Sanctuary Care Limited

Beach Lawns Residential and Nursing Home

Inspection report

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10 November 2016
11 November 2016

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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

Beach Lawns Residential and Nursing Home is registered to provide accommodation and nursing care for up to 82 people including those who require respite and short term care after a stay in hospital. The service specializes in the care of older people and is divided into four units. Suite A and B are residential units for people not requiring nursing care. Memory Lane is a dedicated unit for people living with dementia and Sandford is for people who require nursing care. Most people in Sandford and Memory Lane have limited communication skills. At the time of our inspection there were 80 people living at the home, but two were in hospital. The home is a large building over three floors with a range of bedroom sizes. There are communal lounges and dining rooms in each unit. Since the last inspection Memory Lane had been refurbished and other units were in the process of being redecorated.

This inspection was unannounced and took place on 9, 10 and 11 November 2016.

Since the last inspection there had been a change in 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. The current registered manager had been in post since July 2016. They were supported by a deputy manager.

At the previous inspection, in August 2015, we found concerns with the level of staff to meet people's care needs. Following this inspection the provider sent us an action plan including how many staff should be on duty and changes they had made to ensure there were enough staff. During this inspection we checked these changes and the level of staff had improved. We found there was now a suitable amount of staff to support the people at the home. Improvements had been made to the allocation of staff. For example, staff now had additional time to complete paperwork. When people's needs changed the service was responsive and an increase in staff was made.

People told us they felt safe and we saw evidence most were. Some improvements were required with the way medicines were managed and one person was not transferred safely. Some guidance provided for staff for 'as required' medicines needed to be reviewed to ensure there was consistency across the home.

Staff had good knowledge about most people's needs. Care plans were in place for all people including those who had recently moved into the home. The majority of these were detailed and were updated regularly.

Most people's care needs were met because staff received regular support and training. People requiring specific diets received them and staff understood about them. People had a choice of meals, snacks and drinks, which they told us they enjoyed. People's choices and religion were supported and respected by staff.

People were supported by staff who had undergone a safe recruitment procedure. Staff knew how to recognise and report abuse. They had received training in safeguarding adults from abuse and knew the procedures to follow if they had concerns.

People were supported by sufficient staff to enable them to take part in a range of activities according to their interests and preferences. The registered manager was currently recruiting more staff because they had identified people's needs were changing.

People's health care needs were monitored and met because staff made sure people saw health professionals when it was required and implemented any recommendations made which people agreed to.

Staff and the registered manager had understanding about people who lacked capacity to make decisions for themselves. People had records and we saw the principles being put into practice. Staff understood about Deprivation of Liberty Safeguards (DoLS) and the process to follow to make sure people's human rights were respected.

People and their relatives thought the staff were kind and caring and we observed positive interactions. People's privacy and dignity was respected. When people were nearing the end of their lives they received personalised support from staff.

Audits were being completed by the registered manager and provider to identify shortfalls. When shortfalls had been identified the registered manager resolved them. People were informed of changes made in line with concerns raised. There were systems in place to manage complaints and the registered manager demonstrated a good understanding of how to respond to 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?

Good

The service was safe.

People were supported by enough suitably trained staff to meet their needs.

People could expect to receive their medicines as they had been prescribed.

People had the risks of harm minimised because staff understood the correct processes to be followed if abuse was suspected.

People were protected from the risks associated with poor staff recruitment because a safe recruitment procedure was followed for new staff.

Is the service effective?

Good

The service was effective.

People's rights were respected, and staff were following the principles of the Mental Capacity Act. People's choices were respected.

People benefitted from good medical and community healthcare support.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

People were supported staff who had the skills and knowledge to meet their needs.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People were able to exercise their religious beliefs. Visitors were

welcome at any time, and people's routines were personalised to allow this.

People's privacy and dignity were respected and supported.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were reflected in their care plans and understood by staff.

People benefitted because staff made efforts to engage with people throughout the day. New activities were being developed in accordance with people's interests.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Good

The service was well led.

Changes had been put into place following the last inspection to make improvements.

