Four Seasons (DFK) Limited

Maple Lodge 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

This inspection was unannounced and was carried out on 11 March 2016. Maple Lodge is registered to provide accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening for up to 60 people. There was a specialist unit for people living with dementia. There were 40 people living at Maple Lodge on the day we inspected, 16 of whom required nursing care.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Maple Lodge provided good care and support for the people that lived there. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. There were good systems in place to make sure that people were supported to take medicines safely and as prescribed. Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were enough staff on duty to make sure people's needs were met. Staff recruitment processes included carrying out appropriate checks to reduce the risk of employing unsuitable people. Staff told us they enjoyed working at the service and that there was good team work. Staff were supported through training and team meetings to help them carry out their roles effectively.

People received their medicines at the times they needed them. The systems in place meant medicines were administered and recorded properly and this was audited regularly by the service and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was re-assessed regularly.

Staff received appropriate training, supervision and support. Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure that people's rights were protected where they were unable to make decisions.

People had their nutritional needs met. There was a variety of choices available on the menus, snacks were freely available throughout the home and people were supported to have sufficient food and drinks to meet their dietary needs. People who required special diets were catered for.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

People told us that they were well cared for and happy with the support they received. We found staff approached people in a caring manner and people's privacy and dignity was respected.

People looked well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

People were involved in the decisions about their care and their care plans provided information on how to assist and support them in meeting their needs. People's needs were regularly reviewed and, where necessary, appropriate changes were made to the support people received. People were supported to maintain their health and had access to health services if needed.

The registered provider actively sought the views of people using and visiting the service. They were asked to complete an annual survey and provided information using an electronic feedback iPad located in the entrance hall to the home. This enabled the provider to address any shortfalls and improve the service.

The service had a quality assurance system, and records showed that identified problems and opportunities to change things for the better had been addressed promptly. As a result we could see that the quality of the service was continuously improving.

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.

Staff were confident of using safeguarding procedures in order to protect people from harm.

People's medicines were managed safely and they received them as prescribed.

We found there were sufficient staff on duty to attend to people's needs. The way in which staff were recruited reduced the risk of unsuitable staff working at the home.

Risks to people's safety and welfare had been assessed and information about how to support people to manage risks was recorded in people's plan of care.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005 and relevant legislative requirements were followed where people's freedom of movement was restricted.

People were provided with a choice of nutritious food. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff.

The home had developed good links with health care professionals which meant people had their health needs met in a timely manner when their needs changed.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected and staff were kind

and attentive.

People were well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

The staff we spoke with demonstrated that they knew the people they supported well and that they understood their needs.

Is the service responsive?

Good

The service was responsive.

People received personalised care. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People had an opportunity to participate in group activities and attention was also paid to people's individual interests and hobbies.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Good

The service was well led.

Staff and people using the service; their relatives and representatives expressed confidence in the registered manager's abilities to provide good quality care.

Care staff were aware of their role and felt supported by the registered manager. Care staff told us they were able to raise concerns and felt the registered manager provided good leadership.

The provider and registered manager regularly monitored the quality of the service provided. Quality assurance audits were completed to identify where improvements could be made to the home and increase the quality of the service provided.

Maple Lodge 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 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 11 March 2016 and was unannounced. The inspection was carried out by one inspector and a specialist professional advisor who specialised in providing nursing services to older people.

Prior to the inspection we reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send to the Commission by law. We planned the inspection using this information. We also contacted the local authority contracting team to ask for their views on the service and to ask if they had any concerns. The registered manager had also completed a Provider Information Return (PIR).The PIR 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.

During our inspection we carried out observations of staff interacting with people and completed a structured observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk with us. We spoke with seven people who lived at the service and eight relatives.

During the inspection visit we reviewed eight people's care records, three staff recruitment files, records required for the management of the home such as audits, minutes from meetings, satisfaction surveys, and medication storage and administration records. We also spoke with eight members of staff, including nurses, senior care workers, care assistants, the activities organiser, the chef, the deputy manager and the operations manager. The registered manager was not present during the inspection as they were taking annual leave.

Good

Is the service safe?

Our findings

People we spoke with told us on the whole they felt safe. One person said, "I still get anxious but I haven't been here long. I think I will feel better once I get to know the place better. Another person said, "Staff are kind and reassuring which I think is a good thing."

