Denestar Limited

Ivanhoe Residential

Inspection report

Ivanhoe Care Home
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Ivanhoe is a care home that is registered to provide accommodation and personal care for 26 older people, including those people living with dementia. The service is situated on a main road between Hessle and the city of Hull. It is close to local amenities and has parking facilities to the front and rear of the property. The service has mainly single bedrooms

We undertook this unannounced inspection on the 18 and 19 February 2016. There were 25 people using the service at the time of the inspection. At the last inspection on 21 January 2014, the registered provider was compliant in the areas we assessed.

The service had a registered manager. 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.

We found there were times when there was insufficient staff on duty, mainly at tea-time at the weekend. The registered provider told us they were addressing this and plans were underway to rearrange the staffing structure at these times.

We found the service was generally clean and tidy in communal areas and bedrooms. However, there were some areas of the environment and practice that could be improved in regards to good infection prevention and control. These were mentioned to the registered manager during the inspection to address.

We found staff were recruited safely although some documentation could be improved regarding the decisions made. For example, when it was difficult obtaining a reference from previous employers or when there were minor issues on disclosure and barring service checks but employment was to go ahead.

We found people received their medicines as prescribed. Medicines were obtained, stored, administered and recorded appropriately.

We found people's health care needs were met. They had access to a range of community health care professionals when required. When people required closer monitoring due to their nutritional intake or risk of developing sores, this was completed consistently.

We found the registered provider worked within the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS] with regards to making applications to the local authority when people who lacked capacity were deprived of their liberty. Staff had a good understanding of the need to obtain consent from people prior to delivering care and support.

People liked the meals provided to them and there was sufficient quantity and choice available. Staff

supported people to eat their meals in a sensitive way when required. We saw there was plenty of drinks and snacks available in between meals.

Staff had received training in how to safeguard people from the risk of harm and abuse. They knew who to raise concerns with.

We saw staff had developed good relationships with people who used the service and treated them with dignity and respect. We saw people had their needs assessed prior to admission. This was added to when people were admitted to the service and plans of care were produced so staff had guidance in how to deliver care that met their preferences and wishes.

We saw people participated in a range of meaningful activities to promote their interests and help prevent them from feeling isolated in the service. Staff also helped them access community facilities.

Staff had access to a range of training in order to meet people's needs. They also received induction, supervision, support and appraisal in order for them to feel confident when supporting people. There was a system to identify when refresher training was required.

There was a quality monitoring system in place which included audits and questionnaires. This helped to identify shortfalls so action could be taken to address them. People told us they felt able to complain and staff had a policy and procedure to provide guidance when complaints or concerns were raised with them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There was a gap in staffing numbers at specific times which could potentially affect the needs of people who used the service. This was being addressed by the registered provider. Staff were recruited safely.

Although the service was clean and tidy, there were some issues with infection prevention and control regarding the storage and use of some items. The registered manager told us they would rectify and monitor this.

People received their medicines as prescribed.

There were policies and procedures in place to guide staff in safeguarding people from the risk of abuse and harm. Staff had completed safeguarding training and knew how to raise concerns.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were met and they had access to a range of health care professionals when required.

People liked the meals and they had plenty to eat and drink; the menus provided choice and alternatives for them.

People were able to make choices about aspects of their lives and when they were assessed as lacking capacity for this, the registered provider acted within the principles of the Mental Capacity Act 2005.

Staff had access to training, supervision and support to help them feel confident when supporting people.

Is the service caring?

Good

The service was caring.

The staff approach when supporting people was observed as kind, patient and caring.

People's privacy and dignity was respected and staff supported people to maintain their independence skills as much as possible.

Confidentiality was maintained and personal records held securely.

Is the service responsive?

Good

The service was responsive.

People received care that was tailored to their specific needs. Assessments were completed and care plans were produced in a person-centred way which helped to guide staff in how to support people in the way they preferred.

There was a range of activities provided which helped people to have meaningful occupation and stimulation.

There was a complaints procedure and people felt able to raise concerns in the belief they would be addressed.

Is the service well-led?

Good

The service was well-led.

There was a quality monitoring system in place which helped to identify areas of concern so issues could be addressed quickly.

