Wellburn Care Homes Limited

St Georges Nursing Home

Inspection report

13 Vigo Lane
Harraton
Washington
Tyne and Wear
NE38 9AH

Tel: 01914191878
Website: www.wellburncare.co.uk

Date of inspection visit:
01 February 2018
07 February 2018

Date of publication:
15 May 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 1 February 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

At our last inspection in November 2016 the service received an overall rating of good. The domain responsive was rated as requires improvement. At this inspection we found improvements had been consistently maintained with regard to record keeping and the rating for the responsive domain has now improved to good. We found the evidence continued to support an overall rating of good.

St Georges is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Georges accommodates a maximum of 38 older people, including people who live with dementia or a dementia related condition, in one adapted building. At the time of inspection 36 people were using the service.

A manager was in post. They had applied but were not yet registered with the Care Quality Commission. 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.

There was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns.

This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People said they felt safe and they could speak to staff as they were approachable. We considered however that staff deployment needed to be kept under review. We have made a recommendation about ensuring staff are appropriately deployed to meet people's needs. We observed activities were not always available to keep some people engaged and stimulated in some areas of the home where staff were not always available.

Staff knew about safeguarding vulnerable adults procedures. Staff were subject to robust recruitment checks. Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. A system was not in place to look at trends and patterns where several incidents such as falls occurred.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received a varied and balanced diet to meet their nutritional needs. Systems were in place for people to receive their medicines. However, we have made a recommendation about the management of medicines.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Detailed records reflected the care provided by staff. Care was provided with kindness and people's privacy and dignity were respected. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided.

People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. People had access to an advocate if required.

Changes were planned to the environment as a programme of refurbishment was to take place. The home promoted the orientation and independence of people who lived with dementia.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Most aspects of the service were safe.

We have made a recommendation that staff are appropriately deployed to meet people's needs safely.

Risk assessments were carried out to keep people safe. Individual analysis of incidents took place and corrective measures taken individually. However, more in depth analysis was required to look at patterns and trends of incidents.

People received their medicines safely. However, we have made a recommendation about medicines management.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service was responsive.

There was good standard of record keeping to help staff provide person-centred care and support.

There was a varied programme of activities and entertainment to stimulate people and to help keep them engaged.

People were aware of how to make a complaint should they need to and expressed confidence in the process.

Is the service well-led?

Good

The service remains good.

St Georges Nursing 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 1 February 2018 and was unannounced. Further evidence relating to the inspection was received by CQC on 7 February 2018. The inspection team consisted of one adult social care inspector, one adult social care manager 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 for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using 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 communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 14 people who lived at St Georges, the manager, six relatives, the cook, seven support workers including two team leaders and two visiting professionals. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for six staff, four people's medicines records, staffing rosters, staff meeting minutes,

meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

People told us they were safe living at the service. One person commented, "I feel safe with staff." Another person said, "I was living alone before, I feel safer here. It is much better." A third person told us, "It is okay here and we're much safer." Relative's comments included, "[Name] is well looked after, I can go home and know they are okay" and "I am so reassured [Name] is looked after." A visiting professional commented, "The security for people is very good here. I have never seen anything untoward."

People told us there were sufficient staff. One person told us, "There is someone nearby." Another person said, "The staff come very quickly when I use the buzzer." Other people's comments included, "We get a lot of help here. The staff work so hard from morning to night, if I won the pools I'd share it with them", "The staff work very hard and they are very fast", There is normally someone here to help", "I don't often use the buzzer there is usually someone about, they [staff] are always coming in and out" and "Staff come to me very quickly when I press the call bell. I sometimes need to call them in the night and they always come quickly." A relative told us, "I think there are probably enough staff here, there is always someone around, it's no different at weekends." A visiting professional commented, "I think there are always enough staff here."

There were 36 people living at the home at the time of inspection. The manager told us 20 people on the ground floor were supported by one team leader and two support workers. 16 people on the top floor were supported by three support workers including one team leader. Overnight staffing levels included one team leader and two support workers.

We considered staff deployment should be kept under review across the home and suitable arrangements made to ensure sufficient staff were available to provide direct care and support to people at all times. On the day of inspection we observed on the top floor staff were particularly busy as only two staff were available to support people for a large part of the day. The team leader, the third member of staff who usually assisted with direct care and support on that floor, was responsible for administering medicines elsewhere in the home, as the team leader on the ground floor was not acting in that role. The manager informed us the deputy manager, who was new in post, was responsible for administering medicines on the top floor. They informed us a morning medicines round usually took place between 8:00am-9:30am. However, we observed morning medicines on the top floor were still being given out at 11:15am.

