Unity Homes Limited

# Highgrove House

## Inspection report

Highfield Road North
Chorley
Lancashire
PR7 1PH

Tel: 01257270643
Website: www.unityhomes.co.uk

Date of inspection visit:
21 September 2016

Date of publication:
24 October 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Good** |

# Summary of findings

## Overall summary

This unannounced inspection took place on 21 September 2016. We last inspected Highgrove house in November 2014. Requirements made at previous inspections had been addressed.

Highgrove House is registered to provide accommodation for up to 43 people who require personal care. The home was over two floors with specific units on the ground and first floors of the home. Some of the people living at the home were living with dementia and they lived on the first floor. This upper floor is accessible by stairs or lift. Each unit has access to a kitchen area, lounge and dining room and bathrooms and toilets. Accommodation is provided in single rooms, four of which are en-suite. At the time of the inspection there were 41 people living in the home.

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

We spoke with people living in the home and they made positive comments about their home. They told us that care staff were available to help them when they needed assistance and that staff respected their privacy. Some people who were living with dementia could not tell us their views but those people who could told us they felt safe living there. We were told "I do feel safe here. I am quite happy".

People who lived at Highgrove House said they knew the registered manager of the service well and saw them every day to talk with and felt comfortable doing so. People told us that they would be comfortable raising and complaints with the registered manager.

We noted that there was a clear structure and lines of responsibility within the home and being promoted by the registered manager. The registered manager had notified the CQC of any incidents and events as required by the regulations.

The registered manager used a range of methods to get feedback from people living, working and visiting home in the and promoted open communication. The registered manager and quality consultant had implemented a programme of auditing the care planning systems and practices in the home to help promote continued improvement .The registered manager was well regarded by people we spoke with who lived in the home and the visitors we spoke with.

They service had safe systems for the recruitment of staff to make sure the staff taken on were suited to working there. We saw that care staff had received induction training and on going training and development and had regular supervision and annual appraisal.

We saw examples of staff giving people their attention, offering reassurance and displaying empathy. We

also saw an example of where this was not applied. We recommended that the registered manager formally checked the level of dementia awareness training of non-permanent staff have before they worked with people living with dementia. This was to make sure they could respond appropriately to the needs of people living with dementia.

People had a choice of meals and drinks and they told us the food was "good" and "fantastic" and that they enjoyed their meals. People were involved in discussions and feedback about food at their 'residents' meetings.

The service worked with local GPs, district nurses and health care professionals and external agencies to provide appropriate care to meet people's different physical, psychological and emotional needs.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves.

There was a system for logging comments made about the service and the care received. We looked at the most recent and how they had been managed. We could see that statements had been taken and enquiries carried out so the matter could be resolved to the complainant's satisfaction.

Medicines were being correctly administered and stored and we saw that accurate records were kept of medicines received and disposed of so they could be accounted for. We have made a recommendation about referring to current National Institute for Health and Care Excellence (NICE) medicines guidance regarding best practice guidance.

The environment was being redecorated and was being kept clean by domestic staff. The registered manager had identified the need for changes in the environment to support people with dementia. This included new furnishings and dementia-friendly features to support people with visual, hearing and mobility impairments associated with dementia. We have recommended that the registered provider seek advice and guidance on dementia friendly environments to enhance the support of people living with that condition.
Some items of furniture such as easy chairs had tears in the fabric. We have made a recommendation that the registered provider acts in line with current best practice in infection control. This was to replace damaged furniture to minimise the risks from cross infection.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was safe.

There were sufficient numbers of care staff at all times to meet the assessed needs of people living in the home.

Systems were in place to safeguard people from abuse and these were being appropriately used.

People received their medicines correctly and on time.

Some aspects of good practice concerning medication and infection control required review to make sure they reflected current best practice.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Training relevant to staff roles had been provided.

People were supported to have a nutritious diet.

