Bupa Care Homes (ANS) Limited

Freelands Croft Care Home

Inspection report

Redfields Lane
Fleet
Hampshire
GU52 0RB

Tel: 01252855340
Website: www.bupa.co.uk

Date of inspection visit:
13 March 2017
14 March 2017

Date of publication:
12 April 2017

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

We carried out an unannounced comprehensive inspection of Freelands Croft Nursing Home on 13 and 14 March 2017.

Freelands Croft Nursing Home provides accommodation and personal and nursing care for up to 64 older people who are frail or are living with dementia. Accommodation is provided over two floors with the first floor providing nursing care. At the time of our inspection 54 people were using the service.

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 is required by a condition of its registration to have a registered manager.

The provider operated effective quality assurance systems. Regular checks and audits were completed which enabled the registered manager and staff to continually evaluate the quality and risks in the service. We found these systems had been effective in driving improvements for example, in relation to staff supervisions and daily activities in the service for people. Clinical governance systems enabled nursing decisions to be reviewed and monitored to ensure care was being provided in accordance with best practice standards.

The provider implemented safe recruitment practices and we found all the required staff pre-employment checks had been completed to ensure staff would be suitable to work at the service.

People received their prescribed medicines safely and had access to healthcare services when they needed them. People liked the food and told us their preferences were catered for. People received the support they needed to eat and drink enough.

Staff had a good knowledge of their responsibilities for keeping people safe from abuse. Staff sought people's consent before they provided their care and support. Where people were unable to make certain decisions about their care the legal requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed.

Care plans were based around the individual preferences of people as well as their medical needs. They gave a good level of detail for staff to know what support people required. Staff received training and supervision to support them to meet the individual needs of people effectively.

Staff knew people well and supported people living with dementia to manage their anxiety and agitation. People were treated with kindness, compassion and respect and staff promoted people's independence and right to privacy. The staff were committed to enhancing people's lives and provided people with

positive care experiences.

People knew how to make a complaint. People told us the manager and staff would do their best to put things right if they ever needed to complain.

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 felt safe when supported by staff and staff understood their responsibilities to report abuse.

People's risks to their health and safety had been identified and staff knew how to protect people from the risks associated with their care and treatment.

There were enough suitably skilled staff deployed to meet the needs of people. Recruitment processes for new staff ensured they were suitable to work with vulnerable people.

The provider had appropriate arrangements in place to safely administer people's medicines when required and staff understood the risks associated with people's medicines.

Is the service effective?

Good

The service was effective.

People received effective care and support from staff who received the training and support they needed to perform their roles.

People's rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked mental capacity relatives and other professionals were consulted when decisions needed to be made about people's care and treatment.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs and preferences.

Effective liaison with health professionals ensured people's health needs were addressed.

Is the service caring?

Good

The service was caring.

People and their relatives gave positive comments about staff and how caring they were when supporting people. We observed staff offer support that was kind and compassionate.

People received care from staff who knew their history, likes, needs, communication skills and preferences.

Relatives felt, and observations showed, people's privacy and dignity were maintained.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and care plans detailed how people wished to receive the support they needed. The environment had been adapted to support people living with dementia to remain independent.

People had access to activities and events which they enjoyed. They were supported to maintain their personal relationships.

People and their relatives told us they felt involved and their concerns and complaints were listened to and acted upon.

Is the service well-led?

Good

The service was well-led.

The provider had systems in place to monitor safety and drive improvements in the quality of the home. The service worked in partnership with other organisations to make sure they were following current practice and providing a high-quality service.

People and staff were positive about the leadership of the registered manager and staff were clear about their role and responsibilities.

There was an open and transparent culture in the service. Staff, people who used the service and relatives were encouraged to

identify risks and to support the improvement of the home.