After the inspection we discussed the staff deployment with the registered manager and we were told two team leaders were now available to administer medicines. This meant the top floor team leader was available to provide more direct care and support as they were not busy elsewhere in the home. We observed at lunch time, as it was a protected meal time more staff were available to assist people with their meal.

Risks to people's safety had been identified and actions taken to reduce or manage hazards. Risk assessments were recorded in people's care records. The documents were individualised and provided staff with a clear description of any identified risk and specific guidance on how people should be supported in relation to the identified risk. For example, from falls or risk of choking.

Regular monthly analysis of individual incidents and accidents took place. One relative told us, "I think the service is responsive. There were a couple of issues previously but lessons have been learned from these and it has been about monitoring risk." Individual incidents were reviewed, with action taken to reduce risk to the individual. However, we did not see evidence of analysis of groups of incidents which may have occurred looking for any trends and patterns such as location and time of day with action being taken to reduce their likelihood of re-occurrence. For example, with regard to the numbers of unwitnessed falls. We discussed this with the manager who told us it would be addressed.

Staff had receiving training about safeguarding, they had an understanding of safeguarding and knew how to report any concerns. Staff were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse. One staff member told us, "I'd report it to the manager or the safeguarding team."

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

With regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). A letter was available from the GP authorising the medicine. However, the 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as the best interest decision had not involved the relevant people. We discussed this with the manager who told us it would be addressed immediately.

We recommend the manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Robust recruitment processes were in place. This included thorough checks of applicants for any role. The service ensured the correct information was available in personnel files. This included proof of identity, criminal history checks, and references from prior employers, job histories and health declarations. The service ensured only fit and proper persons were employed to care for people.

There were appropriate emergency evacuation procedures in place, regular fire drills had been completed and all fire extinguishers had been regularly serviced. Arrangements were in place for the on-going maintenance of the building.

Good

Is the service effective?

Our findings

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. A visiting health care professional commented, "The staff know all their residents very well, they don't ring me all the time with little things. When they ring me I know that what they tell me will be accurate."

People and relatives praised the effective care provided, in terms of their health or family members' health and well-being. One person said, "When I came here I could hardly speak. I think staff have helped me to get my speech back." One relative commented, "Staff noticed a change in [Name]'s health and dealt with it immediately. They're better now, I'm happy [Name] is getting the best medical care." Another relative told us, "I know [Name] is looked after, "They [staff] care carrying out [Name]'s regular monthly blood tests and the chiropodist visits regularly."

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information
about their medical conditions, dietary requirements and their daily lives.

People enjoyed a varied diet. One person commented, "There is plenty to eat." Another person told us, "The food is very good and I'm quite particular with my food." Other people's comments included, "The food is very good here. Staff make me a sausage butty [sandwich] every morning, they know what I like" and "There is a menu and you can choose what you want." People received drinks of juice, water, tea and coffee throughout the day. One person told us, "They [staff] are always bringing food and drinks around." Another person said, "There's always something to eat, we get tea, coffee and cakes in the morning and afternoon from the trolley." A relative told us, "There is always fresh water in [Name]'s room." We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. One relative told us, "[Name]'s weight was going down, but staff have started giving them fortified yoghurts." Another relative commented, "Staff encourage [Name] to eat and if they don't want what is there, they will find something [Name] likes." The cook told us people's dietary requirements such as if they were vegetarian, vegan or required a culturally specific diet were checked before admission to ensure they were catered for appropriately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We

observed staff demonstrated a sound understanding of their duty to promote and uphold people's human rights. The registered manager had submitted DoLS applications appropriately and told us 16 authorisations were in place and 14 applications had been submitted for processing by the local authority.

Staff made positive comments about their team working approach, the support they received and training attended. One staff member commented, "The training is very good." Another member of staff said, "I've just finished a National Vocational Qualification (NVQ) at level two. I'm now ready to do level three." Other staff member's comments included, "There's loads of training", "My training is up-to-date", "There are good opportunities for training", "We have supervision every two months", "I'm responsible for three staff supervisions" and "A trainer comes in to do training with us."

The staff training matrix showed staff were kept up-to-date with safe working practices. The staff training records showed and the manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included, dementia care awareness, end of life care, nutrition and diet, mental capacity, person-centred care, continence promotion, communication, principles of care, confidentiality, pressure area care and challenging behaviour.