The home's environment had not been given consideration against accepted best practice in dementia care to support the needs of the people who lived with this condition

### Is the service caring?

**Good**

The service was caring.

People told us they were happy living at the home and felt that they were well cared for.

We saw that staff in the home attended to care needs promptly and people's privacy was being promoted. People were able to see personal and professional visitors in private.

Support was provided so people could follow their own faiths and to maintain relationships with friends and relatives.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Assessments of individual need and risks had been undertaken to identify people's personal care and support needs

Care plans were person centred however, a therapeutic intervention had been introduced without an assessment of need and the intended outcome for the person involved.

There was a system for logging comments made about the service and the care received.

## Is the service well-led?

Good

The service was being well led.

People who lived in the home were asked for their views on how they wanted their home to be run.

Quality audits were being used to monitor care planning, medication management and service provision. The registered provider had employed the services of a quality consultant who had implemented a programme of auditing the care planning systems to help promote continued improvement.

Staff told us they felt supported and listened to by the registered manager. The registered manager welcomed feedback to help them learn and develop the service provision.

# Highgrove 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 took place on 21September 2016 and was unannounced. The inspection team consisted of three adult social care inspectors.

During the inspection we spoke with nine people who lived there. We spoke with people in communal areas and in private in their bedrooms. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We looked in detail at the care plans and records for seven people and tracked their care. We spoke with two relatives.

Some people living at Highgrove House were living with dementia and were not able to give us their views and opinions about the home and their care. To help overcome this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us. It is a useful tool to help us assess the quality of interactions between people who use a service and the staff who support them.

We spoke with three members of care staff, a member of the domestic staff and the laundry staff on duty. We spoke with the registered manager for the home and the quality consultant. The consultant was being employed by the registered provider to implement and oversee a programme of audits and quality monitoring. We also spoke with the visiting hairdresser who visited the home weekly to provide a hairdressing service to people living there.

We looked at records, medicines and care plans relating to the use of medicines in detail for people living in the home. We observed medicines being handled and discussed medicines handling with staff. We looked at medication and records for nine people living in the home at the time of the inspection.

We looked at records that related to the maintenance of the premises, the management of the service and

regarding how quality was being monitored within the home. We looked at the staff rotas for the previous month and at the recruitment records for seven staff working in the home. This included new staff. We looked at records of staff training and supervision.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals made to the local authority, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

Before the inspection, the registered manager completed 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 any improvements they plan to make.

Requires Improvement

# Is the service safe?

## Our findings

We asked people who lived at Highgrove House what it was like living there. One person told us "I am very happy, I wouldn't like to leave. It is so comfortable". We were told by another person "I do feel safe here, I am quite happy with it here". People also told us that the home was kept clean.

We looked at the staff rotas and observed staff deployment during the inspection. A person living at the home told us, "The staff change an awful lot" and we were told by another that "Sometimes they are short staffed but if I need anything I ring my bell. They (staff) come pretty quickly." The registered manager confirmed that recruitment was ongoing. On the day of the inspection there were sufficient staff available to support people's different needs. The registered manager assessed the dependency of the people in the home to plan staffing. The registered manager told us that in order to maintain a safe staff establishment they had used agency staff. This was reflected on the rota.

Staff we spoke with told us there were "usually" sufficient staff on duty and that agency staff were used rather than let the number of staff on duty fall. There were also two domestic staff on duty to keep the home clean and fresh, a laundry assistant to attend to the washing and ironing and the cook preparing the meals. The home also had a part time activities coordinator who was on leave at the time of the inspection. We saw that safe recruitment procedures were in place to help ensure staff were suitable for their roles. This included making sure that new staff had all the required employment background and police checks and references had been taken up.

During our inspection we looked at accident and incident records and found that reporting systems were in place to report these. We noted that the approach being taken by staff to managing risk was not consistent. There was no evidence that anyone had suffered a negative outcome because of this but it presented a risk as staff had taken different risk management approaches. We discussed this with the registered manager and the importance of having a consistent approach to help ensure staff always adopted best practice. The registered manager addressed this issue with senior care staff on the day of the inspection and further training and instruction was given. They provided us with a clear formal protocol that all staff should follow. The understanding and application would be monitored via supervision. Records indicated that staff were receiving regular supervision.

