MMCG (2) Limited

Heritage Care Centre

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Good** ●
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

We inspected Heritage Care Centre on 20 and 26 September 2018. This was an unannounced inspection.

Heritage Care Centre has been established for a number of years and has previously been managed by different providers. This was the first inspection of the service since it was taken over by MMCG (2) Limited.

Heritage Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Heritage Care Centre provides personal care with nursing for up to 72 older people, some with a diagnosis of dementia. The home is split into four units, two on the ground floor and two on the first floor.

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

People and their relatives were extremely positive about the care and support they received from staff. We saw some examples of outstanding care being provided to people during the inspection, with staff showing real and genuine empathy towards people. The strong, person-centred culture at the service was embodied by the registered manager and this was passed down to the rest of the staff team.

Respect for privacy and dignity was embedded in the home and people were supported to maintain relationships that were important to them and engage in things that were of personal importance to them as individuals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were only deprived of their liberty to receive care and treatment when this was in their best interests, the provider sought legal authorisation to do so under the Mental Capacity Act 2005 (MCA).

The provider demonstrated its commitment to promote a positive culture within the home by being open and transparent to new ideas and collaborative working which had a positive impact on the care provided to people. We received positive feedback from health and social care professionals about the good working relationship they had with the service.

There was a strong emphasis on quality assurance within the service which was led by a quality team and the internal management team within the service. There was an emphasis on continuous improvement which was done through the results of any audits, learning from complaints and incidents and accidents.

These were all used as a learning opportunity, and feedback was provided to staff to drive improvements.

The staff team were recruited on the values that they demonstrated and were motivated. There was a high level of compliance in relation to staff training and said they felt well supported. There were opportunities to progress within the organisation.

People told us they felt safe and their rights were protected by staff. People's support needs, including in relation to their medicines, nutrition and ongoing health needs were managed well. Staff made appropriate and timely referrals to health professionals if needed and acted upon recommendations given.

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 and their relatives told us they had no concerns about safety within the home.

Risks to people and the environment were managed appropriately. The service managed the control and prevention of infection and followed good hygiene practice.

Staff received their medicines from trained staff who were competent in their practice.

The provider had robust recruitment procedures in place which helped to ensure only suitable staff were employed.

Is the service effective?

Good

The service was Effective.

Staff were provided with appropriate training to meet the needs of people.

Thorough assessments took place on admission and the service worked collaboratively with external professionals to ensure people's needs were being met.

People were given appropriate support in relation to their nutrition.

The service was working within the principles of the Mental Capacity Act.

The home was clean throughout, with consideration given to both private and communal spaces.

Is the service caring?

Outstanding

The service provided excellent care.

There was a strong, visible person-centred culture at the service which was evident through the registered manager to all levels of

staff.

People and their relatives praised the registered manager and other staff for their caring attitude and their empathy.

The service ensured that staff focussed on building and maintaining open and honest relationships with people and their families, friends and other carers.

Is the service responsive?

Good

The service was Responsive.

The service used complaints as an opportunity for learning.

Care plans were up to date and reflected people's individual needs.

Is the service well-led?

Outstanding

The service was extremely well-led.

People and their relatives were consistent in their opinion that the service was managed well.

There was a strong leadership culture within the service.

The service was open and transparent and worked in partnership with external organisations, with an emphasis on continuous improvement and better outcomes for people using the service.

Heritage Care Centre

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 comprehensive inspection took place on 20 and 26 September 2018. The first day of the inspection was carried out by one inspector and two specialist advisors. The specialist advisors were registered nurses. The second day of the inspection was announced and was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection, their area of expertise was residential care for older people.

Before the inspection, we reviewed the information we held about the service. This included notifications sent to us by the provider and other information we held on our database about the service. Statutory notifications include information about important events which the provider is required to send us by law. We used this information to plan the inspection.

During the inspection we spoke with seven people using the service and five visiting relatives. We also observed staff supporting people during the inspection. We spoke with 10 staff, including the registered manager, quality and compliance manager, deputy manager, nurses and care workers, activities co-ordinator and head chef. After the inspection, we got feedback from four health and social care professionals to gather their views of the service.

We reviewed a range of documents and records including; nine care records for people who used the service, five staff records, as well as other records related to the management of the service such as complaints and audits.

Good

Is the service safe?

Our findings

People using the service told us they felt safe in the presence of staff. Typical comments included, "Yes, very safe" and "Definitely." One relative told us, "I sleep well at night knowing that [my family member] is okay." Another said, "We don't feel we have to come every day as [my family member] is in a very safe environment."