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. One staff member commented, "There was six days of training when I started work." Staff also studied for the Care Certificate qualification as part of their induction. This ensured they had the basic knowledge needed to begin work. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

Some areas of the home were showing signs of wear and tear. The manager informed us a programme of refurbishment was to take place and this had been identified by the provider's estates department who had recently visited the home. After the inspection we received an action plan that showed an acceptable timescale for the refurbishment was in place. Appropriate signage was in place to help maintain people's orientation. For example, lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence.

Good

Is the service caring?

Our findings

People and relatives we spoke with all said staff were kind, caring and patient. People's comments included, "It's alright here, the staff are good to me and a care worker takes me out sometimes", "The staff are really good, they work very hard and they are very fast. If I want a cup of tea they are there straight away", "[Name] is really well cared for here. It's such a relief to know they are cared for", "The staff are unbelievable, they look after us really well" and "Everyone is so nice to us." A visiting professional said, "The staff all seem very happy working here." A second visiting professional told us, "I feel very positive about the care people receive. I have seen that staff are very gentle, they seem to be trained in dealing with any challenges. They are very caring and able to give good care." One relative told us, "It was wonderful the way staff handled [Name]'s transition from respite to full time care here." Another relative said, "I know [Name] is well-cared for. I can go home knowing they are okay."

During the inspection there was a pleasant atmosphere in the home. Staff interacted well with people. People appeared calm and relaxed as they were supported by staff. Staff appeared to have a good relationship with people and knew their relatives as well.

People were supported by staff who were warm, kind, caring and respectful. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging.

On the day of inspection the atmosphere in the home was lively. On the top floor we noted the atmosphere in the combined lounge and dining room was more noisy than lively, which could have been a distraction if people wanted some tranquillity. Music played constantly on a loop system from morning until night so this meant the same music was repeated during the day. The television was turned on although people may not be sitting near to watch it. The nurse call alarm panel, which was situated on the wall in the middle of the lounge sitting area, sounded very loudly whenever a buzzer rang for staff attention. As well as alerting staff it was very noisy for people who were dozing and relaxing in the lounge. We discussed this with the manager who told us it would be addressed immediately.

Care was provided in a flexible way to meet people's individual preferences. People told us they made their own choices over their daily lifestyle. For instance, people had the opportunity to have a lie-in. They told us they could go to bed when they wanted and staff respected their wishes. One person told us, "They [staff] don't rush me and let me go back to sleep for a lie-in." Another person commented, "I can get a shower two or three times a week, it's enough for me." A third person said, "Staff come around about 9:00am and if I'm not up they ask if I want breakfast. I can go to bed and get up when I want."

We observed the lunch time meal in the dining rooms. People enjoyed a predominantly positive dining experience at meal times. Staff were supportive to people and offered full assistance or encouragement and prompts as required. We heard staff ask people for permission before supporting them, for example with assisting them to the dining table or offering them protective clothing at the meal. Most people were served

in the dining room and staff were available to provide support and encouragement or full assistance to people. Food was well presented and looked appetising and hot and cold drinks were served. A choice of main meal was available at each meal. People sat at tables that were set with tablecloths, linen napkins, condiments and flowers.

In the top floor dining room the atmosphere was noisy as music and the television were playing at the same time. As it was not a tranquil atmosphere it may have distracted people from eating. We discussed this with the manager who told us it would be addressed.

Staff treated people with dignity and respect. One person commented, "Staff help me have a bath or shower, whatever I want. They are respectful and I feel comfortable with them." We observed good practice throughout the inspection. Staff members knocked before entering people's rooms, including when doors were open. Dignity hangers were placed on bedroom doors when people's care being attended to in their bedrooms, so people did not interrupt unnecessarily. Staff were discreet when speaking to people about their care and treatment. People looked clean, tidy and well presented. One relative commented, [Name]'s previous hairdresser comes and does his hair, they let him use the salon here."

People's care records were up-to-date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. Written information was available that showed people of importance in a person's life.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

Improvements to care records had been consistently maintained since the last inspection in November 2016. There was a good standard of record keeping to ensure people's needs were met in a person-centred way.

Before people used the service they received information about the home and an initial assessment was completed to ensure the service could meet the person's needs. Care plans were developed from assessments that provided some details for staff about how the person's care needs were to be met. For example, with regard to personal hygiene and nutrition. However, care plans were not broken down to detail what the person could do to be involved and to maintain some independence. Although they contained information, care plans did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. We discussed this with the manager who told us it would be addressed.