The service had policies and procedures with regard to safeguarding adults and whistleblowing (telling someone). Staff demonstrated that they were able to identify any safeguarding concerns and were clear that they were responsible for protecting people. They told us that people's safety was discussed at team meetings. When we spoke with staff about their responsibilities for keeping people safe they referred to safeguarding polices and confirmed they had received training about safeguarding adults. Information the Commission had received demonstrated the registered manager was committed to working in partnership with the local authority safeguarding teams and they had made and responded to safeguarding alerts appropriately.

We reviewed how risks to people were managed and saw that the risk to people was identified and where possible reduced or eliminated. For example standard supporting tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments to ensure peoples' nutritional and pressure sore risks were minimised. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. We also saw that any incidents or accidents were reviewed to prevent reoccurrence or to analyse trends and patterns such as whether falls were occurring at a specific time of day or location.

Risk assessments on the environment had been carried out to ensure risks such as trip hazards were identified and eliminated. There were emergency plans in place should the service need to be evacuated and staff were aware of what to do in the event of a fire. There was a Health and Safety champion appointed to support the role of the maintenance person. We were told the role included checking equipment used by staff which maybe hazardous and reporting back to the registered manager. There was an on-going maintenance plan to ensure the upkeep of the building.

We walked around the building and saw grab and handrails to support people and chairs located so people could move around independently but with places to stop and rest. Communal areas and corridors although homely, were free from trip hazards.

The home was clean. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

We looked at the recruitment records for three staff and found they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any

gaps in employment. The records showed a clear audit trail of the recruitment processes including interview questions and the checks carried out. Appropriate checks such as, proof of identity, references, satisfactory Disclosure and Barring Service [DBS] certificates had been obtained. The DBS provides criminal record checking and barring functions. This helped reduce the risk of the provider employing unsuitable people. We saw the registered provider had a system to check, each month, the current status of nurses' professional qualifications with the Nursing and Midwifery Council (NMC).

We asked relatives we spoke with about their view on staffing levels. One relative said, "On the whole there seems to be enough staff, occasionally it feels like there's no one around but they are usually busy helping someone and come quite quickly." People who lived at the service commented they felt there were sufficient staff on duty. One person said, "There's always someone close by."

We were told by the deputy manager that there would normally be two care staff working in Willow, the dementia care unit, with two nurses and three carers covering the remainder of the service. We were told one of these was a 'floater' who could be called to assist anywhere in the building. Care and nursing staff were supported by ancillary and kitchen staff. There was an administrative member of staff on duty Monday to Friday who took responsibility for greeting visitors to the service and answering the telephone, this meant care and nursing staff could focus on providing care and support to people. There was a qualified nurse and two care staff on duty during the night.

Our observations during the inspection told us there were enough staff on duty to meet people's needs. Although staff were kept busy we did see staff spend time with people other than to complete care tasks. The operations manager told us the service used a dependency assessment tool to assist in determining if there were sufficient staff to meet people's needs and there was flexibility to increase staffing if it was required. The operations manager explained the service had a very low turnover of staff. They told us they did not use agency staff but employed bank staff to call upon to cover sickness, annual leave and any staff vacancies. They recruited 10% above their standard staffing in order to ensure vacant hours could be covered by staff who they had recruited, trained and were familiar with people living at the service.

Medicine was administered by senior staff who were trained to do so, and had their competency checked on a regular basis. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. We saw the date that the medicines had been opened was recorded and they were labelled correctly. The medicines administration records (MARs) were personalised with a photograph of each person. We also saw information about people's allergies was recorded, where appropriate. There were four colour-coded sets of blister packs – one for morning, lunch, tea and evening.

We observed the nurse safely administer medicines to people. Medicines were given in a considerate manner allowing the person to take their time and ensuring that they were taken properly. Explanations were given to the person as to what was being offered.

We saw that when people where prescribed topical applications there was a body map in the person's care records. We looked at the records for one person who was prescribed a topical medicine. We saw the records contained a body map which detailed the name of the medicine and when it should be applied. We also saw the area where the cream was to be applied was 'shaded' on the body map. This meant staff were provided with clear guidance to ensure peoples' topical medicines were applied safely.

Anticipatory medication for pain relief was available for those people who were at the end of their life. This was recorded on the MAR sheet so that this information was readily available to those responsible for administering it. We saw drugs liable to misuse, called controlled drugs, were stored in a suitable locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record. We noted that where people were prescribed PRN (as required) medicines, information was recorded about the circumstances under which the medicine could be administered.