The service kept records of any safeguarding concerns that had been raised. These records were completed in a timely manner with the outcome of any resulting action clearly documented. The local authority safeguarding team confirmed that there were no underlying trends or areas of concern identified. Training records showed that over 95% of staff were up to date with their safeguarding training. Staff we spoke with demonstrated a good understanding of how they would identify and report and safeguarding concerns.

Risks to people were managed appropriately. This was done through effective risk assessment and management plans. For example, one person was identified at risk in relation to nutrition. The risk management guidelines included for them to be weighed monthly and to monitor any significant weight loss or gain. Staff were adhering to the guidelines in place. Other areas of risk included, hydration, choking risk assessment, oral health assessment, moving and handling and Waterlow (to determine the risk of developing pressure sores).

Antecedent-Behaviour-Consequence (ABC) Charts were in place for some people that displayed behaviour that others could view as challenging. An ABC Chart is a direct observation tool to record information about a particular behaviour. These were used to document any incidents of behaviour that challenged and were used to share information and make referrals to the community Behaviour and Communication Support Service (BACSS) team. The BACSS team work to support care home staff in Wandsworth to understand and manage behaviours that they find challenging in their residents.
Incidents and accidents were reported to the quality team and there were explicit reporting expectations which both the manager and deputy manager were aware of. The provider had detailed information regarding each incident and actions taken so that trends could be analysed. Post investigation recommendations were made to try and minimise incidents and accidents from occurring in future.

Medicines management and administration was safe. We observed a nurse administering medicines, which they did so competently, in a polite and considerate manner. They wore "do not disturb" tabards and told people what medicines they were giving and asked for their consent. They asked them if they required any pain relief medicines. Prescription charts had people's photo, date of birth and were colour coded for easy identification. They also contained other important information such as their GP, pharmacy, allergy and fluid /weight charts). Medicine trolleys were well organised, clean and were locked after medicines were dispensed.

Medicines Administration Record (MAR) charts were correctly completed. MAR charts were reviewed every three months and there was a monthly medication audit, which showed a high level of compliance of 93%. External audits were completed by the Pharmacist.

The provider had robust recruitment procedures in place which helped to ensure only suitable staff were employed. Staff files contained evidence of recruitment checks such as their application form, health screening questionnaire, documents to verify their right to work, criminal reference checks and references. Nurses' NMC registrations were also verified.

Rotas were planned four weeks in advance which allowed for any changes to be planned for. Staffing levels were good with each of the four units led by a nurse and supported by care workers.
An agency was used for recruitment of agency staff, the deputy manager told us they used the same, trusted agency who provided regular staff. Some people needed one-to-one support, this was provided outside of the usual staff rota and by regular staff so that consistency of care was maintained.

The service managed the control and prevention of infection well. All areas of the home, individual bedrooms and communal spaces were clean. There was a dedicated domestic team that were a visible, but discreet presence in the home. There were antiseptic dispensers around the home and hand washing techniques were displayed in bathrooms. Infection control audits were undertaken, these included an annual legionella audit, pest control and daily cleaning records completed.

The kitchen team followed good hygiene practice. For example, there was a separate cleaning area for catering equipment. Meat and vegetables were stored separately, opened food was labelled with the date they were to be used by. Cooked food was temperature checked before it was served. Good food hygiene guidelines were on display. The home had received a 5* food hygiene rating from the Food Standards Agency.

There was a full-time maintenance worker employed who was responsible for overseeing aspects of health and safety. This included weekly and monthly checks on fire equipment, hoists and beds. Current inspection safety certificates were seen for hoists, slings, bath hoists, sluice machines, gas and electrical safety.

Good

Is the service effective?

Our findings

Staff were given a thorough induction and ongoing mandatory training at regular intervals which helped to ensure they were competent in carrying out their duties.

New care workers completed the Care Certificate and induction training. They completed workbooks to evidence their learning and were supported by 'people champions', experienced care workers acting as buddies to new recruits. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers.

Mandatory, refresher training was all done internally either through e-learning or practical face to face. Medicines, manual handling and first aid were completed as practical training. These were supplemented by observations to ensure staff were competent to carry out these roles. There was a high level of compliance with regards to training which was closely monitored. The registered manager said that if any training was overdue, care workers were given four weeks to update their training, and if they failed to do so were then subject to potential disciplinary action. Once training had expired, they were not allowed on the floor unsupervised.

