Bupa Care Homes Limited

Mornington Hall Care Home

Inspection report

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London
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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

The service provides accommodation and support with nursing and personal care for up to 120 adults. At the time of our inspection 118 people were living at the service. The home was divided into four units each capable of accommodating up to 30 people. One unit specialised in residential care, one in nursing care, one in nursing and dementia care and one in residential and dementia care. At the previous inspection of this service in April 2016 we found that they were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because not all staff had up to date training about supporting people living with dementia. During this inspection we found this issue had been addressed. In addition, at our last inspection we found that care plans did not always include details of people's past life history. During this inspection we found this issue had been addressed.

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

The service was safe and had practices in place to protect people from harm. Staff had training in safeguarding and knew what to do if they had any concerns and how to report them. People who used the service told us they felt safe and protected from harm.

Risk assessments were personalised and detailed. Staff had the information they needed to mitigate risks.

Staffing levels were meeting the needs of people who used the service.

Recruitment practices were safe and records confirmed this.

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Newly recruited care staff received an induction and shadowed other members of staff on various shifts. Training for care staff was provided on a regular basis and updated regularly. Staff spoke positively about the training they received.

Care workers demonstrated a good understanding of the Mental Capacity Act (2005) and how they obtained consent on a daily basis. Consent was being recorded in people's care plans.

The service was supporting people who were subject to Deprivation of Liberty Safeguards (DoLS) in an effective way.

People were supported with maintaining a balanced diet and the people who used the service had access to the kitchen without restriction.

There was mixed feedback about the food and some people told us they were unhappy with it. The service

was actively engaging with people to obtain their feedback and act on their suggestions for improvement.

People were supported to have access to healthcare services and receive on-going support and records confirmed this. The service made referrals to healthcare professionals when necessary and advice from healthcare professionals was followed.

Staff demonstrated a caring and supportive approach towards people who used the service and we observed positive interactions and rapport between them.

The service promoted the independence of the people who used the service and people felt respected and treated with dignity.

Care plans were reviewed every month and any changes were documented accordingly.

Concerns and complaints were encouraged and listened to and records confirmed this. People who used the service told us they knew how to make a complaint.

The registered manager had a good relationship with staff and the people who used the service. Staff spoke positively about the registered manager and their management style.

The service had robust quality assurance methods in place and carried out regular audits.

Feedback from people was mixed about how quickly staff attended to their needs. Some people who used the service told us it took a prolonged amount of time for staff to attend to them when they used their call bells. We have made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected from harm and told us they felt safe.

Staff had a good understanding of safeguarding and how to raise any concerns.

Medicines were managed, stored and recorded safely.

Staffing levels were meeting the needs of people who used the service.

Some people told us that it could take a prolonged period of time for staff to respond to call bells and we have made a recommendation about this.

Is the service effective?

Good

The service was effective. Staff induction and training was thorough and relevant to their role.

Staff had a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Feedback about the food was mixed but the service was actively working to make improvements in line with feedback received.

People had on-going access to healthcare professionals.

Is the service caring?

Good

The service was caring. People had formed positive and caring relationships with staff.

The service supported people to make decisions about their care and promoted their independence.

People told us they were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and

reflected people's individual care needs and preferences.

Care plans were reviewed monthly and any changes were recorded.

Complaints were recorded and responded to in line with policy.

Is the service well-led?

Good

The service was well led. There was a supportive culture at the service and people spoke positively of management.

The service carried out regular quality assurance practices.

Staff meetings took place regularly as well as meetings for relatives and residents.

Mornington Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our 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.

Before the inspection we looked at information we already held about this service. This included details of its registration, previous inspection report, notifications, safeguarding alerts and monitoring information from the local authority.

The inspection took place on 25 and 26 July 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we spoke with 23 people living at the home, five relatives, five care assistants, two clinical leads, one domestic staff, a unit manager, a registered mental health nurse, three activities coordinators, the chef manager, the registered manager, general manager, resident's experience manager and regional director. We observed care and support in communal areas and also looked at people's bedrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at 17 care files and 12 staff files, including supervision and training records, medicine records, policies, procedures and risk assessments.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe at the home. One person told us, "Yes, I do feel safe here. There are alarms in the rooms and nothing is a danger to me here." Another person told us, "Yes, I feel safe. Yes, they're very good." A relative of a person said, "[Relative] is definitely safe here." Another relative told us "Things are always good and safe here."

