CareTech Community Services Limited

Radnor House

Inspection report

139 Canterbury Road
Hawkinge
Folkestone
Kent CT18 7AX
Tel: 01303 894693
Website: www.caretech-uk.com

Date of inspection visit: 3 and 5 June 2015
Date of publication: 14/08/2015

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

The inspection was carried out on 3 and 5 June 2015 and was unannounced. At the previous inspection in November 2013, we found that there were no breaches of legal requirements.

Radnor House provides accommodation and personal care for up to six adults with a learning disability whose behaviour may challenge others. There were six men living at the home at the time of the inspection. The accommodation is over two floors and consists of four bedrooms and two semi-independent flats. People have access to a communal lounge/dining room and a quiet room. There is an enclosed garden to the rear of the home. .

The home was run by a registered manager who was present on the day of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 home had taken reasonable steps to make sure that people were safeguarded from abuse and protected from risk of harm. Staff had received training in how to safeguarding adults and knew what action to take in the event of any suspicion of abuse.

Medicines were managed and stored appropriately. Staff received regular training and their competency in giving medicines was assessed, to ensure people received their medicines as intended by their doctor.

Risks to people's safety were assessed and managed appropriately. Assessments identified people's specific needs, and showed how risks could be minimised. The manager also carried out regular environmental and health and safety checks to ensure that the environment was safe and that equipment was in good working order. There were systems in place to review accidents and incidents and make any relevant improvements as a result.

People's needs had been assessed to make sure that there were enough staff on duty during the day and night to meet people's individual needs.

People's health needs were assessed and monitored. A health care professional said that professional advice was sought when it was needed. Health records were written in a format to help people to understand their content.

People were supported to have a balanced diet. Staff understood people's likes, dislikes and cultural preferences.

New staff received a comprehensive induction, which included specific training about supporting people with a learning disability and behaviours that may challenge. Staff were trained in areas necessary to their roles and also completed additional specialist training such as how to communicate effectively and support people with autism, to make sure that they had the right knowledge and skills to meet people's needs effectively.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent on a daily basis and understood how people with limited or no verbal communication made their choices know. DoLS applications were being made for people who lived in the home to ensure that people were not deprived of their liberty unnecessarily.

Each person who lived in the home had a different way of communicating their needs. Staff understood how to communicate in a personalised manner with each person who lived in the home. Staff spoke with people in a respectful manner, treated them with kindness and encouraged their independence.

People's care, treatment and support needs were clearly identified in their plans of care and included people's choices and preferences. Staff knew people well and understood their likes and dislikes. Clear guidance was in place to identify the triggers and action to take when people displayed behaviour that may challenge themselves or other people. This guidance was appropriately put into practice on the days of our visit.

People were offered an appropriate range of activities which included in-house activities and trips in the community. People were supported to keep in contact and visit friends, family members and people who were important to them.

Staff understood the aims of the home were motivated and had confidence in the management of the home. They said there was now a stable staff team after a long period of staff change and that there was good communication in the staff team.

Systems were in place to review the quality of the service and included feedback from people who lived in the home, their relatives and staff. Improvement plans were developed where any shortfalls were identified to make sure that improvements were made and sustained.

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.

Comprehensive checks were carried out on all staff before they started to work at the home and there were enough staff available to meet people's needs. Medicines were stored and recorded appropriately and staff received regular training to ensure they were competent in administering medicines safely.

The manager and staff knew how to safeguard people.

Risks to people's safety and welfare were assessed and managed effectively.

Good

Is the service effective?
The service was effective.

Staff were trained to ensure that they had the skills and knowledge to support people with a learning disability and behaviours that may challenge. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and the importance of gaining people's consent.

People were involved in planning their meals and received a varied diet.

The home assessed and monitored people's health care needs and liaised with other healthcare professionals to promote their health and well-being.

Good

Is the service caring?
The service was caring.

Most people were not able to make their needs known verbally. Staff knew how to communicate with people according to their individual needs so they could understand their choices and decisions.

