P J Care Limited

# Eagle Wood Neurological Care Centre

**Inspection report**

Bretton Way,
Peterborough,
PE3 8DE
Tel: 01733 516300
Website: www.pjcare.co.uk

Date of inspection visit: 23 April and 21 May 2015
Date of publication: 19/06/2015

## 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 |

## Overall summary

Eagle Wood Neurological Centre is registered to provide accommodation, nursing and personal care for up to 105 adults. At the time of the inspection there were 68 people accommodated in the home. The home is divided into four separate units. These units provide accommodation for people who have high dependency complex care, neuro-rehabilitation, long term neurological conditions and early onset dementia. All bedrooms have en-suite bathrooms and there are external and internal communal areas for people and their visitors to use. In addition there is a gymnasium, hydrotherapy spa pool and occupational therapy kitchen on the ground floor.

At our last inspection on 26 July 2014 we asked the provider to take action to make improvements in relation to the management of medicines. The provider sent us

# Summary of findings

an action plan informing us of the improvements that they would take. During this unannounced inspection, which took place on 23 April and 21 May 2015, we found that the improvements had been made.

The service had not had a registered manager in place since March 2015. 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. A new manager was expected to take up post in June 2015.

Staff were only employed after the provider carried out satisfactory pre-employment checks. Staff were trained and well supported by their managers. Systems were in place to ensure there were sufficient staff to meet people's assessed needs and their safety was effectively managed. Staff were aware of the procedures for reporting concerns and of how to protect people from harm.

There were processes in place to ensure people's health, care and nutritional needs were assessed and effectively met. People were provided with a balanced diet and staff were aware of people's needs. People received their prescribed medicines appropriately and medicines were stored in a safe way.

The CQC monitors the operations of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. We found people's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision making process. However, this was not consistently documented. DoLS applications had been made and agreed by the authorising body.

People received care and support from staff who were kind, caring and respectful. Staff respected people's privacy and dignity. Staff were aware of people's religious and cultural values and beliefs.

People were encouraged to express preferences and make decisions about their care. Care records were detailed and provided staff with sufficient guidance to provide consistent care to each person that met their needs. The staff were responsive to people's individual needs and conditions. Changes to people's care was kept under review to ensure the change was effective.

The manager was supported by senior staff, including qualified nurses, care workers and ancillary staff. People, relatives and staff told us the managers were approachable. There was an effective quality assurance system that was used to drive improvement. People's views were listened to and acted on.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

Staff were only employed after satisfactory pre-employment checks had been obtained. There were sufficient staff to ensure people's needs were met safely.

People living in the home were kept safe from harm because staff were aware of the actions to take to report their concerns. There were systems in place to ensure people's safety was managed effectively.

People were supported to manage their prescribed medicines safely.

Good

**Is the service effective?**
The service was effective.

People received care from staff who were trained and well supported. Staff knew the people they cared for well and understood, and met their needs.

People's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision making process. However, this was not consistently documented.

People's health and nutritional needs were effectively met. People were provided with a balanced diet and staff were aware of people's needs.

Good

**Is the service caring?**
The service was caring.

People received care and support from staff who were kind, caring and respectful.

Staff had a good knowledge and understanding of people's care needs and preferences, including cultural or religious preferences.

Good

**Is the service responsive?**
The service was responsive.

People's views were listened to and acted on. People were able to raise concerns or complain if they needed to. The provider had an effective complaints procedure in place.

People's care records were detailed and provided staff with sufficient guidance to provide consistent care to each person.

Good

**Is the service well-led?**
The service was well led.

The manager and staff understood their roles and responsibilities to the people who lived at the home. Staff were well supported by the management team.

The service had an effective quality assurance system. This was used to drive and sustain improvement.

Good

# Eagle Wood Neurological 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 unannounced inspection took place on 23 April and 21 May 2015. It was undertaken by six inspectors 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.

Before our inspection we looked at all the information we held about the home. This included the 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. We looked at other information that we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We also received information from professionals who have contact with the service. These included commissioners and health care professionals including a GP and specialist nurse.

During our inspection we spoke with 17 people and two relatives. We also spoke with the manager and 36 staff who work at the home. These included members of the management team, nurses, care workers, catering staff, occupational and physiotherapists, and a consultant neuro psychologist. Throughout the inspection we observed how the staff interacted with people who lived in the service. We also 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 18 people's care records, staff training records and five staff recruitment records. We also looked at records relating to the management of the service including audits, rosters, meeting minutes and records relating to compliments and complaints.