The culture of the organisation was open which enabled people to speak out and raise concerns with the registered manager and registered provider.

Ivanhoe Residential

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 registered 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 unannounced inspection took place on 18 and 19 February 2016 and was carried out by one adult social care inspector.

Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection, we spoke with the local safeguarding team and the local authority contracts and commissioning team for two local authorities regarding their views of the service. We also spoke to a health care professional who visited the service. There were no concerns from any of these agencies.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with four people who used the service and one relative. We spoke with the registered provider, the registered manager, the deputy manager, three care staff and an activity co-ordinator.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to them such as accidents and incidents and the medication administration records (MARs) for 21 people. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf. We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, the training record, the staff rota, supervision logs, minutes of meetings with staff, relatives and people who used the service, quality assurance audits, complaints management and maintenance of

equipment records. We looked around the service to make sure it was clean and tidy.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they liked living at Ivanhoe and that it was clean and tidy. They said staff responded in a timely way when they pressed the call bell. Comments included, "They [staff] are there quickly day and night", "They [staff] do treat us well", "I'm very happy here" and "They [staff] come and clean my bedroom; there are no smells at all."

People told us staff treated them well and were kind and caring. We spoke with staff about how many of them were on duty during the day and night. There was a care team supervisor on duty from 6am to 6pm every day, three care workers from 6am to 2pm and one care worker from 7am to 12pm. The afternoon and evening shift went from 2pm to 10pm and consisted of three care workers. At night there were two care workers on duty. There were additional staff for domestic, laundry and catering tasks in the mornings and an activity co-ordinator worked 10 hours a week. The registered manager and deputy manager were supernumerary to the staff rota but assisted with caring tasks when required. Between Monday and Friday, there was an additional catering member of staff on duty between 4pm and 6pm to prepare the evening. Care staff completed this task at weekends which potentially left the service short of staff to oversee the people who used the service. The registered provider told us they were reorganising the staff rota to ensure the additional catering member of staff worked 4pm to 6pm, seven days a week, to prepare the evening meal.

We found staff were recruited safely and in line with the registered provider's policy and procedure. Employment reviews were carried out including disclosure and barring service (DBS) checks, obtaining references, looking at gaps in work history and an interview to assess the candidates' suitability to work in care homes. There were some instances when the start date of employment was prior to the return of the full DBS check but the new employees worked alongside experienced staff during this induction phase. The registered provider confirmed the new staff were not allowed to work alone with people who used the service until the full disclosure was returned. Any issues identified on DBS check were discussed with the registered provider who made a final decision about employment, although in one instance we were unable to see this had been recorded. There had also been an issue regarding obtaining a reference for one person despite several attempts by the registered manager. The registered provider adjusted the recruitment policy promptly to take account of minor issues identified during the inspection.

We saw communal areas and bedrooms were clean and tidy. A social care professional told us the service always appeared clean and tidy and had no unpleasant odours. However, there were some areas of the service that required attention to ensure good infection prevention and control. These included how some items such as linen, catheter night bags and bed rail protectors were stored, how some items were laundered and the system for cleaning commode pans. Some bathrooms and toilets had foot operated clinical waste bins but not all. We also found some wheelchairs in need of cleaning. These points were mentioned to the registered manager and some were addressed on the day. The registered manager told us they would add the wheelchairs to the cleaning schedule and the room identified as a sluice was tidied and the toilet fixed. The policy and procedure for cleaning commodes was to be adjusted to reflect practice in the service.

Risk assessments were completed to guide staff in how to keep people safe and minimise the risks associated with specific activities of daily living. These included areas such as moving and handling, falls, pressure areas, nutrition, swallowing difficulties and the use of equipment such as bedrails. We saw one person who was a recent admission to the service did not have a risk assessment for pressure areas when there was a risk of them developing sore areas. This was mentioned to the registered manager who completed the documentation straight away.

We found people received their medicines as prescribed; we observed a member of staff administering medicines to people and this was completed in a calm and professional way. They wore a tabard which reminded other staff not to disturb them during the medicines round. Medicines were stored appropriately in two secure trolleys, one of which was held in the staff room and the other in the dining room. There was no sink where the trolleys were stored but staff used a nearby facility for hand washing. The staff room was small, which could present a risk of overheating in the summer months and affect the correct temperature for medicines storage. However, we were told by staff they monitored this situation and placed a fan in the room to keep it cool.

