Akari Care Limited

Dene Park House

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

We carried out an unannounced comprehensive inspection of Dene Park House on 24 and 25 July 2018. The first day of inspection was unannounced. This meant the provider and staff did not know we would be coming.

At the last comprehensive inspection of the service on 15, 16 and 20 June 2017 we identified breaches of regulation 12, safe care and treatment, and regulation 17, good governance. The provider had not fully assessed and mitigated the risks to people who used the service and infection control procedures where not always followed by staff. The provider failed to ensure that there was an effective system in place to monitor the quality and safety of the service and care records were not always accessible or complete. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

At this inspection the service had made the required improvements. We found no breaches of regulation and the service was meeting the legal requirements. Risks to people were clearly identified, assessed and mitigated, infection control procedures were being followed by staff and there was a new robust governance framework in place. People's care plans reflected their individual needs and risks were assessed.

Dene Park House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home accommodates people in one adapted building over three floors and on the date of this inspection there were 43 people living at the home, some who were receiving personal care, nursing care and some people who had a diagnosis of dementia.

The service had a registered manager in post who had been registered with the Commission since December 2017. A registered manager is a person who has registered with the 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.

People at the home felt safe living there and relatives agreed with these comments. There were safeguarding policies and procedures in place to keep people safe. Staff had received training and attended supervisions around safeguarding. The registered manager appropriately escalated all safeguarding concerns to the local authority.

Staff were safely recruited and were provided with all the necessary induction training required for their role. The registered manager continued to provide on-going development for staff through refresher training and accessing courses to increase staff knowledge and skill. Accidents and incidents were recorded correctly and if any actions were required, they were acted upon and documented. There were enough staff to meet

people's needs. We saw documentation to show staff received regular supervisions and appraisals.

The premises were safe. Regular checks of the premises, equipment and utilities were carried out and documented. These were also audited regularly by the registered manager and any issues identified were acted upon. On the first day of inspection we found three clinical waste bins which were not secure. The registered manager took immediate action with this and requested the maintenance person to secure the clinical waste bins. Infection control measures were in place and the home was clean. We saw domestic staff cleaning the home regularly during the inspection.

The premises were 'dementia friendly' and people had personalised bedrooms. There was pictorial signage throughout the home to help people to orientate themselves. The registered manager was working in partnership with Silverline Memories to create a dementia friendly café in the home.

On both days of inspection, we observed a positive dining experience. There were pictorial menus available in dining rooms to help people make their own choices for food. People were supported to maintain a balanced diet. People told us that they were always offered drinks and food throughout the day.

The home provided safe medicines management. Procedures were in place to ensure the safe receipt, storage, administration and disposal of medicines. There were records detailing other professional's involvement in people's care, for example GPs and dietitians.

The home had records detailing activities people had attended and there were photographs of events around the home. People were positive about the activities offered and this was discussed and documented at the resident and relatives meeting.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of some people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. Staff demonstrated their understanding of the MCA and worked in accordance with this. The registered manager had made applications on behalf of people living at the service to restrict their freedom for their own safety in line with the MCA. We saw staff asking people for consent when supporting people with personal care.

Staff and people enjoyed a positive relationship and we observed kind and caring interactions. Staff knew people well and knew people's likes and dislikes. People were treated with dignity and respect.

There were initial assessments for people which detailed all of their assessed needs. People had person-centred care plans and risk assessments to keep them safe, these were regularly reviewed for any changes in people's needs. We saw involvement from other professionals and family for best interest decisions and mental capacity assessments. All of the care records we reviewed were accurate and up-to-date.

People had access to Independent Mental Capacity Advocates (IMCAs) and independent advocacy services if they wished to receive support. Information related to services was on display in the home.

The registered manager and provider had a clear vision to improve the quality of personalised care at the home. Staff and relatives were positive about the registered manager. There was a robust governance framework in place to ensure the quality and safety of the service provided. The provider carried out feedback surveys. The information from these was analysed and used to improve the home for people.

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 received care from staff who were trained and aware of safeguarding procedures. There were suitable staffing levels.

The premises were safe. Risks which people faced were assessed and reviewed regularly.

Medicines were administered safely and in line with safe medicines management procedures.

Is the service effective?

Good

The service was effective.

People received care that was delivered in line with the Mental Capacity Act (2005) MCA.

Consent was sought before staff provided care to people. Staff providing care to people had received appropriate training and support to carry out their roles.

People were supported to eat and drink well to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Staff upheld people's privacy and dignity.

People were treated with kindness and respect by staff.

People and their relatives were consulted and supported with planning their care.

Is the service responsive?

Good

The service was responsive.