Staff received regular supervision and appraisal. This gave them an opportunity to discuss their performance and any work-related issues. The deputy manager said they often did group supervision if things were not going right and they needed to pass on information to the general staff team.

Thorough assessments took place on admission. These covered a number of areas including maintaining safety, eating and drinking, pressure areas, breathing, personal care, communicating, and mobility and any areas of risk were identified. This allowed the service to have a comprehensive understanding of people's support needs. There was evidence of reviews and assessments by social workers and NHS nurse assessors alongside shared correspondence and shared care plans.

People and their relatives said they were happy with the support they received in relation to their health needs. Comments included, "They were on the ball with the GP and everything was sorted", "[Family member's] health has been good" and "If anything is amiss, I get informed and they let me know."

The service ensured that people received information about their health care and support needs. Health passports were developed and used. Details of health professional and community teams were made available to staff so referrals could be made quickly and visits from external professionals were recorded.

Staff made appropriate and timely referrals to other relevant professionals and services and acted on their recommendations. For example, wound care profiles were in place for people for people with pressure sores. These were comprehensive in scope and included the person's medical history, Waterlow risk assessment, wound care plan and evaluation, wound care records, evidence of referral and input from a multidisciplinary team involving tissue viability nurse, GP and dietitian.

We asked people and their families about the food and whether they were offered a choice. They said, "Very good", "It's fine" and "Food is excellent it's really good." They all reported that they were given a choice, which was reflected in the menu that we saw. If people did not want anything that was on offer from the menu, they were given different options.

People who needed support to eat and drink were given assistance by care workers. People who were on a special diet, for example those that required softened or pureed food were catered for. Dietary requirements notification forms were sent up when a person first moved into the home or there was change in their dietary requirements. There was a list of people with special requirements on display in the kitchen and the chef was aware of them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider carried out mental capacity assessments for people where it was believed they lacked the mental capacity to consent about their care and treatment. There was evidence of best interest decisions that had been made to ensure people's rights were protected. For example, we saw best interest decisions in relation to resuscitation and bed rails. Staff demonstrated a good understanding of the MCA act and consent to care. Where appropriate, people had advocates acting on their behalf. For example, we saw evidence of a person advocating for a person living with dementia and not always able to consent or understand to decisions in relation to their health.

The provider had a system in place to monitor the progress of any DoLS application and their status. They also maintained a DoLS log sheet which summarised any conditions and recommendations of the DoLS authorisation and whether they had been acted upon. This meant that the provider was proactive and conscious about ensuring people's rights are upheld.

The environment was suitable for people, the home was divided into four units. All rooms were en-suite and bedrooms were personalised for each person. The home was clean throughout, with consideration given to both private and communal spaces. Facilities include communal dining rooms, lounges and a small kitchenette to provide snacks and a bar. Consideration had been given to the needs of people, for example there was a projector screen available to hold movie nights on one unit and another lounge had been furnished to provide aromatherapy on another unit with different lighting and new furniture. There were plans in place to improve the environment, for example by having a nail bar, refurbishing the reception area and moving some of the services on the top floor to the ground floor to make them more accessible.

Outstanding ☆

Is the service caring?

Our findings

People and their relatives praised the registered manager and other staff for their caring attitude and their empathy. Comments included, "The culture flows down from the manager", "Starting from the top, everyone is so caring and friendly. They take their time and you can tell it's genuine", "Staff are a top team, very hands on", "We are incredibly happy. It was such big wrench for us to leave [family member], but as soon as we came here we just knew it was the place. We got an immediate sense of tranquillity and calmness. We were really impressed."

The service worked with people and their families to help people maintain their identities and sense of purpose. This was important to them as it was part of who they were as individuals. There were numerous examples of this. One person using the service was a practising priest before they moved into the home. Although they were not currently practising, this role was clearly important to them as it defined who they were as a person. The service empowered and encouraged them to continue with this. The person made themselves available to speak to people as a priest, which they said they really enjoyed doing. The home worked in partnership with the family of a person who was not enjoying the food as it was different to their home cuisine. The person and their family were invited in to devise their own personal menu in keeping with their personal taste, which the chef followed and prepared. Another person had moved into the home because they wanted to be close to their partner who needed nursing care. The provider helped to facilitate their relationship and the person was given the independence to care for their partner which they both liked as it helped them to live as a couple and remember their life before they moved into the home. The above examples demonstrated that people were truly respected and valued as individuals.