We looked in detail at the care plan of a person living at the home who had exhibited some behaviour that challenged the service. We could see that the registered manager had referred to other agencies and taken steps to support and safeguard this person. A management plan had put in place for staff to follow. We could see examples of where the registered manager had acted to promote people's individual rights and best interests when they had believed it necessary to protect people's rights.

There were records safety checks and servicing in the home including the emergency equipment, fire alarm, call bells and electrical systems testing. We could see that any repairs or faults had been highlighted and addressed. These measures helped to make sure people were cared for in a safe and well maintained environment. We looked at the risk assessments in place concerning fire safety and how people would be

moved in the event of a fire. There was an overall fire risk assessment for the service in place. We saw there were notices within the premises for fire procedures.

We looked at care plans and saw there were risk assessments in place and control measures to help minimise them. People's care plans included risk assessments for skin and pressure care, falls, moving and handling, mobility the use of bedrails and nutrition. Care plans were developed from these assessments.

Staff told us they had received training in safeguarding adults and the training matrix and staff files confirmed this. Staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. The staff we spoke with were confident that the registered manager would follow up any concerns they might raise and take action promptly to make sure people were kept safe. Care records indicated that the registered manager had acted promptly to involve other agencies and get additional support for people where it had been identified they might be vulnerable due to their circumstances.

We made a tour of the home and the areas used by people living there. We saw the environment was being kept clean by domestic staff. We noted that some items of furniture such as easy chairs had tears in the fabric. This meant that they were not easily cleanable to help prevent cross infection. The registered manager confirmed that they had made the registered provider aware of the urgent need for replacement furniture.

We looked around the home and saw that staff had access to personal protective equipment. We saw staff using this equipment appropriately when supporting people and delivering care. The service had procedures and guidelines for staff to work to about managing infection control. The laundry was tidy and the walls and floors easily cleanable. Improvements had been made in the laundry where there were separate entrances for clean and dirty linen to promote good hygiene.

During this inspection we looked at the way medicines were managed and handled in the home. We found that medicines were being safely administered and records were being kept of the quantity of medicines kept in the home and those disposed of. We saw that there were appropriate arrangements in place in relation to the recording of medicines administration and records were signed correctly when medicines were given out. We counted nine medicines and compared them against the records and found all the medicines tallied. One person living at the home told us "They [staff] come and give me my tablets on time. They find me wherever I am".

We looked at the recording and storage of medicines liable to misuse, called Controlled Drugs that were being stored at the time of the inspection. We found that this was being done correctly and safely. We saw that medicines requiring refrigeration were stored within the recommended temperature ranges. There were clear protocols for giving 'as required' medicines and when these medicines had been given, it had been clearly recorded. This helped to make sure that people received the medicines they needed appropriately.

We saw that improvements were underway to provide better clinical areas and medicines storage within the home. However temperatures were not being consistently recorded where medicines were being stored on the ground floor. This was because the thermometer being used was faulty. we raised this with the registered manager during the inspection. In addition, when the medicine charts had handwritten changes made to indicate changes or new doses of medicine these had not always been checked by another suitably trained staff member as a precaution against any errors. We spoke with the registered manager about these good practice issues. We recommend they refer to current National Institute for Health and Care Excellence (NICE) medicines guidance on these areas and take any action needed.

Requires Improvement

# Is the service effective?

## Our findings

People told us the staff who supported them knew how they liked to be supported and always checked with them how they wanted to be helped. We asked people about the food and menu choices in the home. People who lived there were positive about the food provided and told us "The food is fantastic", and "The food is great" and "Foods good" and "Foods OK" and "It's not bad". People we spoke with who were able to give us their views felt that staff respected their decisions. We were told "They [staff] do always ask me if it's OK before they help me"

We saw there was a choice of food at all mealtimes in the home and people were asked what they wanted. We saw that people's care plans had a nutritional assessment in place and that people had their weight monitored for changes so appropriate action could be taken if needed. There was also information on people's dietary needs such as diabetic diets and soft meals.