Freelands Croft 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 regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 14 March 2017 and was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people's care services.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, previous inspection reports, notifications and all contacts we had about the service. A notification is information about important events which the service is required to send us by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. During the inspection we spoke with six people who used the service, three relatives and the specialist nurse for nursing home who was visiting the service at the time of our inspection. We spoke with the registered manager, two unit managers, three senior care workers, five care workers, a member of the housekeeping team, the chef, kitchen assistant, a nurse, an activity co-ordinator, the Area Manager and the Regional Relief Home Manager who supported the registered manager.

We attended the daily staff catch up meeting. We viewed a range of records including care documents for six people who used the service, five personnel files and records relating to the running of the service.

We had previously inspected the service in January 2016 and no breach of regulations were found.

Good

Is the service safe?

Our findings

People and their relatives told us they had no safety concerns when people received support from staff in the service. One relative said "I feel safe and reassured, we see staff giving care and (loved one) is well cared for, the care is good. We visit at different times of the day and always see staff being kind and considerate, they are respectful". They said they would be confident speaking to any member of staff or the registered manager if they had any concerns. Staff had completed adult safeguarding training as part of their induction and ongoing training. They were able to identify the procedures they needed to follow should they suspect a person in their care had been or was at risk of abuse. Records showed the registered manager had reported and investigated allegations or suspicions of abuse in accordance with the agreed multi-agency procedures. Systems were in place to ensure people were protected from abuse.

Staff knew how to follow whistleblowing procedures and how to raise concerns anonymously if required. They told us they were confident that any issues they raised would be addressed to keep people safe and to improve the service people received. One staff member told us "If I had any concerns about my colleagues I will speak immediately to the senior carer or nurse. If they are not here I will speak to the manager and they will definitely do something about it''. Staff were also aware of other organisations with which they could share concerns about poor practice or abuse.

Risks to people's safety and staff supporting them had been identified using universally recognised screening tools, effectively managed and reviewed. These areas of risk included any potential hazards in the environment, risks when people were supported by staff to move or transfer, risk of falls, weight loss, choking and the development of pressure ulcers. For example, one person at risk of falls had been assessed and appropriate arrangements were put in place so staff would know how to support them to mobilise safely. They had been provided with the necessary equipment such as a mobility walker and we observed staff supporting them in accordance with their mobility plan.

Records showed when people fell they were observed at regular intervals to assess for any injury so that medical support could be requested in a timely manner if required. People's care plans had also been reviewed after a fall to ensure their mobility risk management strategies would remain effective. Staff had received training in safe moving and handling and could describe how they would use hoisting equipment safely. Another person had turning charts in place which demonstrated that people at risk of developing pressure ulcers were having their position changed as highlighted in their risk assessment to relief the pressure on their skin. Staff demonstrated that they knew what action to take to keep people safe in accordance with their care plans.

Staff had been required to undertake full pre-employment checks before they were offered employment and could work with people unsupervised. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had also been completed to ensure nurses were fit to practice. The provider had used the interview process to assess staff's relevant skills and experience and to support the registered manager to plan an induction for new staff. The provider had taken into account all known risks relating to each candidate when making recruitment decisions to ensure staff's

suitability to work with people.

People, relatives and staff told us there were enough staff to meet people's needs and keep them safe. The provider used a systematic approach to determine how staff were to be deployed on a daily basis. New referrals to the service and the changing needs of people in receipt of a service were reviewed monthly and the staffing levels adjusted accordingly. This ensured that sufficient staff would be available to meet people's changing needs. For example, we saw additional staff were provided for one to one support to keep people safe when they were at high risk of falling or became anxious and confused.

We observed there were sufficient staff; for example, we did not notice any people left waiting to be attended to, and on the occasions when we heard the call alarms or people calling for assistance they were responded to quickly. When people were supported for example, to eat during lunch time, this was unrushed and provided at people's pace. The provider continued to recruit to staffing vacancies and when agency staff were used they were familiar with people's needs and had worked at the home for some months. Care staff were required to work both days and nights and this ensured people always received care from staff that knew them.