# Is the service safe?

## Our findings

The people we spoke with said that they felt safe and did not have any concerns about the way staff treated them. One person told us, "'I am safe because the staff look after me." Another person told us, "The staff are lovely here and I feel very safe." On person's relative said, "It's a lovely home and my [family member] is safe here."

All the staff we spoke with told us they had received safeguarding training. Staff showed a good understanding and knowledge of how to recognise, report and escalate any concerns to protect people from harm. One member of staff told us, "Of course I would report [any poor practice] ... There is information in the office." Another member of staff said, "We can access the whistle blowing system where we can make anonymous reports. If I had exhausted everyone in the organisation I would contact CQC or the local authority."

Staff had considered how to care for people in emergencies and plans were in place to respond to these. For example, personal emergency evacuation plans had been completed, were up to date and contained sufficient detail to be useful to staff in the event of an emergency. Care and other records showed that risk assessments were carried out to reduce the risk of harm occurring to people, whist still promoting their independence. These included, but were not limited to, risks such as skin care, nutrition and roads. For example, we saw a risk assessment in relation to one person who sometimes tried to harm themselves. We saw that the actions in relation to this risk assessment were being followed, including constant observation and the reporting of any marks on the person's body.

Staff were aware of the provider's reporting procedures in relation to accidents and incidents. A quality and compliance manager audited incident and accident reports and identified where action was required to reduce the risk of recurrences.

The staff we spoke with told us that the required checks were carried out before they started working with people. Records verified that this was the case. The checks included evidence of prospective staff member's experience and good character.

Questions had been asked by a commissioner prior to the inspection about staffing levels, so we looked closely at this area. During our inspection people told us, and we found, that there were enough staff to meet people's needs. One person told us that when they pressed their call bell, "Staff come straight away usually." Another person said, "I don't have to wait long for staff but weekends can be busy." Staff also told us there were enough staff to meet people's needs. One staff member said, "The staffing levels are incredible." Another staff member commented on how much this had improved in recent months.

Each unit had an identified team consisting of a unit manager, qualified nurses, senior health care workers, health care workers and an administrator. The manager and staff told us that vacancies were filled by existing staff working extra hours, and agency staff. The manager told us that wherever possible, agency staff were booked in three month blocks to provide continuity of care. Staff told us that the agency staff usually knew the home and people's needs.

During people's pre admission assessment staff took into consideration the staffing levels in the home and adjusted them if required to meet people's needs. Staff told us that people's dependency levels were formally monitored monthly. These were then used to determine the staffing levels. However, staff also told us these were kept under constant review and changes were made to staffing levels as the need arose. We saw that some people had additional staff allocated to them to ensure their needs were met. For example on one unit, two people were accompanied by a member of staff at all times. Another person was accompanied by two staff members at all times. This was in order to ensure people's needs were safely and effectively met. We saw that the staff members observed the people they were caring for. The staff members gave people space to move around the unit but were always nearby to ensure other people's safety.

People told us they always received their medicines on time. One person told us, "I get my medication on time." Another person told us that their "medication is on time. Staff tell me when it's tablet time. They are very good."

Nurses told us that they were trained to administer medicines and that their competency was checked twice yearly. We observed that staff were respectful of people's dignity and practiced good hygiene when administering medicines. We found that medicines were stored securely and at the correct temperatures. Appropriate arrangements

# Is the service safe?

were in place for the recording of medicines received and administered. Checks of medicines and the associated records were made to help identify and resolve any discrepancies promptly.

We noted that one person's medicines administration record showed they were prescribed a medicine to be administered 'when required' but contained no further guidance for staff. The person's health action plan showed this medicine was to be administered within a specific time period of the person having a seizure. It also advised the time period after which an ambulance should be called. We spoke with one of the nurses who worked with this person. They told us they would not give the person the medicine, but that they would call an ambulance. This meant that the person may not be given the medication at the correct time and cause the seizure to go on for longer than necessary. The person's record showed they had had two seizures within the last month. Neither seizure had lasted sufficiently long to require intervention. During our inspection the provider took immediate action to ensure nurses were aware of the treatment plan for this person.