The service had taken steps to reduce the risk of people being abused. There was a safeguarding adult's procedure in place. This made clear their responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission. There was also a policy that covered whistle blowing, known as the 'Speak Up' policy which made clear that staff had the right to whistle blow to outside agencies if appropriate. Staff had undertaken training about safeguarding adults and understood their responsibility for reporting any allegations of abuse. One member of staff said, "Straight away I have to report it to my manager and then we have to inform CQC, social services and family members." Another member of staff said, "I would report it immediately to the home manager." The service kept a record of all safeguarding incidents and had a 'referral tracker' that documented when referrals were made, outcomes and actions and records confirmed this.

Medicines were managed, stored and administered safely. We saw that appropriate arrangements were in place for recording the administration of medicines and these records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. Medicines audits were completed on a weekly and monthly basis by the unit manager and records confirmed this. Any discrepancies arising from audits were discussed in monthly nurses meetings or during supervision sessions and action plans were created as necessary.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. The registered manager told us, "When there is an accident, we record it and look at the actions. It's kind of like a summary and I give feedback and go through it in our risk meetings. It's about reflection and learning and we will make referrals accordingly. We've reduced a lot of incidents recently, for example in May we only had one reported accident."

Risk assessments were in place which set out the risks people faced and included information to mitigate those risks. Risk assessments covered risks associated with moving and handling, falls, smoking, skin integrity, medical conditions and medicines. For example, one person had a risk assessment in place for their diabetes which documented the signs for low and high blood sugar levels and what action should be taken should symptoms become apparent. Another person had a risk assessment in place for when they became agitated and this said, "[Person] becomes distressed when some of the residents are very noisy along the corridor or in the TV or dining room. [Person] needs support when upset. Staff to offer [person] to go outside and show [person] the greenery and flowers and walk in the garden." This meant that staff had the information they needed to support people with risk management.

The service had robust staff recruitment practices in place. Staff told us and records confirmed that appropriate checks were carried out on prospective staff before they were able to commence employment at the service. One staff member said, "They asked for references of where I was working and then they did the DBS check." The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Another staff member said, "They did all the checks. They checked my passport, my DBS, my status to be in the country, everything." Records showed the service carried out various pre-employment checks including criminal record checks, employment references, proof of identity and proof of right to work in the UK. This meant the service had taken steps to ensure it employed suitable people to work at the service.

The premises were well maintained. The service routinely completed a range of safety checks and audits such as fridge temperature checks, fire system and equipment tests, gas safety, and water temperature checks as well as infection control practices. The systems were robust and effective. The home environment was clean was free of malodour. During our inspection we observed members of staff carrying out cleaning practices and we saw that they used protective clothing and gloves.

The regional director told us about staffing levels and the rota at the service and said, "We recruit an additional 20 people to enable us to cover sickness and holiday. We don't use agency staff but we have a good bank staff system. We have also recruited two area nurses and carers so that there is also surplus staff." The registered manager told us, "At the moment we are above our usual staffing level." The service's staff rota showed that a suitable level of staffing was being implemented across the service and any unexpected absences had been covered.

Feedback from people was mixed about how quickly staff attended to their needs. Some people who used the service told us it took a prolonged amount of time for staff to attend to them when they used their call bells. One person said, "Push the bell, nobody will come. One day I had heart pain, I pushed the bell and waited half an hour for the spray." Another person told us. "Sometimes through the day, you can wait for half-an-hour." However, one person told us, "Yeah, they have enough staff." Another person told us, "Sometimes I've called out and they're pretty good on this unit [with responding]." A relative of a person who used the service stated, "They listen and they act." We asked the provider about the extended waiting times and they said they were aware of the delays as reported to them by people who used the service, and records confirmed that investigations were carried out to ascertain the reasons for the reported delays and action plans had been created and circulated to staff. Since our inspection the provider has informed us that all of the call bells throughout the service have been tested to ensure that there are no faults, call bell response times are being audited and also being discussed at all team meetings. The provider gave us assurances that they are taking action to ensure that call bells were responded to promptly. We recommend that the service continue to implement systems to monitor how long it takes staff to respond to call bells.

Good

Is the service effective?