People were being kept safe because most notifications were made in line with legislation. Where concerns were identified during the inspection the registered manager took immediate action to address them.

Most people had their care needs met and were kept safe because the provider and registered manager had quality assurance systems in place.

People benefitted from living in a home where the provider and registered manager had a clear vision which was communicated to staff and relatives. Staff understood the clear lines of accountability.

People and others were able to make changes at the home as they were consulted about their views on how the service could be improved.

Beach Lawns Residential and Nursing 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 9, 10 and 11 November 2016 and was unannounced. It was carried out by one adult social care inspector and a specialist advisor nurse. The specialist advisor nurse had a background in and experience of working with older people.

At the time of this inspection, the provider was in the process of completing a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the previous PIR, spoke with other health and social care professionals, looked at the action plan from previous inspection and looked at other information we held about the home before the inspection visit.

We spoke with seven people that lived at the home in detail, three relatives and a health professional. We also had informal conversations with people at the home as we walked around and completed the inspection. We spoke with the registered manager, regional manager, deputy manager and 11 members of staff including nursing staff, activities staff and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people could not talk with us.

We looked at 16 people's care records and observed care and support in communal areas. We looked at five staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints and complements files, staff and resident meeting minutes, medication files, people's questionnaires, environmental files, activity records, person information guide, statement of purpose,

provider internal communication documents and a selection of the provider's policies.

Good

Is the service safe?

Our findings

At the last inspection, in August 2015, concerns were found with people not being supported by enough staff. As a result, call bells were not always answered quickly, some of the service was dirty and paperwork was incomplete. Following the last inspection the provider sent us an action plan to demonstrate changes which were taking place. This included ensuring a set amount of staff were working and how staff's work was allocated. At this inspection improvements had been made for staffing.

At this inspection we found people were now supported by a sufficient number of staff. People said, "Always seem to be staff", "Think there must be enough staff" and "There is enough staff". Other people told us, "Have to wait a little while if busy" and "I think there should be more for their sake". A health professional told us "They [meaning staff] are definitely very busy but the care has definitely improved, staff are very responsive". Staff members had a mixed opinion about whether there was enough staff. One staff member told us the registered manager had spoken with their unit and was about to put an extra member of staff on shift; the registered manager and regional manager confirmed this change. Other staff told us they had dedicated times to complete paperwork which meant they could concentrate on people's care at other times. Call bells were all answered promptly. The registered manager was regularly monitoring them as part of their continued work on staffing levels. At night additional checks on whether call bells were in reach was being completed by the nurses. We saw rotas which reflected the staff levels stated in the action plan. The service was clean throughout because there were enough staff to maintain high standards of cleanliness.

Care plans contained risks assessments which outlined measures in place to enable people to take part in activities with minimum risk to themselves and others. Others risk assessments were in place to reduce the likelihood of pressure sores, falls and malnutrition. Staff were aware of these risks and how to reduce them.

Prior to this inspection we had received concerns about the way staff supported people with poor mobility with transfers. Most people told us they had been supported appropriately when they needed help transferring from one place to another. Staff promoted independence. All walking aids were kept close to people so they could move around without assistance. However, one person was at risk of injury when two staff supported them inappropriately whilst transferring them between an armchair and wheelchair. The Registered Manager arranged for the two staff members to attend refresher training in moving and handling on the last day of the inspection as the provider had also identified the poor transfer technique. Separately, other care home staff members, who had witnessed the incorrect transferring of the person had informed them.

Most medicines were managed well. Some guidance provided for staff for 'as required' medicines needed to be reviewed to ensure there was consistency across the home. There were ten occasions when additional medicines had been added or removed from the records by hand with no accompanying note from the doctor. This meant there was no guidance from the prescriber the changes were correct and authorised. For example, one person had a medicine to improve bowel movements with the instructions "Please give regularly", but nothing specific.