An equality, diversity and human rights approach to supporting people's privacy and dignity was embedded in the service. Respect for privacy and dignity was at the heart of the culture and values of the home and staff demonstrated these values. Staff were encouraged to sign up as dignity champions. Staff were constantly reminded of the importance of dignity in care; dignity champions were a key driver of this, ensuring that dignity was at the forefront of care provided to people. During the week of the inspection, the focus was on dignity in care in eating and drinking and how this could be enhanced. This included tips for staff to enhance the dining experience, we saw that staff followed these tips and lived these values. For example, a person appeared distressed during breakfast. A care worker came up to them and sat with them, stroking their hand. They were offered breakfast which they ate with the care worker sitting with them and offering words of comfort. Although they were able to eat independently, the care worker offered to assist them due to their anxiety which they accepted and then after they were settled the care worker asked them if they wanted to eat by themselves which they did. The care worker stayed with them, talking to them even though they were settled.

The service anticipated people's needs and recognised distress and discomfort at the earliest stage, offering sensitive and respectful support and care. We also saw some excellent examples of staff showing real empathy to people. During the inspection, we saw a person who was distressed and anxious, talking about their family. The registered manager talked with genuine empathy, asking what was wrong, and reassuring them. They offered them some tea and took the person into her office, asked them if they would like to

speak with their family and phoned them on behalf of the person. We later saw the person settled and content.

The service ensured that staff focussed on building and maintaining open and honest relationships with people and their families, friends and other carers. Relatives said, "I've got the mother daughter relationship back as they are looking after her so well", "Always get really warm welcome, I feel like I can come here anytime" and "It's reassuring for me to know she is well looked after here". One relative spoke in detail about the transition period when their family member moved into the home. They could not speak more highly of the staff during this process, telling us they took all the pressure off the family at a distressing time.

The provider demonstrated its commitment to promote a positive culture within the home by being open and transparent to new ideas and collaborative working which had a positive impact on the care provided to people. They had worked with a local primary school to set up an after-school club for children. This involved a weekly visit by the school children to the home where they took part in activities with the people using the service. People enjoyed the interaction with the children, it gave them a sense of purpose as they were able to help the children to read and play board games with them. These activities were documented in a record book for people and children to look over. The care home club children had signed up to become dementia friends through the Alzheimer's society. The Alzheimer's Society's Dementia Friends programme is the biggest ever initiative to change people's perceptions of dementia. This relationship meant that people felt part of the local community. It also helped the children and in turn the wider community to have a better understanding of Dementia and how it impacted on people.

The service ensured that staff in all roles were highly motivated and offered care and support that was exceptionally compassionate and kind. They cared for individuals and each other in a way that exceeded expectations. Candidates that had applied for a position within the home were vetted carefully to ensure they were suitable for a career as a care worker. Interview notes were completed which showed that people were employed on the basis of their caring qualities. For example, they were asked how they would work inclusively with people from different backgrounds, what values they held to support people in a care home, their understanding of the difference between basic and superior care, of privacy and respect. Staff that were employed scored highly on the responses they had given. Staff carried these values through and we saw numerous examples of empathy shown towards people, as mentioned above, that demonstrated people were at the heart of the service.

The service positively welcomed the involvement of advocates. We saw one example where the provider had sought the involvement of an independent advocate for a person that did not have any family involved in their care when they had to come to a decision involving a Deprivation of Liberty (DoLS) application.

The registered manager, deputy manager, clinical lead and activities co-ordinator had attended the Care Home Research Network annual conference to explore ways in which they could improve care within the home. As a direct result of this, they had been introduced to Namaste care and had attended training in this area. Namaste care is a structured approach to care, provided by staff to make a difference to the care of people living with advanced dementia. This is done through personalising care, that focuses on engaging with each person's senses through sound, touch, smell, taste and sight, offering meaningful activities that reflect their interests. Namaste care was being led in the home by the activities coordinator and she had linked with other homes that had implemented the Namaste programme to learn from them.

There was a reminiscence corner in the home so that those people who that had passed away would not be forgotten. The registered manager said they often maintained contact and were open to establishing a continued relationship with families of those people that had died. Relatives were invited to a remembrance

day, church services and other events such as garden parties.

The strong, visible person-centred culture at the service was evident throughout the service, from staff recruitment, through the observations of care we saw during the inspection and the feedback received.

Good

Is the service responsive?