There was a policy and procedure to guide staff in how to safeguard people from the risk of harm and abuse. Staff completed safeguarding training and in discussions were familiar with the different types of abuse, the signs and symptoms which may alert them to concerns and how to refer an allegation to the appropriate agencies.

We found the environment was safe and there were systems in place for dealing with emergencies. There were first aid boxes, which were checked to make sure items used were replaced and each person who used the service had a personal emergency evacuation plan. Equipment used in the service was checked and maintained. All staff were responsible for highlighting any issues which needed repair or replacement and maintenance personnel completed a series of environmental checks; they kept a log of all tasks identified and signed it when they had been completed. These included wheelchair tyres, light bulbs, batteries on fire alarm exits, fire zone tests and hot water outlets. All windows had restrictors on to prevent them opening wide and posing a risk.

Good

Is the service effective?

Our findings

People told us they were able to see their GP and community nurse when required. They also told us they enjoyed their meals and were able to make choices about aspects of their lives. Comments included, "They get the doctor straight away and yes, I get my tablets on time", "I see my doctor, the chiropodist and my hairdresser", "I can do whatever I want, get up and go to bed when I choose – it's my choice", "Yes, I have choices; I like to lie down in the afternoons as my back aches", "The food is smashing; there is plenty to eat and they ask you if you want any alternatives", "The food is lovely", "I like the food" and "The meals are fine; there are no problems there."

A visitor told us they couldn't praise the staff enough and said he was always kept informed about issues that affected his relative. He told us how there had been contact with the person's GP to discuss medicines and he had been involved in decisions.

We found people had access to a range of community health care professionals such as GPs, community nurses, speech and language therapists, dieticians, dentists, emergency care practitioners, chiropodists and opticians. Staff recorded when people had appointments with health care professionals and any advice or treatment prescribed. In discussions, staff were clear about when to contact health professionals for advice and guidance; they gave examples of the signs and symptoms that would alert them to a person whose health was deteriorating.

We found people's nutritional needs were met. People who used the service had their nutritional needs assessed during the admission process; this included their likes and dislikes, and any swallowing difficulties. Risk assessments were completed and people were weighed in line with the result. Dieticians were involved when required and staff were aware of the referral system. Menus provided choices and alternatives and we observed drinks and snacks were available throughout the day. Special diets were catered for. We observed the lunchtime experience for people on the second day of the inspection. The dining room was light and airy and tables were set out to seat four people at each; there were special dining chairs with wheels and brakes to assist staff when positioning people at the table. People had clothes protectors and plate guards when required. The meal provided looked well-prepared and well-presented and people enjoyed it. Staff supported specific people to eat their lunch by sitting next to them at the table and providing support at a pace which met their needs. We saw some visitors were included and assisted their relative to eat their lunch.

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. We saw assessments of capacity had taken place and best interest meetings held for specific people and particular issues. Assessments and care plans had a 'decision making' section, which detailed the support the person required in making their own choices. In discussions with staff, they had an understanding of MCA and the need for people to consent to care provided. Staff said, "We use care plans for

information and guidance", "We would ask people if it's ok. [Person's name] can't speak but we still give explanations; we know when they don't want to do something" and "We ask people, reassure them and tell them we are there to help. If they decline care we would go back later – sometimes that works."

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 saw the registered provider was working within the principles of the MCA and DoLS. We saw applications for DoLS had been made for specific people but they had yet to be assessed and authorised by the local authority. We saw an email that the registered provider had sent to the local authority which asked for an update in the DoLS assessments; the registered provider told us this would be chased up at intervals until decisions were made. We found staff had completed basic training in MCA and DoLS and had been given prompt cards by the registered provider so they had the main principles to hand. The registered manager is to keep the Care Quality Commission informed of DoLS authorisations.