Most medicines were stored in suitable storage facilities including secure storage for those requiring refrigeration. Staff used printed medication administration records. These records included the person's preferred name, a risk assessment for each medicine administered and a record if there were any swallowing difficulties. By having these details it helped staff to follow people's preferences. All medicines entering the home from the pharmacy were recorded when received and when administered or refused. Records and stock relating to medicines that required additional security and recording were appropriate and correct.

People's medicines were administered by staff who had their competency assessed on an annual basis to make sure their practice was safe. The registered manager and deputy manager supported all staff and training had been provided.

People told us they felt safe at the home and with the staff who supported them. When we asked people if they were safe they said, "Yes I feel safe", "Yes" and "I like to feel I am safe. Yes". When relatives were asked if people were safe they said, "Yes" and "No question about that".

Risks of abuse to people were minimised because there was a recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. Staff told us and records confirmed they had not started work until their references and checks had been completed. The registered manager and the PIR told us the provider had a good system in place which flagged up if any staff checks were due.

Staff told us, and records seen confirmed all staff received training in how to recognise and report abuse. For example, some staff were able to tell us about changes in people's behaviour as a potential sign. One member of staff said a person would become "More agitated. More fretful. Moods would change". All staff were confident any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Good

Is the service effective?

Our findings

At the previous inspection, in August 2015, people sometimes missed medical appointments due to staff shortages; at this inspection this was no longer the case. People told us they always attended their medical appointments. One person was supported to visit a family member in hospital. There were always qualified nurses on duty in Sandford to make sure people's clinical needs were monitored and met. In all other units the district nurses visited regularly. One person said, "A doctor and nurse have come around". We saw another person had dressings changed by the district nurse. During the inspection the registered manager had arranged for the local doctors surgery to provide people with the flu vaccination.

People with specific health conditions, such as diabetes, had specialist health professionals involved in their care. Staff had regular contact with specialist nurses and doctors. Other health and social care professionals were involved in people's care. For example, some people had recently seen a physiotherapist to assess their mobility needs. By involving a range of health and social care professionals people's needs were being met.

People received effective care and support from most staff who had the skills and knowledge to meet their needs. Staff told us, and records showed they had received a range of training. One staff member said, "I have been on a dementia course". Other staff told us about training for moving and handling and supporting people with behaviours which can challenge. During one lunchtime there were occasions some staff supporting people with their meals started to have conversations with each other rather than involving people. These staff told us they regularly supported people with their meals but had not received training in providing mealtime support; this meant they were unsure about how to support people appropriately. We spoke with the registered manager who confirmed they would complete their own observations and support the staff when assisting people with their meals.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. A new member of staff told us they had completed their induction using the Care Certificate. The Care Certificate is a set of standards created by Skills for Care which all health and social care workers should follow in their daily work. They are the new minimum standards that should be covered as part of induction training for new care workers. They had completed shadow shifts alongside more experienced staff prior to working independently.

People were supported by staff who received regular support and supervision. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. In addition, new nurses were effectively supported by the deputy manager on a regular basis. The nurses were positive about the way they were helped. All staff had received recent group supervisions. The registered manager explained as they were new they wanted to greet all the teams, find out if there were any immediate concerns and set expectations. Staff told us, and records seen, demonstrated staff had received annual appraisals. This meant staff were given feedback on their performance, any concerns could be raised and development opportunities could be planned.

Some people at the home lacked the capacity to make decisions for themselves. 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. Decisions made in a person best interest consider what the person would choose if they had the capacity. We checked whether the provider was working within the principles of the MCA and they were.

People were always asked for their consent before staff assisted them with any tasks. One person told us staff always "Get permission" before helping them. Staff told us they give options to people even if they lacked capacity. We saw staff getting approval before supporting most people. All people able to had provided consent to have their flu vaccination. When people lacked capacity the correct process had been followed to act in people's best interest.

People can only be deprived of their liberty so they can 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 conditions on authorisations to deprive a person of their liberty were being met. The appropriate applications had been made to the local authority when people were being restricted, which could result in a deprivation of their liberty. The people who had a DoLS authorisation in place contained no conditions the home had to follow.