Our findings

At the previous inspection of this service in April 2016 we found that they were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because not all staff had up to date training about supporting people living with dementia. During this inspection we found this issue had been addressed. Basic dementia care was included as part of the staff induction and all staff working at the service were expected to complete a six day training course about dementia. One of the unit managers told us, "I had a six week dementia care course; you go on one day a week for six weeks. All of them [staff] have done it on my unit." An activities coordinator told us, "The dementia training was fantastic." Records showed that nearly all staff had either completed this course or were part way through it and dates had been identified for the remaining staff to attend this course.

Staff told us they undertook regular training. One staff member said, "I did end of life training, nutrition, leadership, medicines, moving and handing, safeguarding and fire training." Staff undertook an induction training course on commencing work at the service. This included a week's classroom based training and working at the service shadowing experienced members of staff. One newly recruited staff member said, "Induction was for one week. We covered how to do the job, how to look after people, dignity, respect, all those things. Then I did shadowing at the home."

Records showed staff undertook training in various areas including moving and handling, safeguarding adults, food hygiene, first aid and pressure ulcer care. Most training was up to date and where it was not the service was able to show dates had been arranged for staff to attend the required training in the near future.

Staff told us they received regular one to one supervision from a senior member of staff. One staff member said, "Every six weeks I have supervision. We talk about my performance, if I need more training, how I am managing the unit. Its good, I get the time to talk about things." Another member of staff said, "[line manager] always does it once a month. If there are any changes she informs us and if I have anything to say she will ask." A third staff member said of their supervision, "We discuss personal development, areas that I or he feels needs improving. How to relate to residents and family, time keeping, team work." Records showed that supervision covered staff training, performance and issues relating to people who used the service. Each staff member also had an annual appraisal of their performance and development needs. This enabled the service to identify areas for improvement in staff and to set achievable goals for staff members.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found the service had up to date policies and procedures in relation to the MCA so that staff were

provided with information on how to apply the principles when providing care to people using the service and we were made aware of people subject to DoLS authorisations. At the time of inspection people who used the service had authorised DoLS in place because they needed a level of supervision that may have amounted to a deprivation of liberty. The service had completed appropriate assessments in partnership with the local authority and any restriction on people's liberty was within the legal framework. We found that the service had submitted notifications to the CQC about the decisions of applications submitted for DoLS for people who used the service. The service kept a record of all DoLS applications, authorisations and refusals and this helped them to track if any authorisations were expiring.

The service carried out mental capacity assessments to determine if people had capacity or otherwise to make decisions about their care. Where people lacked capacity we saw best interest decisions had been made and recorded, for example in relation to administering medicines to a person. Family members and relevant health professionals had been involved in making best interest decisions for people.

People had signed consent forms to allow relevant parties to access confidential information about them. Where people lacked capacity to give this consent family members had signed the forms on their behalf.

Staff told us how they supported people to make choices, for example one member of staff said, "I will open the wardrobe and take out two [items of clothing] and say 'which one do you want?' Sometimes they say neither so I take out another two until we find something they like." One person who used the service said, "They're pretty good with me. I get to choose what I want to wear."

People who used the service gave mixed feedback about the food at the home. One person told us, "I think it's excellent [the food] and you get a choice from two mains. I have a seafood allergy so I never have the fish." Another person said, "It's very good; the food's good." A third person told us, "The food is not so good. I told the cook the food is not good." A fourth person told us, "The food is alright. They can't make rice properly, it is too hard, but it is getting better after we are making noise about it." The chef manager told us that they had spoken to people who were unhappy with the food and we looked at records of feedback forms where this had been documented. The chef manager had recorded their discussions with people and the actions that they were taking to improve the food. The regional director told us, "We've recently had another chef from another of our homes give support to our chef as a result of the feedback we have received from residents. The chef manager has also carried out meetings with the residents who were not happy to gain feedback." This meant the service were responding to the feedback received from people and were taking action to support people who were unhappy with the food.

In addition, the residents experience manager told us, "If a resident wants something in particular [to eat] we do our best to accommodate. The chef will introduce herself to the residents to see what everyone's preferences are. It's about verbally talking to service users and it's a weekly thing. As a result of talking to service users about the food, we picked up through their feedback that they wanted meal times spaced out more so we have implemented this." Records confirmed that meal times were now spaced out in accordance to the feedback the service had received from people who used the service and this was communicated to people in a poster entitled "You said, we did."