We saw staff had access to training to enable them to feel confident in their roles. The deputy manager had overall responsibility for maintaining the training plan and records. Documentation indicated staff had completed training considered as essential by the registered provider. This included fire safety, moving and handling, food hygiene, health and safety, infection prevention and control and safeguarding people from abuse. Staff who administered medicines had completed training and most staff had completed a dementia awareness course and equality and diversity. Some staff had also completed training in behaviours that could be challenging, oral health care and care of substances harmful to health. Two staff had completed end of life training. The training was a mixture of external facilitators, in-house training, practical sessions, and watching DVDs with questionnaires. There was a system for identifying when training required updating. The training records showed that out of 22 care staff, five had achieved a recognised health and social care qualification and 11 were registered on the courses. Four staff had completed a leadership course. There was a large notice board in the conservatory which acted as training resource for staff and included information on dementia care, nutrition, dignity, infection prevention and control, end of life and pressure area care.

We saw staff had access to formal supervision meetings and ongoing day to day supervision and support. There was a structured plan of supervision and appraisal which was completed by the deputy manager and registered manager. The deputy manager told us formal supervision meetings were a little behind but all care staff had had one supervision session since December 2015. Staff spoken with told us they felt supported by the registered manager, deputy manager and care team supervisor. They confirmed they had received a formal supervision session. Comments included, "It really is a nice home to work in", "Support is really good", "You can go to the office anytime" and "Yes, I have had supervision and my appraisal is soon."

We found there had been some adaptations to support the needs of people who used the service. For example, there were grab rails in corridors, toilets and bathrooms and raised toilet seats. On the ground floor, toilet doors were painted yellow as a memory aid for people living with dementia; the registered manager told us the toilet doors on upper floors were also going to be painted yellow. There were words and symbols on the toilet doors. All doors had closures which were linked to the fire alarm system. This enabled them to be left open so people with mobility aids could pass through independently but they would close when triggered by the fire alarm. We found bedroom doors could have names and information on them to aid people living with dementia to recognise their own room. This was mentioned to the registered manager to review.

Good

Is the service caring?

Our findings

People spoken with were complimentary about the staff team. They said staff were caring and treated them in a kind way. Comments included, "The staff are brilliant, they knock on doors and wait for me to shout come in", "They always make sure my teeth, nails and glasses are clean", "I have two to three baths a week; you can have whatever you want", "I can't think of any improvements, they do everything possible", "The staff are really nice", "Yes, I like it here; I'm quite happy with everything" and "The staff are all ok with me." A relative said, "The staff are absolutely great, wonderful in fact; I can't praise them enough" and "I come here three times a day and they always ask me if I want a cup of tea."

We observed positive staff approaches and interactions with people who used the service. They provided explanations to people prior to tasks being carried out and ensured they had enough time to respond to questions asked of them. For example, we observed a member of staff talking to one person about their lunch. They had decided they didn't want the choices on offer when they arrived so they went through options with them until the person found something they liked. We also observed another member of staff speak to a person in a caring and compassionate way and adjust their clothing for them following removal of a clothes protector used at lunchtime.

A social care professional told us they had completed three care reviews recently at the service and the families were all very happy with the support people were receiving. They advised the review for one person was attended by an advocate and another by a continuing health care professional, who were both also happy with the care and support the people received.

In discussions with staff, they were clear about how they would promote privacy and dignity and how they supported people to remain as independent as possible. Comments from staff included, "We keep people covered when supporting them and explain what you are doing", "Make sure people have clean clothes and offer to wash food from their faces after meals if they need it; offer clothes protectors too", "Make sure people have choices and ask them if they want a hot or cold drink rather than just a cup of tea", "Knock on doors and introduce yourself and ask if it's ok to do personal care. Give people what they want to wash themselves with; some people are able to wash themselves with a little help" and "We ask people and don't just do things to them." We observed there were privacy screens between the beds in those rooms which had shared occupancy.

We saw people were kept informed about issues within the service. There were notice boards providing information on the menu of the day, pictures of the staff team that were on duty, the activities planned each day and training that staff had planned/completed. There were leaflets available, for example on advocacy. The registered manager told us one person had support from the advocacy service at a recent review of their care. On admission to the service, people were provided with a welcome pack which included the service's statement of purpose and service user guide. There was also information on the complaints procedure, decision making, assessments, care plans, reviews of care and a sample of the menu.