Systems were in place to ensure people received their medicines safely as prescribed. People's medicines were stored safely and those requiring refrigeration were monitored appropriately. Controlled drugs (CDs - medicines with potential for misuse, requiring special storage and closer monitoring) were stored securely. Nurses carried out weekly stock balance checks and managers reviewed CD stock levels regularly. Unwanted CDs were safely disposed of and CD records were kept according to legislation.

People's medicine administration records charts (MARs) were stored securely and included details of peoples' allergies and there were no missed doses. There was a record of decision making which included the GP and pharmacist, when people were given their medicines covertly, for example hidden in food. Information was available to staff to ensure "When required medicines" were given in a timely and consistent way by the staff.

Medicines errors and near misses (errors that are identified before the medicine reaches the patient) were reported, investigated and discussed by staff and they told us of the teaching sessions they had attended to reflect and learn from medicine errors.

We observed the morning medicines round and saw staff followed best practice when administering people's medicines. Nurses and senior care workers administered peoples' medicines. They completed annual medicines administration training and assessments were carried out to ensure they were competent to administer medicines safely.

Staff understood each person's vulnerability to infection and took action to protect them from the spread of infection. We saw staff washed their hands prior to undertaking any procedures and when delivering care. Staff and visitors had easy access to hand washing facilities in the home. There were sufficient supplies of protective equipment such as gloves and aprons and staff used these appropriately. Records showed that regular cleaning and infection control audits had been undertaken to ensure staff complied with the provider's infection control requirements. The service was well maintained and clean throughout the inspection.

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet people's needs. Care staff had undergone an induction programme that met the requirements of the Care Certificate standards. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. There was an induction programme for newly appointed nurses and the provider had developed a competency framework for the nursing and care team to evidence staff had all of the skills needed to meet the needs of people.

Staff were complementary of the training opportunities they were provided. One staff member told us ''There is more than enough training and I feel confident that I have the skills I need'' and another said ''This was the best induction I had ever had''. Training had been developed for staff to meet health and safety, mandatory and statutory training requirements as well as staff receiving training to support people's specific individual needs, such as dementia care and nutrition.

Staff told us they felt supported in their role. Their comments included "The managers are always available if you have any questions'', ''The managers know the residents very well so they can always give meaningful advice'' and ''We meet regularly as a team and I have supervision to discuss any concerns I have''. There were a variety of methods for keeping staff informed and updated of changes in people's needs and practice. These included daily Take 10 meetings, staff meetings, head of department meetings and clinical risk meetings. Nurses and senior staff also met routinely with the specialist community nurse for nursing homes who reviewed people's needs with staff and demonstrated good practice. The specialist community nurse for nursing homes told us this had supported and trained staff to enhance their skills and improve their confidence by building on existing good practice.

People were supported by staff who had regular supervisions (one to one meetings) and an annual appraisal of their performance with their line manager Staff told us this had given them the opportunity to reflect on their practice, to identify their learning needs and to be more aware of the needs of the people who live in the home. Staff had received the support they needed to meet people's needs.

Some people did not have the mental capacity to independently make decisions about their care arrangements. Staff had undertaken training on the Mental Capacity Act (MCA) 2005. 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff showed a good understanding of this legislation and were able to tell us about their responsibilities under the MCA. One member of staff told us, "You must always assume people can make their own decisions and help them to make them. For example we will show people the lunch choices if they find it easier to make the choice when they can see what is on offer''. Staff were observed seeking consent and explaining the tasks they were about to carry out, for example when asking people if they wanted any pain relief.

Nurses and senior staff were responsible for undertaking mental capacity assessments when people were deemed to lack the mental capacity to make decisions about their care and treatment. They had received relevant training and records showed they had a good understanding of the legal process and the documentation they needed to complete. Staff had also encouraged people to make decisions about their care, treatment and preferred place of death whist they still had the mental capacity to make these decisions independently. Where people lacked capacity to make decisions about their care we saw these had been made in their best interests for example, when people could not consent to taking their medicine.