We observed staff respect a person's decision to decline their medicines. The person accepted the medicines when staff offered them later in the day. Staff told us about three people who were given their medicines covertly. This meant these people were not aware they were taking the medicine. We saw that staff had assessed that these people did not have the mental capacity to make a decision about their medicines. However, staff confirmed that no best interest decision had been recorded in relation to this. The unit manager told us a new form had been devised that would guide staff to do this and capture this information. However, this had not been implemented at the time of our inspection.

# Is the service effective?

## Our findings

People told us that they were happy with the staff and that their care needs were met. One person told us, "I am very happy. [The] carers are good and look after me." Another person told us "The staff are good. They are fun." A third person said, "Most staff are good" but that "some of the agency staff are useless." We received a mixed response from commissioners and healthcare professionals, with some telling us that not all staff were well trained, competent or knowledgeable about people's needs.

The staff members we spoke with were knowledgeable about people's individual needs and preferences and how to meet these. They told us that they had received sufficient training suitable for their roles, and in relation to the conditions of the people they cared for. The manager told us that a new education and training manager was in November 2014. They explained to us they had implemented a new induction and training programme for staff. A new member of staff spoke enthusiastically about the induction they had recently completed. They said it was a "really good induction." They told us it had included classroom sessions which included health and safety, safeguarding and managing challenging behaviour. The induction also included shadowing more experienced staff providing care. This meant that staff were provided with an induction into their roles that meant that they could meet the needs of the people they cared for.

Agency staff were also encouraged to attend the provider's training sessions. One agency care worker told us, "I have gained a lot of experience and insight here. They are the best staff I've ever met. Their relationship with agency staff means we are equal. There is no discrimination and I feel like a permanent member of staff".

Staff were also supported to gain qualifications to increase their knowledge. This included Qualification Credit Framework (QCF), formerly National Vocational Qualifications (NVQ) and Apprenticeships in Health and Social Care and other pathways. One member of staff told us, "The new training manager is very helpful." They went on to tell us about opportunities for additional clinical training. The training manager told us the home had recently been accredited by the Open University to train senior care workers to be nurses over a period of up to seven years.

Staff told us they liked working at the home, felt well supported by their managers and spoke with them regularly. One person told us, "I have weekly supervision and chats with the deputy [manager]." Another member of staff who had been in post for one year told us they had, "not had supervisions sessions yet but [I] feel very supported by the nurse and unit manager." One member of the clinical team told us they had regular management supervision, and that clinical supervision was "being organised".

People's rights to make decisions were respected. People's capacity to make day to day decisions had been assessed by senior staff where appropriate. Where people lacked mental capacity to make decisions, some care plans showed that consideration had been given about how to support people with decisions in their best interest. However, this was not consistent. For example, a best interest decision had been recorded and guidelines were in place in relation to a visitor for one person who lacked capacity to make this decision. However, no best interest decision had been recorded in relation to another person whose medicines were administered covertly. Where best interest decisions had been recorded, this involved people who knew the person well, such as their relatives or other professionals.

We spoke with a formal advocate for one person who visits the home monthly and a best interest assessor for another person. Both made positive comments about staff awareness of Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how best interest decisions were managed at the home.

People told us they had enough to eat and drink and said that the food was good. People were offered choices in a way they could understand. For example, with the use of pictures or visual prompts. One person told us, "The food is very nice. There are several things on the menu to choose from." Another person said, "I am well looked after and I get lovely dinners." However, one person said, "There are a lot of drinks on offer," but that, "There is not a lot of choice that I like." One person told us the menu was the same every week and that when asked, some of the support workers did not know what the names of the food were or what they contained.

During the meal time we saw some positive interactions between people and staff. For example we saw one care worker supporting a person who sat in a very low chair. The

# Is the service effective?

care worker was on the floor and talked with the person as well as encouraged them to eat their meal. However, we also saw that one person was not told what they were eating or drinking and there was little communication from the care worker. We saw other, positive interactions at meal times where staff encouraged and supported people to eat and drink. Drinks and snacks, including breakfast, were available and made on the unit in the small kitchenettes.

Records showed that people's nutritional needs were assessed and their weight was monitored regularly. Where appropriate, advice from health care professionals had been sought and followed in relation to people's diets. This included where people had swallowing difficulties.