People told us and we saw they liked the food which was being served. One person said, "Can't fault food" and continued to explain they choose on the day when staff "Tell us what is on the menu and tell us any extras". Other people said, "Good varied diet" and "Always get bowls of vegetables. Can choose which one you want. Eat as much as you like. Nice to help yourself". All people told us they would get an alternative meal if they did not like the options. A relative told us, "Food is always edible" and a health professional said, "The food is very good and nutritious". A member of staff said, "[Staff] go round in the morning with menu for lunch and tea". In Memory Lane people were shown the options they could choose from at the time of the meal. This was important because they may not remember what they had ordered earlier in the day.

At lunch time we saw people were able to choose when and where they ate their meal. For example, some people sat in the lounge, some in their bedrooms and some in the dining areas of the units. If people required support this was provided by members of staff and relatives. Nibbles were provided at tables whilst people were waiting for food; this included crisps, pickled onions and pieces of cheese. Unless a person required a modified diet all vegetables were placed in serving dishes so people were able to help themselves. For people with modified diets the food was already prepared and served on one plate. The registered manager wanted people to have options and encouraged people to try different things.

People who were at risk of malnutrition and dehydration had their needs met. For example, several people living in Memory Lane had detailed food and fluid charts. People were receiving enough fluid because their records demonstrated significant fluid intake.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. One person said, "Wonderful, wonderful. Young ladies who work here absolutely wonderful. They care for you". Whilst others said, "All very nice to talk to. All very kind. All very good to me", "So kind and gentle", "Very good care staff" and "Looked after too well". A member of staff told us "It is their [meaning the people's] turn to be looked after"

Most of the time staff greeted people as they walked into rooms and demonstrated kind and caring responses. For example, one member of staff came in a lounge and said to a person "You look lovely in purple". Whilst another member of staff assisted someone with their medicine. Prior to administering the medicine they said, "Good morning [name of person]". We saw a few occasions where members of staff would walk into a room or through a room and not acknowledge people. For example, when one member of staff was busy completing another task and they did not greet other people in the room.

People's privacy was respected and all personal care was provided in private. A person told us staff, "Always tap on the door. Nobody ever walks in unless they are asked". All staff knocked on people's doors before entering. Members of staff were able to tell us how to protect someone's privacy and dignity when supporting them with more intimate care. For example, one staff member told us they always, "Shut the door and curtains". Whilst other members of staff explained they put towels across certain parts of people's bodies. By protecting people's modesty they were demonstrating respect for their privacy and dignity.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. During the inspection we saw people had visitors in their bedrooms with the door open or closed. For people who were unable to have their relatives visit there was an option of using a telephone. Another person had their meal prepared early so they could eat prior to their family member visiting. This meant staff facilitated visits by personalising the person's daily routine.

People made choices about where they wished to spend their time and the care they received. One person told us they preferred their own company and this was respected. Another person said, "I Get asked my choices". A member of staff told us they "Give options". Some people preferred not to socialise in the lounge areas and spent time in their bedrooms. When an activity was due to begin people were asked if they wanted to join in. Those who did were supported to the correct part of the building by staff. Often they were encouraged to walk independently whilst staff sang to them in encouragement. People laughed, smiled and joined in these songs as they were moving. One person stopped to tell us how much they enjoyed this.

Staff were aware of issues of confidentiality and did not speak about people in front of others. The registered manager took us aside or into a room with a closed door when they needed to speak about sensitive information. When all staff discussed people's care needs with us they did so in a respectful and compassionate way. A member of staff told us two staff had been allocated to check people's dignity and privacy was respected. The staff member said, "They are eyes and will pick up on things then report at [daily] meetings". This was so any areas for improvement could be addressed by senior staff.

People had individualised end of life care to meet their preferences and provide dignified care. The registered manager made sure anyone nearing the end of life had someone with them. If the person's family were not present then a member of staff would sit with the person. Other staff spent time finding out each person's preference. For example, a member of staff knew for one person an activity they had participated in supporting local children at a church group was important. They went and filmed all the children giving messages to the person. This was played through the person's television in their bedroom. They sat up to watch the television and at the end turned to the staff to say "Thank you". Another person was shown pictures and sounds of places they had visited as a young person.