The chef manager told us how they managed all of the different dietary requirements and specific needs of people who used the service. They said, "We divide each unit's specific dietary needs and we laminate them, for example halal, weight management, pureed, cultural foods." We saw that each unit's requirements were laminated and displayed in the kitchen for all kitchen staff to access. The chef manager told us, "Normally the nurses update me with people's preferences via care plans but we also use feedback forms. I will go and meet with the residents as a result of their feedback and find ways to meet their needs." People who

required a pureed diet had each food item pureed separately and we saw this during meal preparation. The chef manager told us, "We separate it and make it look attractive in presentation."

The registered manager told us about 'restaurant day' whereby people who used the service and their families could have a four course meal and records confirmed this. The registered manager explained, "It's a special day where we have a four course menu. The kitchen staff dress as waiters and waitresses and we serve wine and beer. It's a family event and people can spend time with their families having a meal." The chef manager told us, "We have restaurant day coming up and we are preparing now." Records showed that preparations and planning was underway and people's friends and relatives were being invited to attend.

People's health care needs were documented in their care plans and the service supported people to access healthcare professionals as needed. Records showed people had access to various healthcare professionals including GP's, dentists, opticians, chiropodists, tissue viability nurses, district nurses and dieticians. We saw where professionals were involved, their guidance was followed. For example, a district nurse had provided guidance about supporting a person with a pressure ulcer which included regular turning of the person and records confirmed this was being done. One person who used the service told us, "They fought like cat and dog to find a dentist for me when [I needed one]. They took me to one in [location] I went in my wheelchair."

Good

Is the service caring?

Our findings

People told us staff treated them well. One person who used the service told us, "I get good care." Another person told us, "It's the whole package – it's about as good as it gets. I can't think of anything they could do better." A third person stated, "This is a very nice place, very nice."

During our inspection we observed caring and friendly interaction between people who used the service, their relatives and staff. A person who used the service told us, "I think they're lovely and they treat you with dignity – like a real person. They don't make me feel like I'm a burden to them." A relative told us, "They're pleasant and friendly and they've got a lot of patience."

The service sought to promote people's independence and care plans reflected this. For example, the care plan for one person stated, "[Person] is able to wash and dress himself. He is able to apply cream to his face, hands and legs. He requires staff assistance to apply cream on his back and to ensure his body is dry before applying cream."Staff had a good understanding of how to promote people's privacy, dignity and independence. One member of staff said, "First of all I have to knock on the door. I greet the person and ask if they would like a bath or a shower. I have to give them a choice." The same staff member added, "I know they can do things for themselves so I have to give them their independence. I have to give them time to do what they can." A person who used the service told us, "They knock on the door and I can do things at my own time and pace."

Another member of staff said, "If I am washing them I make sure I cover their private parts. I ask them what they want and give them choice. Assist them but let them do what they can. They might wash their face and I do their back and legs." A third member of staff said, "Ask them first if they want to have personal care. We have to respect their wishes. We ask them what they need help with and let them do things for themselves." A fourth staff member said, "We go in there and make sure we draw the blinds. We speak to the person and let them know what we are there for. We don't just do things; we let them know what we are doing." A person who used the service told us, "I get regular personal care; bed washing which is all right with me. They do it safely and respectfully." Another person told us, "I have a bath on Sundays and yes they do respect my (privacy and dignity)." A third person said, "They always knock on my door; and they cover me for bed washes."

We looked at people's bedrooms with their permission and found these were homely and personalised to the person's taste. For example, they contained family photographs, religious iconography and personal possessions such as televisions and radios.

People who used the service were supported to receive care in line with their cultural needs. The residents experience manager told us, "We recently found some music [from a specific culture] and the unit absolutely loved it so we are doing 'culture month'. We have people here of all different religions. We also have one service user who is from [country] and they are limited in their communication but when we put music on for them it changes everything in a positive way. We also have an activities coordinator that speaks the same language as the person." In addition, this person's care plan contained a list of words in their language with

English translation to help staff to communicate with the person.

Care staff recognised the importance of treating people as individuals. The resident's experience manager told us, "We don't have anyone here at the moment that I know of who is LGBT (lesbian, gay, bisexual or transgender). If we do, we wouldn't make a judgement about that." People's care plans contained a section titled, "In what ways does the person like to express their sexuality?" This meant that this could be recorded if the person chose to disclose the information.