People's care records were kept under review. One relative told us, "I've been involved in [Name]'s care planning." Another relative said, "I have not delegated caring for [Name] but instead I have shared the responsibility and staff do keep me involved. I can come in at any time and I do. I help deliver [Name]'s care and that is very important to me." Monthly evaluations were undertaken by care staff and care plans were updated following any change in a person's needs.

Other information was available in people's care records to help staff provide care and support. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. Charts were also completed to record any staff intervention with a person. For example, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. The food and fluid intake of some people was also recorded. However, the fluid monitoring charts did not show that the person's daily fluid intake was always monitored. The manager told us night staff were responsible for this task and it would be addressed immediately to ensure the all charts were totalled each day to show a person's fluid intake to ensure people received adequate hydration.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

People confirmed they had a choice about getting involved in activities. They received a monthly bulletin that advertised planned activities and entertainment. The manager told us, "This is the best company I have worked for in terms of activities." One person told us, "There is always something going on here, they have some really good entertainment." They also said, "The activities co-ordinator has involved us. On Saturday we are going on a bus trip to a museum. There are also church services regularly." Another person commented, "I like dancing and they have a dance here about once a month." Other people's comments

included, "Last week we went to another home, it was a bus trip out past Newcastle. Six of us had tea and coffee there. It was a nice run out", "There is always something going on. We do lots of crafts, they [staff] are very talented and help us to make things", "We played skittles the other day. Musical bingo was good and we do yoga."

An activities organiser was employed who was very enthusiastic about their role. They told us activities were planned according to the interests of people. An activities programme was designed and incorporated these interests to make activities more meaningful to people. There was a large amount of photographs of activities, entertainment and seasonal celebrations that had taken place. One person told us, "Christmas was wonderful. There was all sorts going on, buffets, and dinners, it was like a five star hotel and the decorations were beautiful." A programme of activities included, story-telling, singers, dancing, puppet shows, musical bingo, virtual reality outings and yoga.

At the time of inspection we observed on the ground floor some people were listening to music and talking with staff. Some people went out to the metro centre for lunch on a mini bus trip. However, on the top floor unit there was limited engagement with people as staff were busy. People did not seem as engaged we did not observe activities taking place or an adequate level of staff interaction. We discussed this with the manager who told us it would be addressed. They told us there were usually three staff to provide support to people during the day.

The manager told us there were very good links with the local community. People benefited from the local Mother's union visiting and they held a regular coffee morning. They also brought in magazines and spent time talking with people. We were told some people went out independently into the local community. The home was situated in a residential area near to the shops. There were opportunities to go out on organised trips and these included visits to the metro centre, coastal areas and places of interest. The hairdresser visited weekly and a local member of the clergy visited regularly.

People knew how to complain. People we spoke with said they had no complaints. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place. We saw a complaints investigation would be carried out but there was no evidence of a written response to the complainant to show any action taken if required. We discussed this with the manager and we were told it would be addressed. We saw compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

A manager was in post who had applied to become registered with the Care Quality Commission. The manager had started to work at the home in November 2017. 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 manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary.

The manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The manager and staff were open to working with us in a co-operative and transparent way.

The atmosphere in the service was warm, welcoming and open. A variety of information with regard to the running of the service was displayed to keep people informed and aware and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

The manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were all very positive about their management and had respect for them. They told us the service was well led. They said they could speak to the manager if they had any issues or concerns. One person told us, "The manager could not have been more professional, caring and supportive." Another person commented, "The new manager is very nice, he's always around. He doesn't just sit in the office." A relative commented, "I really like [Name], the new manager. I like the sound of him, he says what he is going to do." A visiting professional said, "[Name] is a real hands-on manager. I think he is going to do very well." Another visiting professional commented, "I feel very positive about this home. I think the manager is pro-active. The first time I met him in here, I think he valued me coming and I think he seems approachable."

People and their relatives were kept involved and consulted about the running of the service. Regular meetings took place with relatives and people who used the service and minutes were available for people who were unable to attend. One relative told us, "I went to the last relative's meeting. It was good the new manager introduced himself. I think he's done well since he started. He's made some big changes."

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "We have a staff meeting every month." Staff said communication was effective to keep them up to date with people's changing needs. A handover session took place, between senior staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member commented, "Handover is called pass the baton and takes place at the beginning and end of each shift." Another staff member told us, "The

night team leader passes over information to the day staff." Staff told us the diary and communication book also provided them with information.

Auditing and governance processes took place within the service to check the quality of care provided and to keep people safe. Audits included checks on medicines management, care documentation, training, kitchen audits, accidents and incidents, infection control and nutrition. Other audits were carried out for falls and health and safety. Monthly visits were carried out by the provider's representative who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.