Good

Is the service responsive?

Our findings

Care plans were in place for all people including those who had recently moved into the home. The majority of these were detailed and were updated regularly. A small number of these required some additions such as poor eyesight being noted in mobility and communication plans and use of specialist equipment.

One person had changes in their support needs and their care plan was not always updated. They had recently been assessed by a physiotherapist as requiring a higher level of support and a different routine. The person still had information about using a different piece of equipment which did not match their new needs. We spoke with the registered manager and regional manager who revised the person's care plan.

When people's needs changed staff adapted the care provided. For example, one person had become unwell in Memory Lane. Staff identified this even though the person was unable to verbally communicate. Care was then provided in line with the person's new needs. There was a daily meeting where senior staff shared important information and any changes to people. A member of staff told us "There are meetings every day and they [meaning the senior staff members] come back and tell us everything". We saw one of these meetings and changes or concerns about people were identified along with actions required or completed. By being responsive to people's changing needs they were seeking appropriate advice and care to meet their needs.

Each person had an assessment before they moved into the home to make sure their needs and expectations were met. Most care plans showed there had been involvement of the person and others important to them such as family members and health and social care professionals. By involving people and others close to them in their pre-admission assessment it meant people's needs could be understood, care needs met and necessary risk assessments put in place. It also meant for those who had difficulty communicating their wishes, preferences and needs were understood and met by staff.

People were able to take part in a range of activities according to their interests. One person told us "I go to church on Friday morning to take communion. Staff takes me". Other people said there were "Exercise classes, music and bingo", "Something going on every day" and "Plenty of activities". We saw an activities meeting being run by people and supported by the activity coordinator. During the meeting they discussed plans for some people becoming regular volunteers at a children's church group. Some recent events with other services in the area were spoken about as well as their plans for the Christmas period. This included Christmas card making, baking, community singing group and creating a "Church" in one of the lounges for the Christmas day service. The activity coordinator told us people chose to have a service at the home so everyone could attend. They were making stained glass windows and wooden style door to make the lounge resemble a church.

People had activities personalised to meet their preferences and care needs. If people chose to stay in their bedrooms one to one activities occurred. The activity coordinator and their assistant would take art and craft equipment on a trolley. Some people would choose to sit and talk as their activity. If people had memory loss due to medical conditions they could participate in reminiscence activities on a handheld

tablet computer. This involved looking at pictures or videos of things to trigger memories. Some people were unable to leave their bedrooms due to mobility issues. The activity coordinator had developed virtual woodland walks. A person would interact with objects such as leaves and sticks whilst watching a video on the tablet computer from their bed.

There were many compliments received by the home. This included a selection of cards, letters, emails and pictures. One relative said, "Thank you to all at Beach Lawns for the wonderful care you gave to [name of person] throughout her years with you". Other relatives said, "We would like to thank all the staff involved in caring for our father [name of person]" and "We want to thank you so much for the loving and kind care you gave to mum [name of person] during her three and a half years as a resident".

The registered manager sought people's feedback and took action to address issues raised. There were regular meetings for people who lived at the home and their relatives. One person said they "Had a resident meeting last week". Another person told us they "Always tell you when resident meeting. I can go if I want to make a complaint". Records showed when people shared concerns actions were taken. For example, people struggled to understand the nursing staff because English was not their first language. The registered manager had found additional courses for some of the nurses to complete. They had recently introduced a 'You said', 'We did' poster for the communal notice board. This informed people of other changes they had made in line with their requests. For example, in the latest resident annual questionnaire the response to people not having enough snacks between meals was a basket of snacks in each lounge.