For some people a best interest decision had been made to live at the service as they no longer had the capacity to understand the risks to their health and safety and the arrangements in place to keep them safe. The registered manager made an appropriate Deprivation of Liberty Safeguard (DoLS) application for these people. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This meant people's rights were respected because staff understood their responsibilities in relation to the MCA.

People spoke positively about the quality and quantity of food available at Freelands Croft Nursing Home. One person told us ''The dinner is nice I have a choice every day, sometimes my wife will join me" and another person said ''The food choice is good, I get asked if I want to eat in the dining room but I don't often want to, the staff don't push that and I can have my meals in my room". We observed the dining room experience of people at a lunch-time. It was a calm, pleasant atmosphere with most people sat at dining tables. People required different levels of support and those who required help with their food were supported in a dignified way. People were supported to make their meal choice. The chef told us that if someone did not like the menu options offered then they would offer them an alternative of their choosing and the kitchen staff were aware of people's food and portion preferences.

People's nutritional needs had been assessed. Referrals were made to health professionals where people were at risk of malnutrition and the guidance received from the GP or the specialist community nurse for nursing homes was recorded in people's care plans. People's weight was monitored and staff were aware of those people who had lost weight and what action was needed to support them. Staff could describe how they supported people whose swallowing had diminished by encouraging small spoonfuls of food and ensuring food was of the correct thickness to prevent choking. The chef was able to tell me us how they met the needs of a people who required pureed food. We saw people were regularly offered something to drink and jugs of water and juice were available in people's rooms and communal areas to ensure people remained hydrated. Staff promoted the importance of good nutrition and hydration.

Staff monitored people's health and wellbeing and records showed changes in people's health were identified promptly and care staff alerted the nurses when for example; concerns relating to people's skin, pain management, swallowing or mobility had been identified. People were supported to access a range of health professionals as required. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, community nurses, mental health nurses, diabetic nurses and podiatrists (foot specialists). A local GP visited the home at least weekly and also routinely reviewed people's medicines. People told us they were satisfied that their health needs were met. One relative told us "My mum looks healthier than she has been for a long time". People's health conditions for example, diabetes were well documented in their care plans and staff understood the support they needed to stay healthy.

Good

Is the service caring?

Our findings

People and relatives told us they liked the staff at Freelands Croft Nursing Home. People said, ''They are a lovely bunch, I am very happy here, they are very caring" and ''I can't fault them, you couldn't get nicer people". A relative told us "She is happy, they know her very well, we can tell that she is happy, she seems less stressed than when she was at home, more relaxed, like a huge weight has gone from her shoulders''.

Interactions between people and staff were good humoured and caring. Throughout the inspection, staff showed care and concern for people's wellbeing. People appeared relaxed, comfortable and responded positively to staff when asked what they wanted to do or eat. Staff gave people time to respond to their questions, used short sentences and encouraged people to concentrate so that they could make their wishes known. We observed the registered manager was present in the communal areas to observe and monitor how staff interacted with people.

Staff supported people with consideration and kindness when they became distressed. When people living with dementia asked questions to make sense of their day or became anxious staff had a consistent approach. Staff knew people well and understood people's behaviour. They responded promptly and patiently with answers to their questions and offered reassurances. We found staff identified promptly when people were becoming distressed and offered reassurance and comfort in a timely manner.

People were encouraged to be as independent as possible and were involved in making decisions about things that affected them, for example; people were encouraged to manage their personal hygiene and appearance. Care plans included details of those areas people were independent in. Staff told us how they aimed to support people to maintain or develop their independence.

Staff told us they respected people's wishes on how they spent their time and the activities they liked to be involved in. When people chose to spend time in their rooms we saw people's tables were near them and their glasses, remote controls and books were within easy reach. For those people who had specific preferences their care plans noted what they liked to have at hand when in their rooms.

People had been involved in decisions about the décor of their rooms and were surrounded by objects they held dear. We observed laughter and banter between people and staff. The language heard and recorded in care records was appropriate and respectful. Staff used touch to support people to understand instructions, we saw this was done appropriately and people seemed comfortable and reassured through physical contact with staff. Contact was unrushed, with smiles and kindly gestures, such as when asking where people would like to sit or when people appeared not to understand what was asked of them.