People received person-centred care which met their needs and

was regularly reviewed and updated. People were supported with end of life care.

People enjoyed a wide range of social activities.

The provider had a robust complaints procedure in place. This information was used by the service to learn and continuously improve.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post. The registered manager understood their role and responsibilities.

The provider and registered manager had a clear vision, strategy and plan to deliver quality care.

The provider had quality and assurance processes in place to monitor the quality of the service and rectify any issues identified.

Dene Park House

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 site visit took place on 24 and 25 July 2018 and was unannounced on the first day of inspection, this meant the staff did not know we would be visiting the home. The second day was announced. The inspection was carried out by one adult social care inspector.

Prior to the inspection, the registered manager completed a Provider Information Return (PIR). This is a form that the provider is required to send to CQC with key information about the service, what improvements they have planned and what the service does well. We also reviewed the information that we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events, which the provider is required to send to us by law.

We sought feedback from the local authority contracts monitoring and safeguarding adults teams, and reviewed the information they provided. We contacted the NHS Clinical Commissioning Group (CCG), who commission services from the provider. We also contacted Healthwatch, who are the independent consumer champion for people who use health and social care services.

During the inspection, we spoke with four people who lived at the home, three relatives and ten members of staff including the registered manager, the regional manager, the nominated individual, the deputy manager, one nurse, one senior care assistant, two care assistants and two domestic assistants. We reviewed the care records for three people living at the home and the recruitment records for four members of staff.

We looked at quality assurance audits carried out by the registered manager and the provider. We also looked at the staffing rotas, training records, meeting minutes, policies and procedures and information related to the governance of the home. We looked around the building and spent time in the communal areas. We spent time with some people who lived in the home and observed how staff supported them. We

used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At the last inspection in August 2017 we found a breach of Regulation 12 in relation to risk management and infection control. During this inspection we found the registered manager had adequately addressed this, mitigated any risks to people's safety and staff were actively following infection control procedures.

People and their relatives told us they felt safe living at Dene Park House. One person told us, "I'm happy and I'm safe." A relative commented, "I don't worry about [relative]. Safety is not an issue. The manager has improved the whole home." One member of staff told us, "Everyone is safe. Physically and medically safe. We look after them [people living at the home] really well."

We undertook a tour of the premises to make sure it was safe for people living at the home. The premises were safe, clear from clutter and being regularly cleaned throughout the day. We found three clinical waste bins were not secure and unlocked. We raised this with the registered manager who requested new locks to be fitted by the maintenance man.

We saw that there were regular recorded audits of the premises including bed checks, bed rails checks, portable appliance testing (PAT), and firefighting equipment. The home had an electrical periodical inspection certificate.

We observed regular cleaning of the home throughout the inspection and reviewed cleaning audits. There was an infection control policy in place and staff followed procedures. This included the use of personalised protection equipment (PPE) whilst supporting people. There were risk assessments in place for the control of substances hazardous to health (COSHH) and these included data information sheets and protocols for each substance.

There was a fire risk assessment for the home and this was used in partnership with people's personal emergency evacuation plans (PEEPs). A PEEP is an individual escape plan for a person who may not be able to reach an area of safety unaided or in a safe amount of time in an emergency situation. PEEPs included how many staff would be required to support people and what action should be taken. The registered manager had also introduced an emergency evacuation bag for the home. This included people's PEEP's and a pre-written wristband, to make sure that people could be easily identified in an emergency situation by their name.

There was a business continuity plan in place which clearly detailed what would happen in case of emergency or if something happened unexpectedly. This was reviewed annually by the registered manager.

There were safeguarding policies for protecting vulnerable adults available for all staff and people. There was information available to people displayed around the home with contact information for the local authority and Care Quality Commission (CQC). Staff were knowledgeable about safeguarding policies and could explain to us what they would do if they identified potential abuse. One member of staff told us about a recent incident where they had escalated a safeguarding concern. Another member of staff said, "We

document everything and we attend training in safeguarding."

We reviewed the safeguarding information at the home and these records were accurate, linked to the appropriate accident/incident, had in-depth investigation reports, follow up actions highlighted and lessons learned. The registered manager had shared outcomes of investigations with staff and we saw evidence of supervisions discussing safeguarding outcomes. The registered manager had notified the CQC of each incident and provided regular updates during their investigations.

Staff recruitment was safe. There were current Disclosure and Barring Service (DBS) checks in place. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. Other pre-employment checks had been carried out such as gathering references from previous employers. Where applicable, the registered manager had also completed a check of the nursing staff's registration details with the Nursing and Midwifery Council (NMC).