Where people were identified as being at risk of dehydration or malnutrition, food and fluid charts had been implemented. However, we found these had not been consistently completed in sufficient detail for staff to be able to monitor people's food and fluid intake. This meant that from looking at people's records we could not be confident that each person consumed or was offered sufficient food and fluids.

People were not always supported with their healthcare needs. One person told us they had seen a chiropodist. However, they said, "I need the dentist but [the staff] forget." The unit manager confirmed this person had not seen a dentist since their admission to the home over a year ago. The unit manager told us there was not a system to trigger routine check-up appointments with the dentist.

External healthcare professionals told us that the staff referred people to them appropriately. A GP who visited the home regularly told us that staff referred patients to them "appropriately and in a timely manner." They said that nurses co-operated with them and provided them with relevant information. A specialist nurse who visited people at the home told us, "In the past referrals have not always been appropriate and there have been lots of different staff but recently this appears to have settled and they have more regular staff."

Staff told us and records showed that people had access to a range of health care professionals. For example, physiotherapist, occupational therapist, consultant neurologist, consultant psychiatrist, consultant neuro psychologist, dietician, continence adviser, tissue viability nurse, podiatrist and speech and language therapists. This view was echoed by a member of the clinical team at the home who told us there had been a period of change where improvements had been made to the service.

# Is the service caring?

## Our findings

People told us that they liked the staff and that they were kind, caring and respectful. One person said, "[The] staff are nice and kind." Another person told us, "Staff are very nice and they are caring." A third person told us, "It's lovely here Staff are lovely they help me all the time." However, one person told us, "'[The] carers mainly are good though sometimes they don't listen."

We saw that people were treated in a kind and caring way. For example, we saw staff comforted and settled a person who was very upset. A care worker told us about another person, "I can speak some [relevant language] and can talk with [person], and we do speak. But we usually try to talk in English". The person indicated to us they were very happy with the care worker. Staff told us they would be happy with a family member being cared for at the home. One staff member told us, "I would be happy for a relative to be here. Staff like to do their best for residents and families."

Staff knew people well and told us about people's health and personal care needs and preferences. They also told us how they communicated with people who were not able to speak with them. For example, one person had cards with phrases such as 'turn the TV up' and 'close the blinds'. The unit manager told us they were exploring increasing the range of aids available to people. One person understood, but did not speak, any English. Staff had offered to find someone with shared language skills to speak with the person but they had declined. Staff told us they used an electronic translator and the person's body language to understand them.

Staff were also aware of people's religious and cultural values and beliefs. This information had been incorporated into people's care plans and was taken into consideration when care was delivered. For example, one person's end of life care plan made specific reference to the actions staff should take to ensure religious rituals are carried out when the person dies.

People were encouraged to express preferences and make decisions about their care. One care worker told us, "We have to get to know people. We always ask people [what they want]." Staff told us about a person who had the mental capacity to make decisions relating to their care. The staff member was concerned that the person's condition would deteriorate because they were refusing to follow medical advice. The staff member told us they and other staff had spoken extensively with the person. They told us they had also provided the person with the information, including medical journals, to help them make an informed decision about their care. Another staff member told us, "We ask people what they like and try to offer choices. We try and interact all of the time."

We saw examples of staff respecting people's privacy and dignity. We saw that staff assisted people with their personal care in a discreet manner. We saw a staff member step in quickly to support a person recover their dignity when they exposed themselves in a communal area of the home. Staff apologised to people nearby and continued to support the person.

Staff told us that they encouraged relatives and friends to visit at any time and provided private areas where people could enjoy the company of those close to them. The manager told us there was also the facility for families to stay at the home if the need arose. This was verified by visitors to the home who said they were made welcome.

# Is the service responsive?

## Our findings

People said that staff met their care needs. One person told us, "They do help me and know what I need." We received mixed responses from commissioners. One commissioner told us staff, "demonstrated knowledge around the care and needs of the individual and were able to provide relevant information which left me with a clear impression of professionalism from all concerned. The approach was very person centred."

Staff told us they had sufficient information about people's needs. One member of staff told us, "The care plans are fine. Yes, I can find the information I need." Staff told us there were handover meetings when they come on duty. These were used to provide staff with the most up to date information about a person's health or wellbeing. This meant that staff were aware of any changes that were necessary to provide appropriate care to meet people's needs.