People were supported to maintain their dignity and privacy.

Good

Is the service responsive?
The service was responsive.

People received care and supported when they needed it. Staff were knowledgeable about people's support needs, interests and preferences, in order to provide personalised care.

People had opportunities to access the local community and had activities and interests to occupy them when at home.

Information about how to make a complaint available to people in a suitable format and staff knew how to respond to any concerns that were raised.

Good

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

The manager was approachable and there was good communication within the staff team.

Good

Summary of findings

Staff, people and their visitors were regularly asked for their views about the service. Staff had a clear understanding of the home's aims and these were put into practice.

Quality assurance and monitoring systems ensured that any shortfalls or areas of weakness were identified and addressed.

Radnor 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 checked 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 over two days, on 3 and 5 June 2015 and was unannounced. One inspector, who had skills and experience in communicating with people with a learning disability, carried out the inspection.

Prior to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service. Before the inspection, we asked the provider to complete 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 improvements they plan to make. The provider returned a PIR within the set time scale. We also obtained feedback from a care manager and safeguarding coordinator from social services.

Most people were not able to talk to us about their experience of living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two people who lived in the home, observed staff supporting people with snacks and daily activities and communicating with people throughout the day. We spoke to the home manager, five staff including senior and care staff care staff, and the service improvement manger. We saw the communal areas of the home and two people's bedrooms. We spoke with staff about the care needs of three people who lived at the home, spoke with these people, looked at their care plans and observed how staff supported them. This was to track how people's care was planned and delivered.

During the inspection we viewed a number of records including three staff recruitment records, the staff training programme, staff meeting minutes, staff rota, medicine records, environment and health and safety records, risk assessments, menus and quality assurance questionnaires.

Good

Is the service safe?

Our findings

People who were able to communicate with us, told us that they felt safe living at Radnor House. One person told us, "I like it here as it is busy and quiet. There are always staff around to help me. They help me with my medicines".

All staff had received training in how to recognise and respond to the signs of abuse. Staff understood that if they witnessed any form of abuse they should immediately ensure that the person was safe, that they should report their concerns to a senior member of staff or the manager, and accurately record the details of the incident. Staff said they felt confident any concerns they raised would be listened to. However, they knew if their concerns were not taken seriously, they should refer them to a person's care manager or the police. The telephone numbers for these organisations were available to staff, so that there would be no delay in reporting any serious concerns and so keep people safe. The company had a 'whistle blowing' free phone line and an email address to enable staff to share their concerns in a safe way with non-operational management staff. Whistle blowing is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

The manager had a copy of the document 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway'. This contained guidance for staff and managers on how to protect and act on any allegations of abuse. The manager was aware of when and how to contact the local authority about any safeguarding matters so that advice could be sought about how to keep people safe. A member of the social services safeguarding team said that the home cooperated with them when any safeguarding concerns had been raised, and that there were no safeguarding concerns at the time of the inspection.

Medicines were stored securely in a dedicated medicines room to which only senior staff had admission as they were the key holder on shift. All the medicines that we saw were in date. Medicines with a short shelf life, such as creams, were routinely dated on opening and a calendar entry made to ensure they were given before they became unsuitable to administer. Medicines were received into the home from a pharmacy each month. A senior member of staff was responsible for checking all medicines to ensure they matched with the medication administration record (MAR) printed by the pharmacy. Most medicines were administered using a monitored dosage system or "blister packs" so that the name of the medicine and the person for whom it was prescribed was written on each medication. Medicines not contained in blister packs were counted daily and all medicines were audited on a regular basis. All these actions helped to ensure that people were given the right medicine as prescribed by their doctor.