Regular audits were carried out to determine how well the service managed medicines and we saw available an up to date BNF (British National Formulary) and NICE (National Institute for Health and Care Excellence) Guidance for Managing Medicines in Care Homes. We saw evidence that where concerns or discrepancies had been highlighted appropriate action had been taken straightaway in order to address those concerns and further improve the way medicines were managed within the home.

Good

Is the service effective?

Our findings

Staff received the support they needed to provide effective care. The staff we spoke with told us they felt supported and that there was good teamwork. Staff feedback included, "A lot us have worked here for a long time, we get on well and support each other." And, "We are a good team and we help each other out, it's a bit like a family."

We asked the operations manager about staff training arrangements. They told us newly appointed staff completed a twelve week induction based on the new care certificate. The care certificate is a recognised qualification which aims to provide new workers with the introductory skills, knowledge and behaviour they need to provide compassionate, safe and high quality care. Staff also completed a period of shadowing. Shadowing is where new care staff are partnered with an experienced member of care staff as they perform their job. This allows new care staff to see what is expected of them.

The operations manager showed us a training matrix (record) which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff we spoke with told us there were good opportunities to attend training and it was relevant to their role, for example trained nurses would complete additional training to ensure they were clinically competent. Staff confirmed that they had completed appropriate training courses for moving and handling, fire precautions and dementia care and this was relevant to their role.

Staff told us they received regular supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. This meant that staff were well supported and any training or performance issues identified.

There were regular team meetings where the team could share information and discuss issues together. Staff told us 'handovers' also took place between shifts so that important information about each person and any relevant points for staff to note could be passed on.

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).

Staff we spoke with were able to demonstrate an awareness of the principles of the MCA and DoLS procedures. The operations manager told us fifteen DoLS referrals and authorisations had been made as required. We found examples of best interest meetings being held where people were unable to make decisions for themselves. A best interest meeting is a meeting of those who know the person well, such as relatives, or professionals involved in their care. A decision is then made based on what is felt to be in the

best interest of the person. Where best interest meetings had taken place there was information in care plans about the decisions made and the reason the person lacked capacity for that decision. For example, one person's care plan provided information from a best interest decision about them accessing the community with staff support.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do Not Attempt Cardio-Pulmonary Resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

People were supported to maintain their health and had access to health services as needed. Records showed that when required additional healthcare support was requested by staff. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), social workers, dietician, speech and language therapist (SALT), community psychiatric nurses, chiropody and podiatry. The care plans we looked at reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing. Staffing rotas showed that a registered nurse was available at the service throughout the day and night.

People were supported to have sufficient amounts of food and drink to maintain their health and well-being. Where concerns had been identified about weight loss or food intake, support was being provided by the local Speech and Language Therapy (SALT) Team and dietician. Care plans contained clear guidance about the support required and any monitoring charts were filled in as required. People had a Malnutrition Universal Screening Tool (MUST) assessment completed (including swallowing and hydration) to regularly monitor if people were at risk of not eating or drinking enough and all had their weight and BMI recorded and up-to-date. Dietary intake was also recorded in the care records.

We saw that people enjoyed their food and that there was a variety of food available to them. The atmosphere was relaxed and there was quiet music playing in the background. We saw people smile and chat with each other making lunch an enjoyable experience. Tables were set appropriately, with table cloths, cutlery, and crockery. Staff offered people a choice of meal and drink, and showed people sample plates of food which helped people to make an informed choice. People were discreetly offered clothes protectors. Everyone was given the choice, of eating in the dining room, or if they preferred having their meal in their bedroom. We saw that people were assisted to eat at their own pace and in a manner that promoted their dignity. We saw snacks and drinks were available throughout the day. There was also a kitchenette so that staff and visitors could make drinks and snacks throughout the day and night without having to go to the main kitchen. People told us that they enjoyed the food provided. One person told us "The food is good there's always a choice." and another person said "I like the food, it suits my taste."