Our observations included the lunchtime meal in the first floor dining room where 18 people living with dementia were having lunch. The tables were laid with cloths and appropriate cutlery. The chef was in the dining room serving the meals to people. We saw some positive interaction between staff and people who lived in the home. Staff were assisting three people with their meals and were stood or kneeling beside or behind rather than sitting with people to help them eat their meal and prompt them. We recommend that the registered provider finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

We looked at the records held regarding staff training and staff development files. The registered provider's head office held the overall training matrix and they alerted the registered manager when training was due for staff. We saw that staff received an induction to the service and training to carry out their roles. A senior member of care staff we spoke with told us they were being kept up to date with their training and had access to e learning to update. They confirmed they had received and annual appraisal of their performance and received regular supervisions with their manager.

We saw that the registered provider had recently redecorated areas of the home to improve the facilities and the standard of décor in the home. Staff told us that there had been improvements made to the decoration of the home and this had improved the environment for people living there. We could see that some items of furniture had been replaced such as the commodes people used in their rooms. The new ones were modern and easily cleanable to promote good hygiene.

However, we noted that the environment in the home for people living with dementia was not being developed to make it a supportive and enabling one. Research and current good practice in dementia care (for example, Department of Health National Dementia Strategy, Kings Fund) highlight that attention needs to be given to establishing environments that enable people who are living with dementia to find their way around independently. For example, dementia can affect a person's vision so that patterns on fabrics and curtains can appear distorted or the edges of tables and chairs can become blurred. Therefore, attention needed to be paid to matters such as having appropriate furniture. Clear signs (using pictures and words)

help enable people living with dementia to move around more confidently. Items like memory boxes for people to fill with personal items can to help navigate them to their rooms.

The registered manager was aware of this best practice and had identified the need for such changes in the environment. This included new furnishings and dementia-friendly features to support people with visual, hearing and mobility impairments associated with dementia. However, the registered provider had not addressed this aspect of improvement promptly when the maintenance was being done. We recommend that the registered provider seek advice and guidance from a reputable source when they adapt the home's environment so it reflects good practice in the layout to support the needs of the people who were living with dementia.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that 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 the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at care plans to see how decisions had been made and recorded around 'do not attempt cardio pulmonary resuscitation' (DNACPR). We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. No one living there had an advance directive to indicate particular treatment preferences in the event of not being able to make a decision. We saw that people who had capacity to make decisions about their care and treatment had been supported to do so. The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision.

We noted that the information around who held Power of Attorney for a person was not always stated in people's care plans. The registered manager was aware who held this authority and had made efforts to get evidence of these from relatives. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. The manager confirmed that this process would be formalised so evidence could be requested from relatives as part of the admission process. This would help to make sure that people had the legal authority to give consent on care and treatment.

Good

# Is the service caring?

## Our findings

We asked people about living at Highgrove House and if they felt cared for and supported. Those who were able to speak with us made some positive comments about the care they received. We were told by one person, "They [staff] are all my friends" and "They do look after us very well". Another person told us "It's lovely here, the staff are grand, they are lovely". Another person told us that staff were friendly and "We have a good laugh". We were also told, "The staff are all very nice to me". A relative told us "Overall I am very happy with the care [relative] is being given"

People told us that they felt their privacy was respected. We saw that people's privacy was being respected and that staff protected people's privacy by knocking on doors to private rooms before entering. People told us that the staff got the doctor when they wanted them and that doctors and district nurses saw them in their bedrooms for medical examination or any discussions.