Good

Is the service responsive?

Our findings

At the previous inspection of this service we found care plans did not always include details of people's past life history. During this inspection we found this issue had been addressed. Care plans now included information about where people grew up, their education, employment, family, hobbies and interests in a document titled 'my day, my life, my story'. Information was personalised around the needs of the individual. For example the care plan for one person stated, "[Person] likes watching TV in his room, especially sport. He is able to open his laptop and watch news and movies from his country. He likes to read books and to smoke outside." This information helped staff to get a good understanding of the person to aid the development of good relations between staff and people.

The service carried out pre-admission assessments. After receiving an initial referral a senior member of staff carried out an assessment of the person's needs. This was to determine if the service was able to meet those needs. Senior staff members who had responsibility for carrying out assessments for their unit told us on occasions they turned down a referral because they were not able to meet the person's needs. They said, "I will not take on high needs dependency as we can't meet those needs." They gave a recent example of a person who had skin care needs that the unit was not able to meet as they did not provide nursing care.

Care plans included information about supporting people with their communication needs. For example, the care plan for one person stated, "[Person] likes information to be delivered to him verbally. Use short and specific words for him to understand." Care plans gave information about the different methods people used to communicate including verbal, body language, touch and facial expressions.

Bedroom doors in some of the units had a photograph of the person and a short pen profile of them which helped to create a homely environment. For example, the pen profile for one person stated, "I was born in London and used to work in a factory. I enjoy knitting, singing and watching TV. I like to be engaged in group activities." The registered manager told us it was planned that this practice would be widened so that bedroom doors across all the units had a photo and pen profile of the person.

Care plans were in place which set out how to meet people' assessed needs. These were subject to monthly review which meant they were able to reflect people's needs as they changed over time. Care plans covered oral care, continence, eating and drinking and personal care. Care plans contained a good level of personal information about meeting the individual's needs. For example, the care plan for one person about skin integrity stated, "Staff to observe for any skin irritations or breaks while supporting [person] with personal care and report any concerns. Staff to elevate feet over stool when [person] is sitting to prevent further pressure and use pillow when he is in bed. Staff to maintain three hourly turning charts while he is in bed." We observed that the person was sitting with his feet elevated and saw that turning charts had been maintained in line with the care plan. The care plan for another person stated, "Staff will switch off the light in the bedroom at night and leave the light on in the bathroom with the toilet door slightly open." This showed care plans were based around people's individual needs.

The service employed activities coordinators that worked between them seven days a week which meant

activities were provided at weekends. Some people were supported on a day trip to Southend on the first day of our inspection. A relative told us, "I can't believe [relative] has gone out today; I'm so happy about that."

The resident's experience manager told us, "There are activities every day, seven days a week. We have one activities coordinator who works a later shift until 6:30pm and we have found that this fills the gap between dinner and bed time." They also told us, "We have a cinema club, we put a film on and people come together, they get a choice of film. We also have entertainment and we will alternate it so that each unit hosts the entertainment." They told us about their most recent summer party, "We've just had our summer party and it was so hot I went to [local supermarket] and got 12 paddling pools, a sand pit, bubble machine, beach balls and ice-cream. It was like a beach day for everyone that could not take part in the trip to Southend beach." The activities coordinators took photographs at the party and showed us how people enjoyed dipping their feet into the paddling pools and eating ice-cream. A relative told us, "[My relative] has enjoyed the events they have had on here, like the garden party." This meant that the service was proactive in supporting people to enjoy the weather and creating a seaside environment so that they could feel included, despite being unable to go on the excursion.

People's care plans contained an 'activity and interaction recording log' to document the activities they had taken part in. This helped staff to monitor people's interactions and to give people one to one support when needed. During our inspection we observed one to one interface between an activities coordinator and people who used the service whereby a memory box was being used with items such as a smoking pipe, which the activities coordinator used to instigate conversation with the person about their past as a smoker. The activities coordinator told us, "We use things like that to stimulate. For example, quite often I get the world map out and some of the residents point out where they are from and they talk about what they like to cook and their recipes. It's a good tool to get them talking." During our inspection we observed the map exercise taking place and people spoke about their country of origin with enthusiasm.