Our findings

People using the service and their relatives were happy with the way the home managed their concerns. They told us, "Whenever we have a query or concern it is usually dealt with quickly and satisfactorily", "'I feel happy there is nothing to complain about", "I did once few weeks ago, and the lady put it right", "The manager says they are always available", "If I see anything I don't like they [the nurse] just check it" and "Never had a reason to complain."

We saw that when concerns or complaints were raised, these were looked at promptly. Full investigations were carried out, areas of improvements were identified and complainants were kept informed about the outcome. Following one complaint, it was requested that the person be assigned a new key worker, that they were checked more regularly, staff made aware of certain non-verbal clues and behaviour charts completed. We saw that the provider had followed these actions. The provider acted to ensure any learning from complaints were propagated to staff through staff meetings.

People's rooms had information available that included their daily care needs, care home information, how to complain/comment. Their rooms were identified by their photo and name each person had a named nurse and key worker who were responsible for overseeing their care and support needs.

Care plans were based around the individual support needs of people. For example, one person who needed support with mobility had a care plan for maintaining a safe environment. This included an overview of their current ability, their level of dependence including a history of falls and a desired outcome. Care plans were all up to date and were evaluated on a monthly basis. This helped to ensure they contained up to date information for staff to support people more effectively. Another example seen included a care plan for nutritional needs for a person whose weight needed to be monitored to ensure they were maintaining a healthy weight. Other care plans included care plans for personal care, moving and handling, tissue viability and skin integrity medicines management and social interest.

There was a thriving and engaging activities programme in the home. Information about activities was available in people's rooms and on visible noticeboard in communal areas.

People and their relatives said, "On 3rd October going to a concert hall for the elderly classical concert. It was lovely, I went last time I was lost in the music", "Had a lovely garden party, had a fete which [the activities co-ordinator] organised", "The events co-ordinator is brilliant, there is always something going on" and "They have activities every afternoon." We observed a very engaging music and movement activity on the day of the inspection, which people were encouraged to participate in and seemed to enjoy very much.

The activities co-ordinator told us, "We do meetings every month [residents' meetings]. I ask them if they would like me to change anything and I will try and implement it." Activities in the home include cinema events, Thai chi, Namaste programme activities and regular outings from the home. People were encouraged to socialise and had the privacy of their rooms if they preferred. There was provision for people who wanted to stay in their rooms, this included a visiting manicurist and individual music and movement

relaxation in their rooms.

Outstanding ☆

Is the service well-led?

Our findings

People and their relatives were consistent in their opinion that the service was managed well. Comments included, "The standards are high", "Their approach is good, they seem aware of keeping things in line" and "[Registered manager's] professionalism has transferred onto staff. It's tangible that she is on it, her staff work to very strict guidelines." Feedback seen on a care home review website was extremely positive, with an average score 9.2 out of 10.

Both the registered manager and deputy manager had worked together for a considerable number of years and their responsibilities, along with the senior staff were clearly defined. Both were proud of the work and the quality of care that was provided by a well-established team. The nursing staff were clinically skilled and senior leaders were open to new ideas and thoughts about the delivery of care.

The registered manager said, "I trust my deputy and unit managers to lead the home." Opportunities for progression within the service were made available to staff and the registered manager helped to foster an environment where people with the skills and desire to progress were supported to do so. Staff were given responsibilities which empowered them. The creation of new roles and opportunities inspired staff to expand their skills set and provided them with roles they could aspire to. For example, the deputy manager started off as an office administrator who, after being supported to attend a leadership and management programme had worked her way up the organisation and been promoted to her current role. The service had developed a role for a more skilled care practitioner, an intermediary role that care workers could aspire to with more responsibilities such as administering medicine.

Other opportunities for staff included dignity and people champions. People champions helped to support new employees through their induction. They made sure that new starters felt supported and valued as new members of the team. They maintained regular communication with them, including at the end of the first day, week and month as well as being involved in trial period reviews. This level of support meant that there was a reduction in staff turnover which was seen through the length of time that many of the staff had worked at the service.

Dignity champions demonstrated excellent dignity practices. They acted as role models by ensuring they adhered and promoted the values system of the home of treating people with respect. They acted as advocates for people and held regular meetings with them, encouraging them to participate in meetings to empower them to voice their views on the services provided by the home. Relatives meeting took place also took place and they were also able to feedback during meetings and care reviews. Information boards were on display throughout the home with details of menus, activities board, dates of relatives' meetings and the staff on duty.