All staff who administered medicines had received training in how to do so safely and this was regularly refreshed. Staff competency in giving medicines was assessed yearly and a senior member of staff told us that this was to be undertaken every six months. The medicines policy was on display in the medicines room and included information on how to administer, store and dispose of medicines. Medicines that could be brought without a prescription, such as for pain relief and colds, were available and had been checked by each person's doctor to make sure that they did not affect any medicines that the person was taking. Details were kept of each person's requirements in relation to their medicines. This included what people's medicines were for, how people liked to take their medicines and any side effects to look out for. Medication administration records (MAR) were clearly and accurately completed and clear guidance was in place for people who took medicines prescribed as and 'when required (PRN). Staff knew to record on the MAR if people refused to take their medicines and when to call their doctor, to ensure that their health was maintained.

Each person's care plan contained individual risk assessments. This was to ensure that risks to people's safety in their everyday lives were identified, and that action was taken to minimise these risks. These included risks when people were undertaking household tasks, going out in the community and in relation to their behaviours that may challenge themselves or other people. For people who had been assessed as having behaviours that may challenge themselves or others clear and detailed guidance was in place about the triggers that staff should look out for. Positive strategies that staff should follow had been identified to reduce the risk of any of these behaviours occurring or escalating. Staff demonstrated that they understood how to follow this guidance and we observed it in practice on both days that we visited the service.

Good

Is the service safe?

The manager carried out regular environmental and health and safety checks to ensure that the environment was safe and that equipment was fit for use. These included making sure that the water was maintained at a safe temperature, that fire equipment was in working order, that the risk of a potential fire occurring had been minimised and that electrical and gas appliances at the home were safe and that infection control protocols were being followed. The emergency lighting was being fixed on the first day of our visit, as a test the previous day had highlighted that it was not working appropriately. The cover for a radiator in one person's room was broken and did not protect this person from the risk of scalding themselves. The cover was mended on the second day of our visit to ensure this person's safety. An external company carried out a health and safety audit in May 2015 and action had been taken to address any shortfalls.

Each person had a personal emergency evacuation plan (PEEP), which set out the specific physical and emotional requirements that each person had to ensure they were safely evacuated from the home in the event of a fire, both during the day and at night. Environmental risk assessments were also in place to minimise the risks of people living and working in the home from hazards such as slips, trips and falls.

Accidents and incidents were reported to and monitored by the manager. Information about accidents and incidents were also sent to the company's head office, so that any trends or patterns could be identified and action could be taken to reduce the occurrence of any of these events.

People had been assessed as requiring high levels of staff support to keep them safe. Five of the six people who lived in the home required one to one support. Six members of staff were allocated on the duty rota each day between the core hours of 9.30am and 7.30pm. At night time there were two waking night staff. Our observations were that there were enough staff to support people in the home and for people to go out in the community.

People applying for a position at the home completed an application form and attended an interview. At the interview applicants completed a short written test and answered a number of standard questions to ensure that each applicant was treated fairly. If the person was successful, the manager checked the applicant's work history, references and undertook identification checks. All the information was then sent to head office who understood reference checks and criminal record/barring and vetting checks. Therefore, all checks had been carried out to ensure the applicant was a suitable person, before they started work at the home.

Good

Is the service effective?

Our findings

One person told us they chose, brought and cooked some of their own food. A menu planning meeting was held so people could be involved with and choose what they wanted to eat. The menu was presented in picture format so people could understand what was available to eat at each meal. People could also make drinks and snacks throughout the day.

A record of what people ate each day was recorded and people were encouraged to maintain a balanced and nutritious diet. There was a four weekly menu with meal options. People's likes, dislikes and cultural needs with regards to food were contained in their plans of care. To encourage people to socialise, people ate their meals in the dining room.

The home had reliable procedures in place to monitor people's health needs. People's care plans gave clear written guidance about people's health needs and medical history. Each person had a "Health Action Plan" which focused on their health needs and the action that had been taken to assess and monitor them. This included details of people's skin care, eye care, dental care, foot care and specific medical needs. These plans were written in a way which helped people to understand their content. For example, for a person with a specific health care need, information and pictures were used to explain their condition and the medicines they needed to take to keep them in good health.