We spoke with the hairdresser who visited the home weekly. They told us that the people that came to get their hair done were always" well dressed" and "clean and tidy". They told us that they had never seen anything to suggest people were not happy and well cared for.

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home, who could not tell us what they thought about their care, were being supported. We joined people living with dementia in a communal area of the home and at lunchtime. During our time on the units where people lived we saw that the staff were available to give people assistance but not all the staff took the time to chat and interact with people.

We raised this with the registered manager to pursue with relevant staff. We were told that some staff were not permanent and that might affect their interactions and it would be addressed with them. We recommend that the registered manager formally checked the level of dementia awareness training the non-permanent staff had before they worked with people living with dementia. This was to make sure they could respond appropriately to the needs of people living with dementia. The recently employed quality manager also recognised this as a weakness in training and took action to address this during the inspection.

Equally we also saw examples of staff giving people their full attention, offering reassurance and displaying empathy. We observed a permanent member of the care staff sitting with a person who was living with dementia interacting in a way the person seemed to find soothing.

All the bedrooms at Highgrove House were for single occupancy and this meant that people were able to spend time in private or see people in private if they wished to. Bedrooms we saw had been made more personal with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things. People were able to see their friends and families as they wanted and go out into the community with support. There were no restrictions on when people could visit the home. People were able to follow their own interests, practice their religious beliefs and see their friends and

families as they wanted.

We found that care staff had received training on supporting people at the end of their lives and someone had done the 'The Six Steps' palliative care programme. This was a programme aimed to enhance end of life care and support. The district nursing service and the person's GP also worked with the home to provide the right care and treatments at the end of a person's life. We saw that people had plans in place stating their preferences should their health deteriorate or at the end of life. This included where they wanted to be cared for.

We looked at comments and compliments the home had received from people and families who had used the service. One relative had written a comment about the home in a survey saying, "I was happy to find Highgrove. I visit most days and know [relative] is well cared for. I would recommend Highgrove".

Requires Improvement

# Is the service responsive?

## Our findings

The service had a complaints procedure that was available in the home for people living there and visitors to refer to. We asked people what they would do if they had any worries or complaints. We were told by one person "I would go to see [registered manager] if there was anything I didn't like, but I never need to because everything is fine". One person living in the home told us, "I am well able to make a complaint if I need to and say what I think".

There was also a system for logging comments made about the service and the care received. We looked at the most recent and how they had been managed. We could see that statements had been taken and enquiries carried out so the matter could be resolved to the complainant's satisfaction.

We saw on the home's notice boards many pictures of social events and celebrations that people living there had taken part in. One person told us about going out on a trip to Southport the previous week that they had enjoyed. There was an activities programme displayed in the home. The programme indicated that on the day of the inspection there should be craft activities and individual activities. The activities coordinator was on leave and so not in the home that day so we did not observe these organised activities taking place during the inspection. People living in the home told us that usually there were organised activities going on over the week led by the activities coordinator and that they were supported to take part.

We saw that televisions were on in the lounges but people did not appear to be watching the programmes and some were asleep. Some people preferred to stay in their bedrooms. One person told us, "I would rather sit here and watch my television or read my books. I'm not that interested in the activities that go on". Information on people's preferred social, recreational and religious preferences were recorded in individual care plans.

One person was walking around carrying a doll that we observed had been given to them by a member of care staff. They were cuddling and singing to the doll and stroking its hair. The use of dolls to enhance the wellbeing of people with dementia is called 'Doll Therapy'. It can be used as part of therapeutic activities available to people living with dementia. It can increase interactions between staff and people they support who can talk about the doll and carry out activities relating to it together such as folding its clothes.

This intervention like any other intervention needs to be provided as part of the person-centered care plan stating the intended aims and benefits are for the person. We saw no evidence of this being done as part of an individual care plan where its application had been assessed as beneficial to the person. There was no formal monitoring being done on desired beneficial outcomes for the person using the doll, such as behavioural measures. Management and care staff had not received training on using this therapy. We recommend that the registered provider seek specialist advice and guidance from a reputable source about supporting people and staff in relation to the application of any therapies and adjust their practices accordingly.

