed views about the food offered. Positive responses included, "I am a vegetarian. We and I mean the three others too, get Indian food", "I am a vegetarian and I like the food I am given" and "They will make a sandwich or eggs or chips or fish fingers. I just choose what I want." However, one person told us, "I like the breakfast, but not the lunch and dinner. I am from [country of origin] and our food is different but it would be nice if they would introduce some of it." Another person said, "Terrible. It has no flavour." We raised this with the registered manager who said they would ask the chef to talk to these people with a view to resolving the issue.

Staff were knowledgeable about people's dietary needs and preferences. Kitchen records contained people's specific dietary needs and included people's preferred or recommended portion sizes, allergies and people who had been identified as at risk of choking. This meant catering staff were able to take appropriate action to manage people's associated nutritional risks. Fresh, chilled and frozen food was stored appropriately and fridge and freezer temperatures were monitored daily. Records confirmed fridge and freezer temperatures were maintained at the correct temperature and the temperature of all cooked food was checked before being served to people.

People made their choice of meal in advance but were able to change their mind on the day. At mealtimes staff showed people two different plated meals to help them make their choice. People who required assistance to eat were supported appropriately and given time to eat at their own pace. Records showed that people had a monthly nutrition review which included their monthly weight and the type of weighing equipment to be used. People who were at risk of malnutrition had their weight checked on a weekly basis. Weight records were up to date.

People told us and records confirmed that people were able to access support from healthcare professionals as required. For example, we saw records of visits from the GP, tissue viability nurse, dentist and optician. People's health was also discussed at the daily meeting held between the registered manager, deputy manager and unit lead staff. The GP visited the service to review people during the inspection. The registered manager told us the GP visited twice a week but would visit other times if needed. This meant people's healthcare needs were met as needed.

Good

Is the service caring?

Our findings

People who used the service told us staff were caring. One person told us, "Yes they are [caring]." Another person said, "They are alright." A third person told us, "All the staff are good. Most of the them are happy to do things for me." We observed staff interacted with people in a kind, caring and respectful manner. There was a friendly and relaxed atmosphere throughout the inspection.

Staff told us how they got to know people and their care needs. Comments included, "Through their care plan and through handovers", "You have to have a caring heart to do this job. First of all, you have to read the history, talk to the family. Ask [person] how they like tea, how they like food and what they would like to do" and "Introduce yourself. Let them know that you are here to help them. Do it from the heart, reassure them. Treat them like your parent."

The provider had a keyworker system in place where each person using the service had a named nurse and a named carer. A keyworker is a staff member who is responsible for overseeing the care a person received and liaising with other professionals or representatives involved in a person's life.

Staff were knowledgeable about enabling people to maintain their independence. One staff member told us, "We give them the opportunity to try for themselves." Another staff member said, "You don't do things for [people who used the service]. You are there to support them." A third staff member said, "You should not do for them. Give [person] chance to do for themselves."

The provider had a privacy notice which explained to people who used the service how their personal information would be kept securely and confidentially. We asked people if their privacy and dignity was respected by staff. Four people told us, "Yes they do." One person told us, "Oh yes definitely. They don't do anything until they shut the door."

We observed staff knocked on bedroom doors and awaited a response before entering.
Staff were knowledgeable about maintaining people's privacy and dignity. One staff member told us, "By giving them choices. Keeping confidentiality. Close the curtains and door." Another staff member said, "Knock when you enter and the door has to be shut, the windows have to be closed." A third staff member told us, "Make sure the curtains are closed, the door is closed, always cover them."

Staff demonstrated awareness of equality and diversity issues. Comments included, "By meeting each and everybody's needs, regardless of who they are. People are different", "You have to treat [people using the service] equally no matter who they are and treat them with respect" and "We will bring them in and integrate them. Give them the chance to speak and have choices."

Care plans documented people's end of life wishes, for example, whether they wished to remain in the home or be in hospital to receive end of life care. The provider had a system in place to carry out regular end of life care audits which included the date of admission and whether each person had a do not resuscitate form in their care plan. Staff told us they provided person-centred care for people at the end of their lives that was

tailored to the needs and sensitivities of the people and families.

Good

Is the service responsive?

Our findings

People told us that staff took account of their preferences when delivering care. One person told us, "I tell them what I like and want and they do remember that." Another person said. "Yes they do. They spoil me to bits."

Staff were knowledgeable about providing personalised care. One staff member told us,
"It's about the way [the person] wants their care. For me, if I work for you, I will give you my time. You have to give 100%." Another staff member said, "It's about giving people choices." A third staff member told us, "Knowing the person according to the [person's] needs and their choices. You need to organise your work and prioritise your work then you get time to give personalised care."

People had their care needs assessed before they began to use the service. Care plans were comprehensive and personalised and included the person's basic details and personal histories. Records contained people's preferences including food, drink, activities, time to get up and time to go to bed. One person's care record stated, "[Person] likes to wear t-shirt and tracksuit bottoms. [Person] likes to have shower. Prefers male carers but does not mind female [carers]. [Person] is able to brush his teeth. [Person] is able to tell staff how to support him. [Person] is able to choose his clothing." Records showed that care plans were reviewed each month and sooner if a person's needs changed.

Care plans included information about people's health, communication, personal care and cultural or religious needs. Each unit had an 'At a Glance' information sheet which was kept at the nurses' station. This sheet contained the name of each person living on that unit and a snapshot of their needs including medical history, allergies, dietary requirements, which monitoring charts and which hoists or slings they used. This meant important information about each person was quickly and easily available to staff.