A record was made of all health care appointments including why the person needed the visit and the outcome and any recommendations. People's weights were recorded monthly so that prompt action could be taken to address any significant weight fluctuations. In addition each person had a "Hospital Passport". This provided the hospital with important information about the person and their health if they should need to be admitted to hospital.

The home had links with health care professionals, including the chiropodist, dentist, psychiatrist and speech and language therapist and community learning disability team. The service had received a compliment from a health care professional who said, "There are good communication systems in place. The home always refers people to the appropriate services when they are required".

New staff received a four day external induction which covered an introduction to the company and training in the skills that they required for their role. Staff also completed a four day induction at the home, where they familiarised themselves with people's care plans and the home's policies and procedures. Staff completed a workbook, based on Skills for Care's "Common Induction Standards (CIS)".Their knowledge was checked by a senior member of staff to ensure that they understood the information that they had read. CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. New staff also shadowed senior staff undertaking care with people who lived in the home. Each new member of staff was assigned a "learning champion", whose role was specifically support them. Staff told us they found the support from learning champion excellent as they had an allocated member of staff to go to if they needed help and support. Four staff had completed a Diploma/Qualification and Credit Framework (QCF) level two or three in Health and Social Care and a further nine staff had commenced this training, out of a staff team of 21. These qualifications build on the Common Induction Standards and are nationally recognised qualifications which demonstrate staff's competence in health and social care.

Support for staff was achieved through individual supervision sessions and an annual appraisal. The manager supervised senior staff and senior staff, supervised care staff. At annual appraisals staff rated themselves in specific areas and then the manager rated them and gave them feedback about their performance. There was also an opportunity for staff to discuss their training and future needs.

Staff had their own training account and the manager was sent a spread sheet weekly which informed them when staff were required to refresh their training. Most training was undertaken on a computer which staff said was comprehensive. Staff knowledge was tested at the end of their learning to ensure they had gained the appropriate level of skills in each topic area. Moving and handling and first aid training was class room based. There was an on-going programme of development to make sure that all staff were kept up to date with required training subjects. These included health and safety, fire awareness, moving and handling, emergency first aid, infection control, safeguarding and nutrition. Staff also undertook specialist training in the prevention and management of behaviours

Good

Is the service effective?

that challenge, alternative communication and autism awareness. In addition some staff had been booked on "SPELL", which is an alternative type of communication for people on the autistic spectrum.

Some people displayed behaviours that may harm themselves or other people. Staff had received training in how support these people in a non-restrictive way. Staff demonstrated they understood how to put these methods into practice and used them during our visit. Staff used calm and measured approach which ensured that people were not physically restrained when managing people's behaviours.

Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they can be given the care and treatment they need, where there is no less restrictive way of achieving this. Staff understood a principle of the Mental Capacity Act 2005, that everyone should be assumed to have capacity. They said that everyone living at the home had the capacity to make day to day decisions and choices. They explained how people with limited or no verbal communication made their decisions known through signs, body language or actions.

Staff considered people's consent on a daily basis and these decisions were recorded in each person's daily notes. For example, one person had said they did not like their dinner. However, they then sat down and ate it, showing their consent. One person verbally agreed to receive support with their personal care and another person communicated that they did not want to go out for a drive when it was offered to them.

The manager understood the principles of the Mental Capacity Act 2005. He explained the circumstances in which best interest meetings had been held with relevant professionals and relatives to make a decision on people's behalf, when they had been assessed as lacking the capacity to do so. Deprivation of Liberty Safeguards applications had been made for three people living in the home and were being prepared for two other people who lived in the home. These applications varied and included ensuring people could not leave the premises without the staff support that they required to remain safe. These applications ensured that an independent assessment would be made as to whether these people were being deprived of their liberty.