We observed there was enough staff available to support people throughout both days of inspection. The registered manager regularly reviewed the assessed needs of people and this was reflected in the staff rotas. A relative told us, "I can always find someone, they pop in to check we're all okay." At the time of inspection, the home was using 33 hours of agency nursing staff and was actively recruiting a permanent nurse.

There were risk assessments in place at the home to keep people safe. For example, health and safety, bed rails, manual handling belts, choking, mobility, floor sensor mats and garden areas. All risks were fully identified, assessed and mitigated. People's personalised risk assessments were completed in partnership with people, relatives and health professionals.

We looked at the arrangements for the management of medicines. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Medicine stocks were recorded when medicines were received into the home. This meant accurate records of medicines were available and nursing staff could monitor when further medication was required.

Medicines were given from the container they were supplied in and we observed staff explained to people what medicine they were taking and why. People's medicine support needs were accurately recorded in their care records and the medicine administration records (MARs) showed staff recorded when people received their medicines. Entries had been initialled by staff to show they had been administered. Protocols were in place to administer 'as required' medicines. 'As required' medicines are only needed for a specific situation, for example allergies, and are not prescribed as daily medication. The protocols assisted staff by providing clear guidance on when 'as required' medicines should be administered.

Good

Is the service effective?

Our findings

People's treatment and support were delivered in line with current national best practice standards and guidance, such as National Institute for Health and care Excellence (NICE) and the Mental Capacity Act 2005 (MCA). The registered manager discussed learning opportunities and there was evidence of themed supervisions taking place with staff around best practice.

All new care staff who did not have previous qualifications in health and social care, received a detailed induction from the provider in line with the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective and compassionate care.

The registered manager frequently reviewed the training requirements for staff on a matrix. Any knowledge gaps or refresher training sessions were identified. The registered manager had recently enrolled three care assistants in the provider's Care Home Assistant Practitioner (CHAP) development program to increase their knowledge and skills. Nursing staff received regular clinical supervisions and competency checks from the deputy manager. A member of staff told us, "There's an incentive to get your training all completed and up-to-date. [Registered manager] always reminds us and checks we're doing what training we have to do."

Staff received regular supervisions and appraisals. These covered general policies and procedures, safeguarding, duty of candour, training, development needs and well-being.

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, for example, because of permanent or temporary problems such as mental illness, brain impairment or a learning disability. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). For the four people whose records we reviewed applications had been submitted to the 'supervisory body' for authorisation to restrict their liberty, as it had been assessed that this was in their best interests to do so.

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment, for example for bed rails and life changing choices about serious medical treatment or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff.

People's care records showed details of referrals, reviews and appointments with health and social care

professionals. 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, GPs, psychiatrists, specialist nurses, best interest assessors, dietitians and opticians. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various external agencies and services to seek professional advice and ensure the individual needs of the people were being met.

Daily notes were kept for each person. These contained a summary of the care and support delivered and any changes to people's preferences or needs observed by staff. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift. There was a holistic review of people's needs every month and any changes were reflected in people's care plans.

Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped staff identify the level of risk to people. The Waterlow scale was used to assess people's risk of developing pressure sores. Assessments were regularly reviewed and updated to ensure they reflected people's current level of risk. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin.

Some people received support with nutrition and hydration. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. The MUST was used to help staff complete individual risk assessments in relation to the risk of malnutrition and dehydration. Staff monitored some people's food and fluid intake to minimise their risk and recorded this on a chart which the nursing staff checked and evaluated in order to decide if further action should be taken. For example, referral to a GP, dietitian or speech and language therapist. There were clear target fluid intake levels for people in care files. We saw regular recordings of people's weights.

Kitchen staff were aware of people's dietary requirements and preferred choices. When people were assessed by other professionals, for example the speech and language team, and their assessed needs had changed, care plans were updated to reflect these changes and updates passed to the kitchen staff.

Food was well presented at meal times and staff provided drinks throughout the day to people. We observed staff asking people, "Would you like a cold drink to cool you down? I can get you the juice you like." The dining rooms were nicely decorated, tables were set, pictorial menus were available and there was music playing. Staff discretely supported people who needed assistance during meal times. A relative told us, "I help [relative] with her food when I'm visiting. It's more like a lunch club and they really enjoy it." There were different choices of food available at meal times.

The home had a 'dementia friendly' environment. There were contrasting walls, handrails and doors. It was nicely decorated and people had personalised bedrooms. One person's bedroom was painted lilac with matching accessories. Staff told us, "[Person] loves lilac so we made sure it was right for them." There was pictorial signage on bathrooms and toilets. Pictorial signage and menus help people visualise the planned meals, if they are no longer able to understand the written word. The corridors and doorways were wide enough to allow for wheelchair access.