People told us they liked the activities that were offered. One person told us, "Yes I do. Today is the art class." Another person said, "I don't like the exercises. I like the singing. They never force me to do anything but they always ask. When the weather is good activities are done outside. Like Bastille Day and 4th July and there are others that they celebrate."

Records showed there was a wide range of activities offered. Each unit had the weekly activities displayed. These included current affairs discussion, reminiscence, visiting hairdresser, massage therapy, ball games and one to one activities in people's rooms. The activities co-ordinator told us they organised a monthly toiletries delivery for people and the hairdresser visited once a week. The activities co-ordinator also told us they took people to the post office and when the weather was good people could have a picnic in the park. The weekly activities included a church service for all faiths and a visit from representatives from a church. We saw from the activities timetable that the provider held a fortnightly sherry and canapés session on each unit.

Monthly activities included a special occasion day, a cultural, spiritual or religious celebration, a delicious dining day, an outdoor event if the weather permitted and a visiting entertainer. For example, during the

month of September, there was a Macmillan coffee morning, an Asian film afternoon, a Welsh rarebit day, read a book in the garden afternoon and a singing class. The activities co-ordinator told us the service had a visiting clothes show twice a year and an underwear and slippers sale once a year so that people could update their wardrobes. Records and photographs confirmed the above activities occurred. This showed the provider offered a range of activities to suit people's different preferences.

The dementia unit contained an indoor garden with the sound of bird song so that people who chose not to use the garden were able to experience a taste of the outdoors. Rooms were personalised and contained people's choice of pictures and photographs. Bedroom doors were styled like street doors to houses and were different colours to help people to recognise their room. People had memory boxes outside their door which also helped them to recognise their room.

People and relatives told us they would speak to the manager if they needed to complain. The provider had a complaints policy which gave clear guidance to staff on how to handle complaints. We reviewed the complaints log and saw 13 complaints had been made since the provider changed its legal entity. These complaints were resolved according to the provider's policy. For example, one relative had raised concerns about the care of their family member. The relative was given copies of the care records and charts as evidence that care had been given as planned. The relative was satisfied with the response.

The provider also kept a record of compliments and we saw five compliments made since the provider changed its legal entity. For example, one person had written, "Thank you for my stay at BUPA and looking after me so well." A relative had written, "Thanks to you all for looking after [person who used the service]." Another relative had written, "Thank you for all the care and attention given to [person who used the service] in her short stay with you." The above showed the provider had systems to use complaints and compliments to make improvements to the service.

Good

Is the service well-led?

Our findings

The service had a registered manager who was supported by a deputy manager. Both the registered manager and deputy manager knew all the people who used the service by name. We saw positive interactions between the registered manager, the deputy manager and people who used the service. People told us if they had concerns they would speak with the registered manager.

Staff spoke positively about the registered manager. Comments included, "[Registered manager's] so flexible. She doesn't mind you coming to the office", "I do feel supported [by management]. Yes, I do", "[Registered manager] is okay. She is fine. In fairness, she's sweet, she's warm. She has open door policy and she's got listening ears" and "[Registered manager] is a good leader. Always has time and is supportive."

The provider had a system of obtaining feedback from people who used the service. A feedback survey was given to people. This was available in an easy read and pictorial format. We saw 17 people using the service had responded to the 2016 survey. Written comments included, "Kind staff, friendly, helpful", "Everything is good from the cleaning to the management" and "It's a very happy home. The staff are lovely. Couldn't wish for more." The survey analysis indicated 100% of people who responded said they felt safe and secure.

The service held regular monthly meetings for people and relatives. Records showed topics discussed in the last three meetings included news related to the home and to BUPA, welcome to new people using the service and new staff, meal service and housekeeping. The minutes identified actions arising from the meeting and who was responsible for taking the action. For example, one action identified in the August meeting was for tissues to be made available in the lounge areas for people who used the service. We observed that tissues were now available. This meant the provider had a system in place to help them to improve the quality of service provided.

The provider had various meetings with staff. Records showed daily 'Take 10' meetings were held which were attended by the registered manager, deputy manager and unit leads. These meetings were used to update everyone on the well-being of people who used the service and activities and events occurring on the day. The registered manager told us they did a daily "walk around" the home after this meeting had taken place to observe staff performance. Records showed the registered manager's daily "walk around" took place at a different time each day so staff would not know in advance when it would happen.

The heads of departments had regular meetings. We reviewed the minutes of the meeting held on 12 April 2017 and saw discussions were held around the latest internal inspection report, how to improve performance and staffing levels. Staff told us the monthly staff meetings were useful. Topics discussed during the meeting held on 22 August 2017 included teamwork, personal care, choices, nutrition and hydration charts, and continuing the practice of showing plates of food to help people choose their food. This meant the provider had a system to obtain staff contributions for developing the service.

The provider had various quality assurance systems in place. For example, the registered manager did a monthly preventative nursing check which included looking at weight loss, medication and health reviews,

pressure ulcers, falls and incidents. We saw the registered manager's quality check of six care plans on 5 September 2017 identified that one care plan needed updating. The care plan was updated, re-audited and signed off on 8 September 2017. The registered manager also completed monthly checks which included bedrail checks and a nutrition review.

The regional director completed a quality check completed on 12 July 2017. This included a review of acquired pressure ulcers in the home and externally, nutrition and deaths. This meant the provider had systems in place to monitor the quality of the service and taken action when needed.