There was some signage in the home for people whose first language was not English, to help them to find their own room and the bathroom. A new kitchen had been installed earlier in the year and new flooring had been laid. The chairs in the dining area looked worn and we saw an order form which showed that new chairs had been ordered but their delivery was overdue. The wallpaper was coming off one person's bedroom. This person told us they were making preparations to paint their room with staff support. The upstairs bathroom and a downstairs bathroom looked worn and well used. Confirmation had been received from the company that both bathrooms would be refurbished, but the company had not provided a timescale for these works.

Good

Is the service caring?

Our findings

Most people were not able to tell us about the staff support that they received. One person told us they often talked with staff and that they listened to them. We saw this person sitting with two members of staff, drinking tea and chatting. Everyone had a relaxed manner and was very much at ease in one another's company, showing that this was a regular event at the home. The home had received a compliment from a family member who said, "The home is very friendly and approachable. I feel confident that my son is supported to be active and enjoy a variety of experiences. He is supported towards independence and is very happy".

The staff supported people to maintain contact with friends and relatives. This included helping people to send friends and relatives cards, to speak to them on the phone, and to arrange home visits. Staff positively supported friendships that people had outside the home and this benefited the people involved.

On both days of our visit staff communicated with people in an appropriate manner according to their understanding. They communicated with some people using Makaton and other people using short words and phrases. Makaton uses speech with signs (gestures) and symbols (pictures) to help people communicate. We heard one member of staff speaking in a steady and quiet voice to a person who could become anxious. The staff member asked the person short simple questions, in a soft voice, to direct this person to the activity in hand and help them to remain calm.

Each person had a communication passport, which gave practical information in a personalised way about how to support people who cannot easily speak for themselves. The passports gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, and angry or in pain. They also contained information about how staff should respond. For example, one person's communication passport explained that if a person was anxious they would mimic staff and if they became angry staff needed to gain their eye contact and distract them with a drink or an activity.

Most people required one to one support and supervision. Staff ensured they gave people as much freedom as it was safe to do so. One person liked to walk around the home and in the garden. Staff kept a discrete eye on this person so that they could see them at all times, but did not always follow them, to make sure they had their own personal time.

People were supported to be as independent as possible and to take responsibility for aspects of the household routine, and making drinks and some meals. One person was working towards taking their medicines independently. They were able to take their own medicines, but needed staff to be present to ensure that they did so in order to maintain their health.

People's ability to express their views and make decisions about their care varied. To make sure that all staff were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. At the front of one person's care plan it was recorded that the person liked specific music and a particular type of food, but they could also become anxious and unsettled.

Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. When staff spoke about people they focused on the positive aspects of their character and described their enjoyment in supporting people to get the most out of their lives. People were involved in their plans of care according to their understanding and abilities. One person showed us their plan of care and pointed to the words and pictures that were important to them. This meant that this person had been involved in the development of their plan of care.

Good

Is the service responsive?

Our findings

Most people were not able to tell us about their experiences in living at the home. One person told us that if they had any worries of concerns they could talk to the member of staff or the manager. This person voiced some concerns to the manager on the day of our visit. The manager listened carefully to what this person had to say and replied how they would address them. The person was satisfied with the response that they received.

Staff said that if a person told them something was upsetting them, they would try and resolve things for the person straight away. If they could not do so, they would report it to the manager. Staff told us most people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right with them that need further investigation. To help people understand the complaints procedure, it was available in easy read and picture format. The complaints procedure for visitors and relatives included information about how to contact the ombudsman, if they were not satisfied with how the service responded to any complaint. The manager made a record of any complaints, together with the action they had taken to resolve them.

The policy of the company is that people's needs were assessed before they moved into the home, and that an assessment was obtained from the local authority so that a joint decision could be made about how people's individual needs could be met. When people came to the home as emergency admissions, the local authority assessment was obtained. These assessments formed the basis of each person's plan of care.

Care plans contained detailed information and clear directions of all aspects of a person's health, social and personal care needs to enable staff to care for each person. They included guidance about people's daily routines, communication, well-being and activities they enjoyed. Each person had a one page profile so staff could see at a glance, what was important to the person and how best to support the person. Pictures were used in people's plans of care to help them understand their content. One person showed as a map in their care plan which detailed how they travelled from their home to an activity they took part in. Some of these plans were being reviewed by the service improvement manager at the time of our visit to ensure they were personalised and that an accurate plan was maintained for each person.