Each person received a copy of the complaints policy when they moved into the home. People said, "Got it all in paper and go by that", "Take it to main person", "I know how to complain. Never had to" and "No complaints. Know how to complain". The registered manager recorded all concerns and complaints received. They told us concerns were often verbal rather than written. It meant people and their relatives had a way to raise problems so they could be resolved in order to reduce the frequency of formal complaints. It was part of their open door approach where anyone could come and see them. All concerns had a prompt response recorded and no patterns had been identified in the analysis. The service had received one formal complaint since the registered manager began working at the home. This was managed in a timely manner including an initial acknowledgement and had a satisfactory outcome.

Good

Is the service well-led?

Our findings

People, visitors and staff spoke highly of the management and the support they provided. One person said, "The manager [meaning the registered manager] is very, very nice. Spoken to [them] on several occasions". Staff said, "The manager [meaning the registered manager] is good. Lots of support", "Both [meaning the registered manager and deputy manager] are supportive" and "[Registered manager's name] management is how a home should be run". Another member of staff told us, "[The registered manager's name] is very good" and continued "It is like having a captain to a ship. Ready to guide us".

The registered manager had a clear vision for the home to make it the best they could. They wanted to ensure all people were supported like it was home from home. A person told us the service was "Very homely". The registered manager's vision and values were communicated to staff through staff meetings and formal supervisions. A member of staff told us, "Calling residents by names" was promoted which was a change in culture from using room numbers. Another staff member said it was like "One big happy family". Others staff were able to tell us how important it was to treat the people like their parents or grandparents. The registered manager told us they wanted an open door policy so everyone could raise concerns and provide suggestions for improvement.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager was supported by a deputy manager. Staff knew they could speak with the registered manager because their door was always open. One staff member told us the registered manager "Tries to take on board" any changes they suggest. Another staff member said, "If we take something to management it is taken up". The registered manager was supported by a number of other specialists employed by the provider. For example, a regional manager who was easily contactable by telephone and a human resources department for staff issues. The registered manager told us there were monthly managers meetings for the area which provided additional support.

There were quality assurance systems in place to monitor care and plan ongoing improvements. There were audits and checks in place to monitor safety and quality of care. We saw where shortfalls in the service had been identified action had been taken to improve practice. For example, the registered manager had identified staff were not always calling people by their name, but their room number when food was served. There were new lists in place which always had people's names as well as room numbers to remind staff. Some care plans were identified as requiring changes which were completed. During the inspection when any concerns were found such as care plans not containing enough detail action was taken immediately to resolve the issue. However, the quality assurance had missed some areas which required improvement such as risk assessments lacking detail and care plans not containing all necessary information. When concerns were raised during the inspection the management and provider immediately tried to rectify them.

The provider had internal systems to support the registered manager to audit the home. In August 2016 they had introduced a new online auditing tool to support managers. They completed monthly compliance visits. During these, the regional manager would walk around the service speaking with people and staff. They would look at a range of documents and audits including a sample of people's care plans. In September

2016 the director of care completed a further compliance support visit. As a result of these provider visits the registered manager was implementing changes to the service. For example, new furniture was being ordered for different units and there was an increase in call bell response monitoring. By taking actions following the provider's visits the registered manager was proactively rectifying any concerns found.

All accidents and incidents which occurred in the home were recorded and analysed. When action was required it was taken. For example, some people had injuries from falls and they were always dressed appropriately. Every month an analysis of the accidents and incidents was carried out by the management. When patterns were identified actions were taken to reduce the likelihood. For example, the September 2016 analysis identified unwitnessed falls happened mainly at night; additional checks were put in place which reduced the accidents and incidents.

The provider had notified the Care Quality Commission of most significant events which had occurred in line with their legal responsibilities. Recent incidents and safeguarding had been notified because the registered manager had a system in place. However, there were seven DoLS authorisations which had not been notified in line with legislation. During and following the inspection the registered manager completed all these notifications.

The registered manager and deputy manager were registered nurses. They kept their skills and knowledge up to date by on-going training and reading. Both spent days working on the nursing unit to ensure their practical skills were maintained. During these days they provided additional support for other nurses on shift. The registered manager spoke about good practice with other home managers within the provider. They told us where possible they attend local provider events organised by the local authority. In addition, they will be delivering dementia training for staff working at the home.