People's care needs were assessed prior to them moving to the home. This helped to ensure staff could meet people's needs. Care records were detailed and included guidance for staff to follow so they could provide care safely and in the way the people preferred. Examples included guidance on assisting people to move, eat and with continence. We noted that although one person spoke limited English, they did not have a care plan that addressed communication. However, reference was made to this in the person's general risk assessment and staff told us that only permanent staff who knew the person worked with them. Staff were knowledgeable about people. They were all able to tell us about people's needs and how they responded to people who were not able to communicate verbally.

The staff were responsive to people's individual needs and conditions. For example, the manager of one unit told us that some people's seizures were triggered by bright colours and light and so the unit was quite dark and the wall colours were deliberately bland. People's rooms had been personalised to reflect their individual taste and preferences. Some people had agreed to key information about them being stored in their room so that staff had the information to hand. This included, for example, information about key aspects of support, diet, religion and activities the person was interested in.

We saw that assessments included people's skin care needs. Care plans included guidance for staff in any actions they should take to reduce the risk of the person's skin breaking down. This included the use of equipment such as specialist mattresses and assisting the person to reposition. We noted that staff did not consistently record when people were assisted to move. Three of the four people who had pressure wounds at the time of our inspection had been admitted to the home with them. The fourth person was able to make decisions regarding their care and refused to follow staff advice.

We saw that people received physiotherapy where this had been agreed and funded by the commissioner. However, we found two people where the physiotherapist had advised that staff assist them with daily exercises which were not being offered or carried out. The unit manager told us they had consulted with the physiotherapist who advised these were passive exercises and the impact of them not being carried out was low. We saw that the physiotherapist had trained six staff on the unit to assist these people with their exercises. The unit manager assured us that rotas would be monitored to ensure these staff members were available to assist with the people in future.

People had mixed views about the amount of activities that were on offer to encourage them in interests, hobbies or community access. Some people told us they often went to a coffee shop, or out for a walk or took part in more organised activities such as sailing. However, other people told us, "I get bored here. I need to do more things." Another person said "I get little choice about where I go, the cinema would be nice… staff never ask me what I would like to do."

We found that people were encouraged to take part in organised activities and impromptu activities. There were photographs on display which showed people who lived at the home engaged in a wide range of different activities. Staff described activities that people could access and told us what people liked to do. For example, "Snooker, bowling, making things for Easter and Christmas." However they added, "People are often not interested." Staff told us that some activities and outings normally had to be pre-arranged so that staffing levels could be planned and the minibus booked. We also noted various impromptu activities taking place, for example, playing football with a

# Is the service responsive?

large soft ball in the communal area, and a member of staff playing a guitar and singing with people in another area. We also saw that people were supported to access the home's gardens.

One commissioner said that they did not feel listened to, especially by managers. However, people said they knew who to speak to if they had any concerns. One person told us, "I would go to the manager if I had a complaint." Another person said they were not aware of the complaints policy but pointed to their care worker and told us, "I would talk to carers." We had a mixed response from external professionals. One advocate told us, "If I raised concerns I feel listened to and that staff will respond."

Unit managers told us they try to resolve any complaints in the first instance. The provider had employed a family liaison officer. This person's role was to discuss with relatives any concerns they may have regarding their family member's care and try to resolve concerns at an early stage. The family liaison officer also investigated formal complaints on behalf of the manager. We saw that complaints had been investigated and responded to within the timeframe of the provider's policy.

# Is the service well-led?

## Our findings

People and relatives made positive comments about the home and managers. For example, talking about a unit manager, one person said, "The manager is a lovely girl and very helpful when I speak to her." A relative told us, "It's a lovely …My [family member] is happy here." However, some people told us they felt their views about the service were not sought. One person said, "I have never been consulted or asked for feedback about this place." Another person said, "They never talk to me about meetings or feedback either"

External professionals had mixed views about the management of the home. One professional said that managers did listen to their views. However, another told us they felt this not to be the case. A GP told us they felt the provider addressed issues within the service. They told us, "Issues have been resolved by a combination of management actions and improved staffing structure with more regular staff on duty and less agency staff."