Information about people's daily routines, likes, dislikes and preferences were contained in their plans of care, which were written from the person's point of view. For example, one person plan stated that the person liked to have a bath in the morning that they could do this independently, but needed to be reminded to clean their teeth. Detailed guidance was in place for staff to support people who presented behaviours that could harm them or other people. The specific behaviours that the person may exhibit were clearly listed, together with the appropriate response that staff should take and information about what could trigger the behaviour. People's moods and behaviour were observed and recorded together with any lessons learnt from any incident that could inform future ways of positively supporting the person. People's well-being was discussed at staff meetings, reviewed by the manager and health professionals were involved as appropriate.

Information about what activities people liked to take part in was recorded in their plans of care. One person told us that they had a part time job in the local area. During out visits to the home people were occupied in household tasks, watching what was going on and spent time in the garden. One person proudly showed us a pond in the garden which they had helped to build.

People were asked throughout the day if they wanted to go out in the community. People went out to the shops, for a drive, a meal, a walk and to visit family members and friends. One person had a drive in a jaguar car at a local garage which was something that they particular enjoyed.

Good

Is the service well-led?

Our findings

The manager communicated with people according to their individual needs which showed that they knew people well. A social care professional told us that they had given the manger advice on how to support a person who lived in the home and commented that, "They have worked very hard with my client".

The aims of the service were displayed at the home and on the company's website. The manager and staff were clear about the aims of the home. Staff said that it was important that people who lived in the home made their own decisions, were supported to be as independent as possible, that their rights were respected and that they participated in community life. They said that this was made possible by a good manager and a staff team who communicated and worked well with one another.

There had been a high turnover of staff since our last visit to the service in November 2013. The home had been using agency staff to cover shifts until three months before our visit. A core number of staff had worked at the home for a number of years, but most staff had been recruited within the last three months to a year. Staff told us that there was now a full staff team and two senior staff in place which had improved staff morale and their ability to consistency supports the people who lived in the home. Staff said that there was good communication in the staff team that they worked well together and staff meetings were regularly held. Staff demonstrated that they enjoyed their jobs and supporting the people in their care.

The views of people who lived at the home were sought at individual keyworker meetings and service user meetings. The last service user meeting was in March 2015 where people were informed of new staff and helped to choose a new dining room table and chairs. The views of people's relatives and staff were sought through annual questionnaires. There had been a low response to questionnaires from relatives. The manager had phoned a relative who responded that if they had any concerns about the care at the home they would get in contact. Questionnaires for all staff who worked for the company had been sent out in May 2015. We looked at the responses from the previous year, but as they were from staff nationally, they were not representative of the views of staff working at the home.

There were effective systems in place to regularly monitor the quality of service that was provided. Each month aspects of care were audited such as medication, care plans, health and safety, infection control, fire and equipment. The locality manager visited monthly to check that all audits had been carried out. They completed an improvement plan which set out any shortfalls that they had identified on their visit. This plan was reviewed at each visit to ensure that appropriate action had been taken. The compliance and regulation manager from the company visited the home twice a year. During their visit they looked at records, talked to people and staff and observed the care practice in the home. A detailed report was produced about all aspects of care and treatment at the home. It identified any shortfalls which were added to the homes' improvement plan so that they could be reviewed monthly by the locality manager. The report highlighted updating care plans and risk assessments. The service improvement manager was present at the home during our visit to give extra support to the home in updating these records. In addition the companies finance department visited twice a year.

The manager had identified on the provider information return, areas where the home could improve. Action had started to address some of these areas including new observational supervisions by senior staff, developing new care plans and risk assessments in conjunction with personalisation training, and providing sensory equipment for specific people who lived at the home. This showed that the home had systems in place for continuous improvement.