When we looked around the service we saw distinct contrasts between the areas where nursing care was provided and the areas where people living with dementia lived. We could see that consideration had been given to research associated with supportive environments for people living with dementia and this enhanced the surroundings to make them comfortable, usable and stimulating for people living with dementia. For example we saw colour contrasting on door frames and handrails. We commented on the plain walls and we were told the unit had been recently decorated and new themed pictures were waiting to be put up. Rummage boxes were available for reminiscence which all had a different theme. Memory Boxes

were provided outside some bedrooms, to help those living with dementia, so that they were able to recognise their bedroom and maintain their independence. There was a board telling people what day, date and season it was and what the weather was like outside. People had independent access to secure outdoor space with seats available for people to sit and enjoy the garden.

Good

Is the service caring?

Our findings

People gave positive feedback about the caring approach of the service. Comments included, "The staff are brilliant, so caring and kind." Another person commented, "I have nothing but good things to say, the care is fantastic." A relative told us, "A member of staff came into to see my relative when it was their birthday even though it was their day off, they are very dedicated."

We observed during the inspection the atmosphere was friendly and welcoming. Staff were understanding and respectful in the way that they spoke with people, and were quick to attend to people as needed. Reassurance and support was provided to any person who became distressed. And we noted in these instances staff supported people to move to a more private area of the building.

All the people we met on our inspection were appropriately dressed and it was clear that staff had supported people to maintain their appearance. We noted in one person's care plan that it stated they had a collection of necklaces that they enjoyed wearing. We met this person who was wearing a necklace which they were keen to show us. This demonstrated staff took the time and care to assist people in what was important in their lives.

Staff spoke about the importance of ensuring people's privacy and dignity was respected. We were told the service had a Dignity Champion, who took responsibility for monitoring that people's dignity was maintained. Staff gave examples of how they maintained people's dignity. One staff member told us, "I always make sure the door is closed if I am helping someone." Another member of staff said, "I always knock on people's doors."

Some people at the service and living with dementia were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff. We observed staff treating people with kindness and compassion.

Staff took time to involve people in any care and support and respected the choices people made. We observed staff communicating with people living with dementia and noted this promoted individuals' wellbeing. For example we observed one person began pushing a side table around. Another person who lived at the service became anxious about the safety of this. A member staff walked alongside the person and said, "It's ok, she's just doing her housework, I'll make sure she's safe." They continued to walk chatting about housework tasks. It was apparent that the person was engaged and enjoying the conversation.

We observed that people were asked what they wanted to do and staff listened. In addition, we observed staff explaining what they were doing, for example in relation to giving people their medication. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

We noted that people were not rushed and staff supported people with patience; people were not hurried

by staff and were supported to go at their own pace. We saw staff joking and laughing with people and involving them in conversations. We also saw staff addressing people in the manner they preferred.

One person required assistance using a hoist and we observed staff give verbal and physical reassurance; talking to them about what was about to happen in a patient and reassuring manner. We saw people were offered blankets or were assisted to ensure their clothing protected their dignity. During lunch people were offered protective clothing before being assisted.

We saw in the care records we looked at that some information was recorded in relation to people's end of life wishes and that this had been discussed with them or their families as appropriate. Where people received end of life care this was managed sensitively and with compassion. We saw in compliments cards written, "[Name's] needs were met and their dignity preserved. Their final days were as comfortable and happy as possible." And "I was so relived they weren't alone when they passed away." And "[Name] passed away surrounded by such kind and caring people."

Staff spoke about how they supported people to have a dignified, pain free and private death. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place and there was evidence of advance decisions to refuse treatment. There was also anticipatory prescribed medication in place for people approaching end of life. This meant that health and emotional care information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

Good

Is the service responsive?

Our findings

People living at the service had a written plan of their care needs and how these were to be met. Prior to people moving into the service a pre-assessment was completed. This helped the service establish if they could meet the person's needs and would reduce the risk that the person may need to move to an alternative service in the future. It also provided staff with information to support the person during their first few days in the service whilst the person settled in.

We looked at eight people's care plans and saw they were person centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what is important to the person. This was helpful to ensure that care and support was delivered in the way the person wanted.

Care plans included information relating to personal care, mobility, nutrition, daily and social preferences and health conditions. We saw care plans were detailed with corresponding risk assessments in place. They were all up-to-date and had been reviewed monthly and on a more regular basis, in line with any changing needs, and they were reflective of the care being given. For instance we saw that one person, due to increased frailty, needed to spend more time in bed which created a risk of pressure sores. We saw they had been referred to the Tissue Viability Nurse and a specialist mattress had been provided. This meant that the person's changing needs had been monitored. Our discussions with staff indicated that staff knew people well and this reduced the risk of providing inappropriate care.