The local authority had carried out investigations into concerns about the ways people were cared for over the past year. The provider had put an action plan in place to address the issues that were raised. The professional who carried out a recent visit to monitor the action plan stated that the provider had made "good progress in all areas."

Staff made positive comments about the management of the home. Staff were clear about their roles and the lines of accountability. They told us that managers were visible and approachable. Several staff members described the culture as "open". All staff we spoke with were familiar with whistle blowing procedures. They told us they felt confident about reporting any concerns or poor practice to their manager and could raise issues individually or in meetings. Staff told us about a 'Tea for 12' initiative where three senior board directors meet with 12 staff to discuss feedback. These took place monthly with different staff at each meeting. Some staff commented that the senior team were aware of the shortfalls in the service and were working to make improvements.

The manager explained to us that they used innovative ways to encourage staff to learn and test their knowledge. For example, a questionnaire was issued to staff about their new responsibilities in relation to the duty of candour. A completed questionnaire was then drawn from those submitted by a set date and awarded a cash prize.

Senior staff said they felt well supported and could contact more senior managers at any time. One told us, "I have never worked anywhere where there is so much high level involvement. This helps [the directors] know staff and the culture. They are here frequently but we can always ask for advice." We saw managers took action to address areas where staff members' performance had not met with the provider's required standard. This had included referral to a regulator, for example the Nursing and Midwifery Council (NMC).

The last registered manager left the home in March 2015. The Director of Operations was managing the home until a new manager took up post on 1 June 2015. This arrangement was checked with the CQC before it was implemented. The manager was supported by senior staff, including qualified nurses, care workers and ancillary staff. We found that the manager and staff had a good understanding of people's care needs.

The provider issued newsletters to staff, relatives and people with information about any changes or updates to the service. The manager told us about their, and their staff members, links with external organisations, including links with local community groups. Examples of these were visits from the local library, people used local shops and were involvement in sailability. This provided opportunities for people with disabilities to sail. During our inspection people told us about trips to the local shops. This showed the staff supported people to be socially inclusive.

The manager sought feedback from people and their relatives through annual surveys and took action to improve the service. We saw the results of surveys conducted in May and how these had been used to make improvements to the service. For example, the May survey raised concerns about management availability and response. As a result a family liaison officer was appointed in September 2014. Their role was to have contact with relatives to discuss any concerns and resolve at an early stage if possible. The survey conducted in November 2014 showed a marked improvement in positive responses with all respondents stating they would recommend the home to friends and family.

# Is the service well-led?

The manager showed us that there were systems in place to regularly assess and monitor the quality and safety of the service provided. The unit managers provided information for regular clinical governance meetings. This included but was not limited to information about complaints, accidents and incidents. A member of staff from the quality and compliance team carried out an audit of each unit monthly. On one of these audits each month they were accompanied by a member of the board. These audits included the environment and a sample of people's care records. The member of staff who had completed an audit told us they also spoke with people, visitors and staff, although this was not reflected on the audits we saw. The quality and compliance manager told us they used these audits to identify and, if appropriate, address any issues within the units. They said they also used them to identify themes across the home. This helped to maintain and improve the standards of care provided. We saw that any shortfalls found were identified on an action plan and followed up on the next audit, or before for more urgent issues. Other audits were also carried out to monitor the service. For example, a pharmacist had recently audited the administration and storage of medicines across the home. The manager told us that their recommendations had all been implemented.

Records we held about the service, and looked at during our inspection, showed that the provider had not sent all required notifications to the Care Quality Commission (CQC). A notification is information about important events that the provider is required by law to notify us about. However, the provider had recognised this and notified the CQC of recent events appropriately.

Staff told us the provider recognised and celebrated good practice. For example, the provider ran a 'Star Awards' event where people and staff nominated members of staff across the organisation for different awards. They told us a care worker from the home won the provider's Carer of the Year award and a quality and compliance manager won the awards for Leader of the Year and Outstanding Contribution. Staff were also nominated for the Great British Care Awards. These are a series of regional events throughout England and are a celebration of excellence across the care sector. Staff told us that the winners of the regional and national Great British Nurse of the Year award and the Great British Ancillary Worker of the Year award both worked at the home.

The manager confirmed that the regulated activity 'diagnostics and screening' was not carried out at this service. We therefore did not assess this during our inspection. We have asked the provider to consider removing this service from that part of their registration.