There were notices at various points in the service reminding people that Ivanhoe was their home. For

example, these stated, "This is your home – we want you to be happy here" and "Tell us if you see bad practice." There were also notices reminding staff of the six 'Cs' felt important by the registered provider. These were care, compassion, communication, competence, courage and commitment. We saw staff were completing a charity run to raise funds for outings for people who used the service.

The registered manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. People's care files and medication records were held in the care staff office which was lockable when not in use. A care team supervisor told us telephone calls to and from relatives or health and social care professionals were taken in this office to ensure the conversations were not overheard. Staff personnel files and training records were held securely in lockable cupboards in the registered manager's office. We observed the registered manager locked their office when it was not in use. The deputy manager confirmed the computers were password protected to aid security. The deputy manager confirmed the service was registered with the Information Commissioner's Office, which was required when records were held electronically.

Good

Is the service responsive?

Our findings

People we spoke with told us they could participate in activities when they chose to and also that they would feel comfortable raising concerns with staff. Comments included, "I enjoy the bingo, hoopla and skittles, and I put a bet on each week", "I would see the manager; I have no worries about this [raising a complaint]. Up to now I have had none", "I have no complaints at all; if I had I would go to the office", "A relative said, "I have no complaints but yes, I would complain to [registered manager's name]."

We found people had assessments of their needs prior to admission to the service. This helped staff decide whether the service was able to meet their needs and whether there were any concerns they needed to be aware of. The assessment was revisited when the person was actually admitted to the service. The care files we looked at all had comprehensive assessments that detailed information about people's needs and preferences for how care should be provided to them. The assessments included what the person could do for themselves to help staff recognise and maintain their independence skills. We saw each section of the assessment included the person's own view of their needs. This showed us people were involved in the assessment process and their views were important. The assessments included comments such as, "I like the door ajar and the small light on [at night]" and "I like to get up when I'm ready." They also included preferences for food, likes and dislikes.

The assessments and risk assessments were used to by senior staff to formulate plans of care that were person-centred. These were to guide care staff in how to best support the person to meet their needs and preferences for care provision. We saw the care plans included the full range of assessed needs. They prompted staff to ensure people continued to do as much as possible for themselves when they were able to. One of the care plans we saw reminded staff of the person's spiritual needs and how these were met each week. It described daily routines and the social activities they preferred to participate in. The care files contained a body map when any marks were noted during personal care. There were monitoring charts for people who required additional support, for example, pressure relief and food and fluid intake. These were completed consistently by care staff. A social care professional said, "The support plans are good and up to date."

There was a document in each person's care file called, 'What's important to me'. We saw for one person this indicated which newspaper they preferred, that they liked to read the horse racing pages and enjoyed a 'flutter'. We spoke with the person and they confirmed staff supported them to do this in practice. We also saw the person was reading the newspaper of their choice.

We found there was an activity co-ordinator on duty for 10 hours each week and they completed group and one to one sessions with people; they were very enthusiastic about their role and told us they got a lot of pleasure from seeing people join in activities and enjoy themselves. In discussions, they told us this could be extended if there was a specific activity they were completing with people. They also said that every few months they visited each person who used the service and checked what they wanted to do in the way of social activities. A log was maintained of activities and each person had their own profile, for example, this included favourite pastimes, clubs, their level of ability and support required. There was a range of activities

people could participate in which included painting, manicures, movement to music, dancing, dominoes, baking, foot spas, bingo, darts, play your cards right, visiting entertainers and theme nights such as 'racing' and 'pie and peas'. We saw two people took comfort from doll therapy. There were times when people accessed facilities in the local community such as parks and shops. The activity co-ordinator told us staff held a summer fayre last year to raise money for a trip to Filey which six people enjoyed. Five people went to Hull Fair last October and others enjoyed a sample of the fair at the service the next day with sweet treats and games such as 'hook a duck' and skittles. The activity co-ordinator maintained a mobile shop with sweets, crisps and toiletries for those people who did not wish to venture out.

There was a memorabilia notice board which was completed by the activity co-ordinator following discussions with people who used the service. We saw the one for February focussed on St Valentine's Day where people who used the service had provided their memories of what the day meant to them. The activity co-ordinator also held a cleaning club for those people who wished to participate. This included folding napkins, cleaning brass, and drying and polishing tea spoons. One person wanted to use a carpet sweeper so this was purchased for them to use. A social care professional said, "The home has a good activities routine with outings booked throughout the year and thought is given to the number of people in wheelchairs and they are all given the opportunity to access trips."