We spoke with the activity coordinator about the range of activities available to people who used the service. We saw a noticeboard for up and coming events at the home, this included quizzes, craft sessions and film afternoons. We saw there were items available to occupy people located around the building, for example books, magazines and jigsaws. We also saw 'rummage' boxes and memorabilia located around the home to stimulate people's interest and provide something for them do. Chairs were strategically placed around the home to accommodate those people who liked to walk, but needed to rest at regular intervals.

For those people who did not like to join in group activities, this choice was respected by staff, who maintained regular visits to these individuals during the day to prevent them feeling isolated.

People told us they knew how to complain and felt comfortable speaking to staff or the registered manager. We saw information about how to complain was visible in the reception area. One person told us "I would talk to the boss if I had any concerns." We looked at the record of complaints and saw that two had been received in the last year. We noted that letters were sent to complainants to confirm receipt of a complaint and that it would be investigated. There was a clear record of the outcome of any investigation and people were asked if they were happy with the response.

The provider had recently introduced a Quality of Life iPad located in the entrance hall. Feedback, about the care and support, was sent directly to the registered provider via email and the system was set up to monitor any action points. The operations manager told us it was used more frequently when it was first

introduced but felt people were now more likely to use it for convenience rather than having to write formally. They told us its effectiveness would be monitored. Staff were also encouraged to use it.

Good

Is the service well-led?

Our findings

People who used the service and visitors we spoke with gave positive feedback about the staff and management of the service and said they would recommend the home to others. People described the home as, "homely" and "open and warm; family like". People we spoke with told us they knew who the registered manager was and said they regularly saw them around the home and that they were approachable.

We received positive feedback from the local authority and continuing healthcare commissioners with regard to the management of the home and the promotion of effective collaborative working. The provider included, as part of it's quality assurance, a survey of visiting and partner agencies. At the time of the inspection the results of a recent survey were not yet available.

The operations manager told us the service was benefitting from the presence of a new manager. They went on to explain that although the staff team was stable with a low turnover, the service had had some difficulties in retaining a registered manager. The operations manager said they had received positive feedback from staff about the new registered manager; this was reflected in our discussions with staff. They said the registered manager had introduced some good systems and was always happy to listen to staffs' point of view. One staff member said, "We discuss things on a daily basis to try and make things better for everyone." They gave an example of 'flash handovers' which take place at 11am and 3pm. They explained this was an opportunity for staff to come together briefly to share how the day was progressing and whether any changes to staffing were required or people's needs had changed. They also told us the registered manager was introducing 'champion' roles, which gave staff the responsibility to develop specialist knowledge in a specific area and promote good practise throughout the service. For example, we were told of end of life care and infection control champion roles.

Staff meetings had been held at regular intervals, which had given staff the opportunity to share their views and to receive information about the service. Staff told us that they felt able to voice their opinions, share their views and felt there was a two way communication process with managers. We saw this reflected in the meeting minutes that we looked at.

The registered provider completed an annual survey with people who used the service and their relatives to gather feedback on all aspects of the service provided. Survey questionnaires were confidential and analysed by the provider's quality team. Results were published and with appropriate action plans put in place in response. For example, there were some comments about the under use of the conservatory. As a result the conservatory was being repaired and refurbished. There were plans to improve the garden areas particularly for the dementia care unit.

The registered manager had recorded in the PIR returned to the commission their aims for future improvement of the service. They cited the need to improve the effectiveness of residents and relatives meeting and were looking at the configuration and timing of these to improve people's access and inclusion in them. They also recorded improving links with the local community voluntary organisations in order to

support people living at the home accessing the community with a 'friend' rather staff member. This demonstrated the registered manager's commitment to making improvements in order to enhance people's experiences and enjoyment of life.

The operations manager explained there was a range of quality assurance systems in place to help monitor the quality of the service the home offered. This included formal auditing, meeting with senior managers and talking to people who received a service and their relatives. Audits ranged from regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, fire-fighting and detection equipment. Care plan and medicines audits were also completed, all of which helped determine where the service could improve and develop. These were completed and recorded on the iPad which made them immediately accessible.

Monthly audits and monitoring undertaken by regional managers were in place which facilitated managers and staff to learn from events such as accidents and incidents, complaints, concerns and whistleblowing. This reduced the risks to people and helped the service to continuously improve.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty team, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.