Family and friends were encouraged to visit whenever they wanted and staff supported people, who wanted to have regular and frequent contact with relatives. Relatives were encouraged to support people during lunch time if they wanted to.

Staff explained to us that an important part of their job was to treat people with dignity and respect. Our

observations confirmed that staff respected people's privacy and dignity. Staff used people's preferred names and spoke with them in a kind and patient manner. If people required support with personal care tasks this was done discreetly, behind closed doors to ensure their dignity was maintained. When staff spoke with people using wheelchairs they showed respect by crouching or sitting down so that people could have a conversation at eye level.

Good

Is the service responsive?

Our findings

Each person's needs had been assessed and were used to develop a personalised care plan which reflected people's needs and preferences. This included an assessment of the person's needs before they were admitted to the service. One relative told us "The home came to our house before she came in to sort out her care needs. She is very settled here''. The registered manager understood the skills of the staff team and the needs of the people already living in the service. They gave us examples of how they took this into account when making decisions about whether the service could meet the needs of new people.

Records showed relatives were kept informed if people became unwell or their needs changed. They had been given an opportunity to review people's care plans to ensure they provided information that people might not have been able to share. Personal information was available for each person, which included details of the person's background and preferences, such as bed time routines so staff would know how to plan and deliver care.

People had care plans for personal care which were well recorded and included specific details of how staff should support people. These included tasks which people could do for themselves regarding their personal care and what staff needed to help people with. Staff could explain how they used the information in people's care plans about their life and employment history to initiate conversation and were familiar with the care instructions in people's care plans. Relatives confirmed that staff knew people well and what was important to them. One relative told us ''Her clothes are laundered and she wears her jewellery, (loved one) likes to look nice so it is good to see her as she would usually be dressed".

Many people in the service lived with a diagnosis of dementia and staff understood how to support people living with dementia. We saw good communication skills and dementia friendly practices were evident when staff supported people with dementia. For example, we observed care staff supporting people during lunch time. They spoke with people throughout, such as telling them what they were eating, or asking where they would like to eat. One person was becoming anxious and refused their food; staff gave them some time before offering them a meal again which they then accepted. This meant people living with dementia benefitted from meaningful and effective support from skilled staff who understood their needs.

Care plans included information on how staff were to support people living with dementia to meet their emotional needs. Care plans were in place for people who might put themselves or others at risk when they got anxious so that staff would know how people preferred to be supported when they became anxious. For example, we saw staff responded promptly and kept a person company when they became confused and called out for assistance. We observed staff throughout our inspection supporting people with humour, distraction and reassurance when they became anxious till they were at ease and could enjoy their day. Staff explained how they identified people becoming upset and told us speaking calmly and reassuring people were the most effective ways to support people through a difficult time.

Structured activities were available for people every day and they were able to choose whether they wished to join in or not. Events were held throughout the year and relatives were encouraged to take part in

celebrations and events at the service.

We observed an hour long musical session run by an external activity organiser, supported by the service's activity organiser. The session combined music, a general knowledge quiz and gentle exercise around a theme. Each section lasted a few minutes which showed an understanding of people's attentiveness. There was a high level of interaction between staff and people. Staff offered gentle encouragement to enable people to participate, but always ensuring people had the final choice. The visiting organiser knew people well and conversed with them by name. This meant people were given the opportunity to have an active and stimulating day with meaningful engagement.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. The provider's complaints process was available to people and their representatives. This set out how people could make a complaint and how their complaint would be dealt with. Records showed the home had received six complaints and 21compliments in the past year. There was a process for ensuring people's complaints and concerns were logged, investigated and responded to. The provider had used complaints to improve the service. For example, they had improved the handover of people's medicines during respite visits and the management of people's property. People's complaints had been dealt with in accordance with the provider's policy and action taken as a result was used as an opportunity to improve the service for people.