Good

Is the service caring?

Our findings

During our inspection at Dene Park House we saw many positive and caring interactions between people and staff. People and their relatives told us the staff were caring and kind. One person said, "Oh I'm looked after." A relative said, "They treat [relative] like their own. [Relative] can't talk as much now but always smiles at them." A member of staff told us, "You get to know everyone really well and you bond with them. How can you not care about them?"

We observed staff talking with people and explaining what menu choices were available at lunch time. Staff knew what people liked and disliked and they were able to tell us people's preferences. One person told us, "They know how I like my tea and what I like to eat." A member of staff told us, "We know what people like. I can tell you what music to play to make [person] sing or what colour clothes [person] prefers to wear." This demonstrated that staff knew the people they cared for well.

People were supported in an individual way. We saw in one person's care record that they preferred to sit in their room to eat which created a risk of social isolation. To mitigate this staff walked with the person and encouraged 1:1 conversations about knitting, family and tv programmes. Staff encouraged independence and positively supported people in the least restrictive way possible. Consent was always sought before carrying out assistance to people. We observed staff knocking on people's bedrooms and asking to enter.

We saw staff acknowledging people and relatives throughout the inspection. A relative told us, "[Relative] likes to sleep a lot now so I sit in the room. The staff come past and check I'm okay." We observed staff updating relatives about people and their presentation for that day. We saw the registered manager interacting with people and their relatives also. They knew people well and could advise staff on best practice to support people.

Care plans recorded people's involvement in their care planning. This included records to show involvement from relatives for people who did not have capacity to make decisions. We did note that in one care file consent had not been recorded. We raised this with the registered manager who told us they were reviewing all consent forms within files and were taking appropriate action to make sure all consent and care planning was recorded.

The registered manager had a vision to make sure everyone received the best care available and to do this they ensured there were detailed initial assessments for people before moving to the home. The initial assessments documented people's health, sleep, social, family, sexuality and religious needs.

Equality and diversity policies were in place to ensure that people were treated with dignity and respect regardless of the sex, race, age, disability or religious belief. The service made sure that people's dignity was integral to everything they carried out. The registered manager and staff worked with people and their relatives to help increase people's confidence, maximise independence, choice and control where possible.

There was information, advice and guidance displayed around the home which was of benefit to people and

their families such as local safeguarding contact information and leaflets on dementia care, advocacy services and advice on relevant topics of interest. At the time of the inspection no one was actively receiving support from advocacy services. Advocates help to ensure that people's views and preferences are heard.

People's bedrooms contained personal memorabilia to help stimulate memories. There were photographs of family members and activities people had been involved in. One staff member told us, "Pictures are great. People remember things from their younger days and start wonderful talks about their lives."

Good

Is the service responsive?

Our findings

People at Dene Park House received person- centred care. Care plans were developed after a detailed initial assessment of people's needs, for example physical, mobility, diet, personal hygiene and sleep. The care plans created from these assessments provided staff with specific details about to support people. The home carried out a holistic review of people's needs every month and we saw care plans updated to reflect these reviews. Care plans included sections on social, sexual, cultural/religious and emotion as well as their physical needs.

We reviewed four people's care plans which had been written in a person-centred way. Person-centred care planning is a way of helping someone to plan their care and support, focusing on what is important to the person. For example, one person's night time profile detailed what type of duvet they preferred, how many pillows, what time to wake up and what night wear they liked to wear. Another person's social/leisure profile detailed that they enjoyed watching television, what papers they preferred to read, their favourite shops and religious needs.

People and their relatives had been involved in their care planning. A relative told us, "When [person] first arrived here they went through and asked us questions. They wanted to know everything, slippers, shower gels the lot." Another relative told us, "I've been involved with all the care plans. We haven't had a review of it yet though." In one person's file we reviewed we found signatures were missing for consent and agreement to plans. We raised this with the registered manager who was reviewing all files. There was recorded involvement from other professionals, for example GPs, in people's care planning records.

People's care plans in relation to their behaviour management were personalised and specific. They detailed the support staff were to provide and how they should monitor people after an incident. Triggers for the behaviour were documented so staff could recognise them and offer intervention before the person became increasingly anxious and distressed. Staff were directed to offer support to resolve the problem by offering the person time. This provided guidance to staff so they managed situations in a consistent and positive way, which protected people's dignity and rights.

Communication care plans were in place for people and had a recorded aim to keep people independent. The plan included when people liked to talk, how they talked and if they liked to make their own decisions/choices. There was also an end of life communication section in one file we reviewed. This referenced how people would communicate at that stage in their lives and how they would communicate pain. The Abbey Pain Scale was used as a tool within this to show what signs staff should look for if people were in pain.