There was a complaints procedure which was displayed in the service. This described how people could make a complaint and how to escalate it if required. The staff had access to a complaints policy and procedure to guide them in how to manage complaints. This included letters for acknowledgement and forms to record the details of the complaint, investigation and outcome.

Good

Is the service well-led?

Our findings

People who used the service and their relatives knew the registered manager's name and how to raise any issues or concerns with them. One person told us they had completed a survey to express their views about the service.

We found the registered manager and staff within the service worked well with other agencies such as district nursing team and care management teams. There were positive comments from the external teams about them.

We spoke with the registered provider and the registered manager about the culture of the organisation. The registered provider was involved with monitoring the quality of the service. They visited two to three times each week to support the registered manager. They advised they developed a deputy manager post and filled this in December 2015 to ensure support for the registered manager and also so time could be devoted to management tasks such as supervision meetings, quality monitoring and training analysis. The registered manager and deputy manager both spoke about the main focus as being the people who used the service and being available for staff, leading by example, being 'hands on' and maintaining confidentiality. The registered manager spoke about the importance of respecting diversity, team work and having an open-door policy; they helped to complete shift work when there were short notice staff absences. Staff spoken with confirmed the registered manager and registered provider were supportive and they were able to raise issues with them when required. Comments included, "There is an open-door policy; you can go to the office anytime", "We can raise concerns with [registered provider's name]; they respond and do visits. The area manager also does visits; they do the training for the care certificate as well" and "The service users seem happy; I love working here."

Staff were provided with a handbook which explained what was expected of them and contained specific policies and procedures such as whistle blowing and equal opportunities. There was also a staff operational handbook with codes of conduct. The registered manager told us the registered provider gave £450 to each of their services each year to distribute to staff for an incentive to good practice.

There was an annual quality monitoring system in place which consisted of audits, and surveys where people could express their views. The plan for the year consisted of identifying regulations and the actions required to meet them. It identified who was responsible, timescales for completion and expected outcomes. We looked at the information collated for several months in the previous year. This showed people who used the service were asked to complete questionnaires on areas such as activities, complaints, meals, how safe they felt, care plans and key working. Relatives, staff and visiting professionals were also asked to complete surveys. Audits were completed on medicines management, people's personal allowance, records such as care plans and training, the general environment including the kitchen, and infection prevention and control. The medicines were also checked on a regular basis by senior staff when they completed them. Any gaps were highlighted and a message left for the member of staff to record why any medicine had been omitted.

The registered manager completed daily checks such as administration issues, monitoring domestic staff had completed tasks by checking communal areas were clean and safe, ensuring people had easy access to drinks and liaising with senior staff for any outstanding issues. There were also weekly tasks identified such as the audits and staff supervision meetings. There were daily and weekly tasks identified for maintenance personnel and cleaning schedules for catering and domestic staff.

We saw action was taken when issues were identified. We observed some areas of environmental monitoring had been overlooked during recent audits. These areas were mentioned to the registered manager and addressed straight away. They were also added to the audit documentation so they would not be overlooked in the future. We saw reflective practice had taken place which had resulted in a change of policy and procedure following an incident at another of the registered provider's services. This showed there was scope to learn from incidents and to ensure practice was improved.

The registered provider told us that information from audits and questionnaires were sent to them in order to develop an annual business plan each year. The business plan had aims and objectives and was linked to the five key questions the Care Quality Commission checks on inspections. The registered provider told us they had meetings with the registered manager to ensure their tasks were completed.

There were meetings and shift handovers to ensure staff had up to date information about issues affecting the service and people who lived there. Staff were able to participate in the meetings, express their views and make suggestions. There were also meetings for people who used the service. There were pre-meeting questionnaires for people to complete so that issues could be raised by them and discussed.

We saw the registered provider and registered manager were aware of their responsibilities in notifying the Care Quality Commission and other agencies when incidents occurred that affected the safety and wellbeing of people who used the service. We received these notifications in a timely way.