The registered manager told us the provider had actively worked on creating an open culture and opportunities for people and staff to raise concerns. This included the introduction of a Tuesday afternoon social and Wednesday's Breakfast Club. This was an opportunity, additional to the monthly resident and relatives meeting and the annual satisfaction survey, for people to provide feedback about the service. We saw people's feedback had been taken into account when improvements were made to the service. For example, more activities outside of the service had been arranged for the men living in the service as per their request.

Good

Is the service well-led?

Our findings

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. There was a registered manager registered with CQC to manage the service. The registered manager was overseeing the service and staff practice and they were committed to maintaining a good team working in the service. Staff were highly complementary of the registered manager and told us they encouraged good relationships and support among the staff team. This had a positive impact on the people and the support they received. The registered manager was motivated to maintaining a homely environment and ensured there was always time for people and their relatives to discuss things important to them. The registered manager spent some time working alongside the staff to observe how they interacted and supported people.

The registered manager understood their reporting responsibilities and had notified CQC of relevant events and incidences. This had supported CQC to monitor if appropriate action had been taken to keep people safe and whether all relevant agencies had been informed as required. When we arrived at the service the current CQC inspection rating for the service was displayed as required by the Regulations. The rating was also displayed on the provider's website to inform the public of the previous inspection outcome.

The service's aims and objectives were to provide people with quality care and support. The registered manager and senior staff promoted a positive culture that was person-centred, open, inclusive and empowering. Staff told us they had a well-developed understanding of people's individuality and diversity and we saw they put this into practice when supporting people.

There was a system of clinical governance which staff understood and could explain. Nursing decisions were reviewed and monitored to ensure care was being provided in accordance with best practice standards. This included a daily risk meeting and weekly clinical review meetings to review for example, all falls, wounds, nutritional concerns and changes in people's health needs. The registered manager also reviewed their monthly Home Manager Quality Metrics which monitored any risks and trends across the home. They told us the current quality metrics did not show any risks relating to the home. Records showed and staff told us these clinical meetings took place routinely with standard agendas, minutes and action logs for staff to refer to. Staff spoke positively about these meetings and told us it supported them to remain familiar with the provider's policies and helped to clarify their responsibilities. One staff member told us ''I feel confident that decisions for example about wound treatment will be reviewed to make sure they are appropriate.'' People's treatment decisions and progress were reviewed regularly by appropriate staff to ensure their care and treatment were delivered in accordance with best practice guidelines.

The registered manager and provider representatives carried out various audits to monitor the quality of care and support. Different teams such as maintenance, kitchen, housekeeping and care staff had a responsibility to contribute to the process of ensuring quality assurance tasks were achieved effectively. The registered manager and staff team spoke to people, relatives and staff about the daily support received and carried out regular checks. They also analysed information recorded through audits, accident and incidents to identify any trends and patterns that could improve the service and prevent future incidents from

occurring. Staff told us the registered manager shared information with staff so they were aware of what was going on and improvements they needed to action. For example, they told us managers had shared with them the importance of supervision and action had been taken to ensure regular supervision had taken place.

The registered manager had plans to improve the quality of the service they provided. Action plans had been drawn up to address any shortfalls identified and for example, we saw where care plans audits had identified gaps in people's care plans these had been rectified. The registered manager also told us they were reviewing the activities available at Freelands Croft Nursing home to ensure a variety of opportunities would be available to people living with dementia to enable them to have a stimulating and meaningful day.

The service worked in partnership with other organisations and professionals to make sure they were following current practice and providing a high quality service. For example, the registered manager followed updates from the quality and compliance team in the company and sent staff on training to keep their skills updated and to share learning with other staff. The registered manager worked closely with the local clinical commissioning group and the community mental health team advised on medicine and approaches for supporting people with mental health needs. Tissue viability nurses visited and updated the staff team on wound care when required. The service worked closely with the local safeguarding team and communicated with them regarding any safeguarding concerns. We contacted the local authority's quality monitoring team and a commissioner and they had no issues or concerns with the service.