People who used the service told us their relatives could visit them without restriction. One relative told us "Yes, you can visit when you want." A relative told us, "There's always someone to get you a cup of tea and they welcome you here." The regional director told us about the use of Wi-Fi throughout the home and in particular one person who regularly uses Skype and FaceTime to speak to their relatives, "The equipment is set up in their room and they are helped by staff to dial in to their relatives."

The service had a complaints procedure in place. This included timescales for responding to complaints received and details of who people could complain to if they were not satisfied with the response from the service. A copy of the complaints procedure was on display at the service and all people and relatives were provided with their own copy and people told us they knew how to make a complaint. A person who used the service told us "If I had to complain about anything, I'd talk to [unit senior]." We looked at complaints records and saw that complaints were responded to and resolved in line with the policy.

Good

Is the service well-led?

Our findings

Staff told us they felt well supported by senior staff. One staff member said of the registered manager, "She is supportive, she is approachable. If I have a problem I just go straight to her for advice." Another staff member said of their line manager, "She is good. She copes well with staff and residents. We have a good team with her." A third member of staff said of their line manager, "He is a good manager. He wants to work with the team and wants everyone to work like a team." A fourth staff member said, "He is fantastic, he makes sure everything is right. He is easy to talk to and good at listening." A relative of a person told us about the management at the service and stated, "They're very approachable."

The registered manager told us about the ways in which they motivated their staff and supported them to feel valued, "We use 'everyday hero cards' whereby we recognise the work that staff are doing. We give them a thank you card and vouchers. Since we have implemented this we have noticed a boost, it's an incentive."

Staff told us they had team meetings for the staff in each individual unit. One staff member said, "We have quarterly unit meetings. We discuss about team development, supporting service users and meeting their needs." Another staff member said, "They have the meetings for the unit. We talk about the whole thing, residents, staff, everything!" The regional director told us, "We also have a weekly clinical risk meeting with the clinical lead and four unit managers; we discuss things like tissue viability, nutrition and incidents."

The service held a resident and relatives meetings on a quarterly basis and records confirmed this. One person who used the service told us, "The residents' meetings are all right. I put in a request for thinner soup, a consommé." Records showed that this person's request had been documented and the chef was making thinner soups. Meetings for relatives were held on evenings and weekends in order to allow relatives who could not attend during weekdays and records confirmed this. Recent discussions at these meetings included implementing an iPad trial whereby the provider will be researching the use of iPad's in dementia care and developing an app. The registered manager told us, "The iPad's will help us with pictorial support for some people and we are already using certain apps to support people in this way." This meant the service was utilising technology where possible to support people in an innovative way.

The service had robust quality assurance practices in place. The regional director told us, "We have a clinical walk-around every day which is done by the general manager, the resident experience manager and the service manager." We looked at records of the clinical walk-arounds and saw that there was one every day on each unit and looked at aspects such as any clinical concerns, falls, hospital admissions and discharges, GP requests, reviews and identified a resident of the day. The registered manager told us, "The resident of the day will focus on one person and we will invite family, review the care plan, the activities coordinator will get involved, it's a quality assurance tool dedicated to one person every day. It gives us good feedback and action to focus on and gives the resident an opportunity to get involved in their care and feel special for that day."

The service also carried out 'monthly home reviews' and records confirmed this. The regional director explained, "I do these once a month, I go through all of the audits, I check the last two newly employed

starters, admin, cleaning, a general walk around checking if staff are well presented, I'll check high risk care plans, and we check that people who smoke have risk assessments in place." This meant that the service had frequent and consistent overview of the way in which the home was running in order to monitor and rectify any issues.

Spot checks were carried out at night time and early hours of the morning and records confirmed this. The regional director told us, "Normally our night visits are quarterly but now they are monthly." Records showed that there was a recent check at 5am and 03:30am and any issues were addressed and relevant actions were taken and recorded.

The service kept a compliments log. A recent compliment from May 2017 stated, "It is difficult to find the appropriate words to express our gratitude for your care of [person] during the last nine and a half years…" A recent thank you card read, "The staff are so kind to my [relative], he is very settled and happy and feels at home. No complaints."

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when someone has a serious injury. The registered manager had a good understanding of when they needed to notify us. We checked our records and we had been notified when required.