People accessed stimulating and meaningful activities. There were photographs around the home showing previous activities that had been undertaken, for example when entertainers had visited the home. During our inspection we observed staff supporting people to visit the hair dresser. A person told us, "I like to get my hair done. You've got to look your best.". The registered manager was implementing a dementia friendly cafe on the ground floor so people could use this to increase their social activity. People told us they

enjoyed the activities within the home.

The provider had a robust complaints procedure in place and this was documented in a complaints policy. This policy was available to people using the service, their relatives, visitors and staff. There was information within the service detailing how to make a complaint. There was a clear escalation route for complaints, including contacting CQC and local authority. A relative told us, "I've got no reason to complain now. It's really improved since [registered manager] started. I've raised things with them but they sort it straight away."

We reviewed the complaints log for the service and the actions taken. The registered manager addressed all complaints within the designated timescales and took action where required. Lessons learned were acted upon and shared with staff during meetings and supervisions. Compliments received about the service were also shared with staff. The provider regularly attended the home and reviewed any concerns or complaints raised.

The registered manager sought feedback from people about the quality of care received. This included annual surveys to relatives. There were records of meetings between people and the registered manager regarding the quality of food within the home. This detailed any concerns, foods people would like, what meals they enjoyed and meals they did not like.

At the time of our inspection the staff were delivering end of life care. We saw in the care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected. The care plan detailed where the person would like to stay and there were records of relative involvement. Staff had received training in end of life care and records showed this.

Good

Is the service well-led?

Our findings

During the last inspection in August 2017 we found a breach of Regulation 17 in relation to governance. During this inspection we reviewed the governance framework in place at the home and found the registered manager had made all required improvements.

There was a registered manager in post who had been registered with the Care Quality Commission (CQC) since December 2017. This was in line with the requirements of the provider's registration of this service with the CQC. The registered manager was aware of their responsibilities and had submitted notifications to the Commission as and when required. The registered manager was present during the inspection and assisted us. They were extremely knowledgeable about the people who used the service and able to tell us about individual people's needs. People and relatives, we spoke with knew who the registered manager was and told us they were a visible presence at the service.

The registered manager had a clear vision for the service which incorporated the values described in the provider's statement of purpose. The registered manager had worked hard to improve the culture at the home and one member of staff told us, "We've all worked hard. The staff team is happy and good now. [Registered manager] has worked with everyone, put time in and its worked." A relative told us, "The staff have changed, they're more consistent now. The nurse is so friendly and the manager always says hello."

Regular staff meetings took place monthly and we reviewed minutes from these meetings. There were discussions around training, care planning, medicines, housekeeping and admissions. Staff signed an attendance register for each meeting. The registered manager also discussed learning within supervisions and took appropriate action if staff were not completing their refresher e-learning modules. The registered manager had recently nominated three care staff to join the provider's Care Home Assistant Practitioner (CHAP) initiative. This initiative involved upskilling care staff to carry out basic nursing tasks under the supervision of a qualified nurse.

The registered manager held regular relative's meetings and the dates for these were advertised throughout the home. We reviewed the minutes from the latest meeting held in July 2018. Topics discussed were CQC ratings, staff updates, activities, improvements, feedback and the dementia café. The provider sent relatives an annual survey around the quality of care provided. Results were analysed and collated by the provider and the results were used to develop an action plan.

Quality audits were carried out by the registered manager and by the provider's wider management team. These were all documented and used to create action plans which could be analysed to see where the home was performing well and it highlighted areas for development. The registered manager carried out daily, weekly and monthly audits of the service and we saw evidence of these. The provider also carried out a quality assurance audit of the service on a monthly basis. These all allowed for the key areas of the service to be monitored and if any faults or errors were identified they could be acted upon. We saw evidence in staff meetings that learning outcomes were shared with the staff, for example housekeeping discussions around infection control and trip hazards.

The service had an open, transparent and honest relationship with partnership agencies such as the local authority and the Clinical Commissioning Group (CCG) and we saw evidence in people's care files of joint working with external professionals to support people.

The home had their latest CQC inspection rating on display so that people living at the service, relatives, visitors, professionals and people seeking information about the service can see our judgements. The provider had displayed their ratings on their website as well. They also displayed their food hygiene rating of five, certificates of registration and insurance details at the main entrance.

Since our last inspection the registered manager and provider had demonstrated that they have sustained the improvements which were highlighted in the last report and had continued to improve the service whilst ensuring compliance with all of the regulations.