Assessments of individual need and risks had been undertaken to identify people's personal care and

support needs. Care plans were developed detailing how these should be met and these were focused on the needs of the individual. We saw in people's care plans that their health and personal support needs and preferences were clear and personal information was included. People's care plans included risk assessments for skin and pressure care, falls, moving and handling, mobility and nutrition. We saw that care plans were reviewed and updated to show where people's needs had changed so that staff knew what the person wanted or needed. We saw that people's personal care needs and risks were being assessed. Staff we spoke with had a good understanding of people's backgrounds and lives.

People who lived at Highgrove House had access to health care professionals to meet their individual health care needs. The care plans and records that we looked at showed that people were being seen by appropriate professionals to help meet their particular physical, nursing and mental health needs. We saw records in the care plans of the involvement of the community mental health team, district nurses and specialist nurses as well as the dietician, opticians and chiropody services.

Good

# Is the service well-led?

## Our findings

People who lived at Highgrove House said they knew the registered manager of the service and saw them every day to talk with. People told us they felt comfortable talking with them and raising any issues with them. We saw during the inspection that the registered manager was accessible and spent time with the people who lived in the home and engaged in a positive and informal way with them. The registered manager was well regarded by people we spoke with who lived in the home and the visitors we spoke with.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). They had been in post since December 2015. All the staff we spoke with told us that they were well supported in the home and felt that they could speak with the manager or supervisors at any time. They said they had regular staff meetings, individual supervision, and annual appraisals to discuss work practices, performance, any problems and areas for personal development.

We spoke with care staff and people who came into regular contact with the home. We were told, "The manager is very good, very approachable" also "[Registered manager] is brilliant, mucks in proper and will help out with anything". A member of care staff told us, "There have been definite improvements in the home and the decoration is much nicer". We were told, "[Registered manager] is always about, and it's a more open culture now". In our discussions with the registered manager and the quality consultant they had been open to the feedback from the inspection team.

We noted that there was a clear structure and lines of responsibility being promoted by the registered manager. Regular supervision was being provided for staff and performance and disciplinary issues were being promptly addressed. The registered manager was attending to quality monitoring and with the quality consultant had identified areas of the service and environment that needed to improve. The registered manager had requested new furniture to replace the damaged items and believed it to be on order but the new furniture had not been yet been received. These matters had been raised with the registered provider so they could be improved for the people who lived there. We recommend that the registered provider seek guidance on infection control and act in line with guidance and to ensure the prompt replacement of the affected furniture to minimise the risks from cross infection.

The registered manager used a range of methods to get feedback and promote open communication. We looked at the minutes of the 'resident's meetings' and saw that people had discussed a range of issues about what they wanted in their home, such as activities, redecoration and menus. There were staff meetings also being held on a regular basis to discuss work and practices and any changes. There was also a suggestion box in the foyer so people could make comments anonymously if they preferred. We also saw that surveys had been sent out to people using the service and their relatives. One relative had commented, "We have seen the home improve a lot over the last 12 months". We found that the registered manager welcomed feedback to help them learn and develop the service provision.

The registered manager used the systems in place to assess and monitor the quality of the services in the home. There was an auditing programme to monitor service provision and care plans and medication

audits were being done regularly. We saw that audits had been done on care plans and medication records on a monthly basis. This was to help make sure that the information held on file was up to date and that the correct medication procedures had been followed by staff.

The registered provider had employed the services of a quality consultant who had implemented a programme of auditing the care planning systems to help promote continued improvement. The consultant was working with the registered manager to highlight areas that required improvement and an action plan had been developed. Some aspects of the action plan had been achieved such as in infection control measures and health and safety aspects. A health and safety audit had identified the need for pedal operated waste bins and these were in use to promote better infection control.

The registered manager had notified the CQC of any incidents and events as required by the regulations.