The values of the home and were cascaded during staff meetings and individual supervision and appraisals. The registered manager said, "I make sure I demonstrate those values so my team can learn." A relative said, "The culture flows down from the manager."

The service was open and transparent and worked in partnership with external organisations, with a strong emphasis on continuous improvement and ensuring better outcomes for people using the service.

Heritage Care Centre was involved in initiatives with the Care Home Research Network (CHRN) to improve the lives of people using the service, especially those living with dementia. Staff participated in network forums, attended training and workshops where they shared ideas and practice. This learning was cascaded to the staff and allowed them to develop their understanding of the management of behavioural symptoms of dementia, assessment of pain and the importance of non-verbal communication in addressing the needs of people living with dementia. A major benefit of this work, which produced a positive outcome for people was that the practice of assessing pain before the use of medicines was more robust. This led to more effective pain management resulting in reduction of the use of medication to control pain amongst people.

There were other examples where the service worked in partnership with external stakeholders resulting in positive outcomes for people. They worked closely with the Behavioural Communication Support Team, a specialist team of psychiatrists from the local mental health hospital in managing behaviours that could be interpreted as challenging. Another CHRN project was based on using Cognitive Behavioural Therapy (CBT) and meaningful activities to manage incidents of behaviour that challenged. As part of this project, the registered manager and six staff met with the research lead and attended training and implemented the findings at the home. Both these examples of collaborative working had resulted in identifying behaviours more effectively which led to a reduction in the frequency and severity of incidents of behaviour that challenged.

The service worked in collaboration with the GP federation and the CCG as part of the Care Home In-reach team project. The aim of this was to develop the skill set and confidence of staff to reduce avoidable emergency admissions. As a result of this, there was a reduced incidence of inappropriate admissions to hospitals. Since January 2018, there were no incidents or complaints regarding inappropriate admission to hospital. This meant that pressure on local NHS services was alleviated.

The registered manager understood current challenges to the service and the impact this may have on the service provision and took proactive action to address them. She had attended the care home research network annual conference 2018 with members of the senior team and looked at ways in which dementia care could be improved. They had identified Namaste care as a potential avenue to do this and had then taken this further and attended training which enabled them to implement this in the home. The registered manager had also arranged for a local councillor to visit the home and speak to staff about the impact of Brexit on staff recruitment and retention as this was something that potentially could have an impact on the service provision. She attended forums arranged by Skills for Care to support registered managers to keep informed and learn from other registered managers.

There was strong emphasis on governance and quality assurance processes. The registered manager, deputy manager and staff said there was a strong learning and a no blame culture in the home. The home had a comprehensive 'pathways for information' template which was revised in August 2018 stipulating the expectations of reporting within the service and the scheduling of the quality audits and meeting schedules. Both the manager and deputy manager were aware of this schedule and kept to it.
The provider had an initiative in place called 'In pursuit of excellence', a self-assessment tool rather than an audit which was completed and sent to the provider organisation's quality team to look at how the service could be improved. The quality team met every three months to share good and bad practice, identify trends and share information between all their homes. A quarterly quality bulletin was produced and passed down to all staff. Regular meetings were held across all staff teams during which they were given the opportunity to discuss issues of importance to them but also as a way of disseminating information down to

the staff team. This helped to foster a culture of continuous development and improvement across all levels of the organisation.

Audits were completed by an external quality team. The quality and compliance manager told us their remit was to ensure quality audits and standards were managed. They explained the structure of the quality team consisted of regional heads of quality and compliance and a head of clinical standards. The quality team completed quality assurance visits, following which a comprehensive list of actions was compiled with named responsibility for action and timescales for completion. The timescales for completion were clear and achievable.

Health and safety audits were undertaken every two months and a quarterly report that included environmental and maintenance checks was produced. A report from August 2018 showed an 89% compliance with health and safety regulations, safety and maintenance checks were scored at 98%, kitchen records were 95% compliant and room standards were 87.5% compliant.

A training compliance report from August 2018 showed that an extremely high level of compliance. Training scores were 100% compliant for food safety, fire awareness, first aid, COSHH, infection control, health and safety and 98% compliant for dementia awareness, manual handling, the General Data Protection Regulation, medication, medication competencies, fire practical session. The dispensing pharmacy completed medicines audits every six months.

A sample of care plans were reviewed against the CQC Key Lines of Enquiry to help improve the service and were rated red, amber or green so that outstanding actions were given priority according to their score.