Tamaris Healthcare (England) Limited

Abigail Lodge Care Home - Consett

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 7 and 8 December 2016 and was unannounced.

Abigail Lodge provides accommodation for people who need nursing and personal care. The home can accommodate up to 60 people. At the time of our inspection there were 56 people using the service.

At the last inspection on 6, 7 and 13 January 2016 we found the following breaches:-

Regulation 12 Safe care and treatment
Regulation 13 Safeguarding service users from abuse and improper treatment
Regulation 15 Premises and equipment
Regulation 17 Good governance

We asked the registered provider to tell us what actions they intended to take to make improvements and found these actions had been completed.

There was a registered manager in post. 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.

People, their relatives and visiting professionals were complimentary about the service and the staff. They praised individual staff to us for their kindness and caring abilities.

The registered provider had in place a staff whistle-blowing policy where staff were supported to speak up about concerns they had in the service and a staff disciplinary policy. This meant the service had in place systems to give protection to vulnerable people. Staff had been trained in safeguarding and we saw evidence of safeguarding concerns being reported to the registered manager who then took appropriate actions.

Staff recruited into the service had the required checks carried out before they started working in the home. The registered manager had in place a dependency tool which measure people's dependency needs and indicated the amount of staff hours which were required to provide people's care. The registered manager was providing above the recommended levels at the time of the inspection.

People were given their medicines in a safe manner by staff who had been trained in medicines management and assessed as competent.

Staff were aware of people's dietary needs and were able to demonstrate the use of the Malnutrition Universal Screening Tool. This tool is used to demonstrate where people may be at risk of malnutrition

through weight loss. We saw actions had been taken when people lost weight including referrals to dietitians for advice.

The home worked to the principles enshrined in the Mental Capacity Act to ensure people were safe. They had made application to the required authority if they needed to deprive people of their liberty using the Deprivation of Liberty Safeguards.

Staff were supported to carry out their role through a planned programme of induction, training, supervision and support. The registered manager had also identified where practice could be improved and developed coaching sessions for staff.

The registered provider had in a place a system of audits to monitor the quality of the service. We found the registered manager carried out these audits and delegated some of the audits to staff when they were not on duty. The service also had an electronic system of continuous feedback in place. The feedback was aggregated and copies were given to the inspection team. The results showed the feedback was for the most part favourable.

We observed staff did not hurry people but supported them at their own pace.

We found the service had made improvements to people's records and these were up to date and accurate. People's care plans were personalised and described their individual needs. These were reviewed monthly to check on their accuracy and relevance. When people's care planning indicated there was a risk to a person a risk assessment had been put in place with guidance to staff given on how to mitigate those risks.

People's interests and activities were described. Activities coordinators had a plan of activities in place and had taken people on outings to places of local interest.

We found staff displayed a caring attitude and treated people with respect. They cared for people's dignity and privacy.

Staff had referred people to GP's, community nurses, chiropodists, the Speech and Language Therapy team (SALT), opticians and dieticians when their health needs required additional input.

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.

The registered manager had in place recruitment procedures and was able to demonstrate they had carried out relevant checks on staff before they started working in the service.

The registered provider had staff disciplinary policies and whistle blowing procedures to ensure people were kept safe whilst using the service.

People were given their medicines in a safe manner. Staff were assessed as competent to give people their medicines, and they were able to tell us about the medicines procedures.

Is the service effective?

Good

The service was effective.

Staff received support through induction, training and supervision to ensure they were competent to carry out their respective roles.

A programme of work had been carried out in the home to ensure staff understood the needs of people with dementia. Staff confirmed they had received the training.

The service met the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about people's care needs. They were able to talk to us about people's likes and dislikes.

People's independence in the service was promoted and people's care plans guided staff to help support this.

People who used the service and their relatives were complimentary about the service.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and reflected people's individual needs. They were reviewed and checked for accuracy on a monthly basis.

The service had in place a complaints policy and we saw the registered manager had taken people's complaints seriously. They had written to the complainant and provided explanations and apologies when required.

The lead person for each shift was required by the registered manager to sign people's person care charts at the end of their working day to state people had received the care they needed.

Is the service well-led?

Good

The service was well led.

The registered manager had taken actions to improve and develop the service.

There was a system in place of continuous feedback from people who used the service, their relatives and visitors, staff and other professionals.

Regular audits were carried out or delegated by the registered manager to measure the quality of the service. We saw where actions could be taken immediately to address any deficits

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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 7 and 8 December 2016 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist advisor in nursing 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 on this inspection had experience of dementia care.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners.

Prior to the inspection we contacted the local Healthwatch and no concerns had been raised with them about the service. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work.

During the inspection we spoke with six people who used the service, twelve staff including the registered manager, the deputy manager, the care home assistant practitioner (CHAP) the nurse on duty, the activities coordinator and five senior and care staff and ancillary staff. We also spoke with three visiting professionals and five relatives. We reviewed six people's care records. We also reviewed four staff files.

The inspection took place before we had sent the provider 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 spoke with the registered manager and the staff about these issues during the inspection.

Good

Is the service safe?

Our findings

One relative told us their family member, "Was safe and the staff are very diligent." Another relative told us they though their family member was also safe.

The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. We saw the registered provided carried out DBS checks. They also asked prospective staff members to complete an application form which detailed their past experience and learning, and staff were required to provide the names of two referees. We found the references had been obtained by the registered provider and the authors of the references had been contacted to verify they had written the references. This meant the registered provider had in place a robust recruitment process.

The registered provider also had in place a whistle-blowing policy. Whistle blowing is where staff tell someone about their worries. The registered manager told us there were no current investigations into concerns raised by staff.

The registered provider also had in place a staff disciplinary policy which described how they could address any inappropriate behaviour to people in the home. The registered manager told us they had no on-going disciplinary investigations.

The registered manager showed us their dependency tool called CHESS. The tool is used to monitor people's dependency needs and prescribe a number of staff working hours required in the home. The registered manager showed us they were providing hours above the dependency tool stipulations. We noted staff being able to respond to people quickly. One relative said, "There seems to be enough staff, and they are available." One staff member told us they had time in their working day to chat to people in the home. This meant at the time of our inspection there was enough staff on duty to meet people's needs.

Staff had received safeguarding training and could tell us about how to safeguard adults. The registered manager had notified us of safeguarding incidents which had occurred in the home since our last visit including those where staff had alerted the registered manager. This showed staff and the registered manager were aware of what constituted a safeguarding incident and what actions to take.

Staff recorded maintenance issues for the maintenance person to address. We found these had been addressed promptly and repairs undertaken. We saw hot water temperature checks were regularly carried out for bedrooms and bathrooms and were within the 44 degrees maximum recommended by the Health and Safety Executive (HSE) to prevent scalding. The registered provider had a fire risk assessment in place and had arrangements in place to monitor fire alarms and fire extinguishers. This meant checks were carried out to ensure that people who used the service lived in a safe environment.

We looked at the administration of people's medicines and found that all of the medicines were stored in

lockable cabinet and trollies. We looked at controlled drugs, these are drugs which are more liable to misuse and as such have stricter guidelines for storage, administration and disposal. We found the stock count of the controlled drugs was accurate. We found one missing signature in the controlled drug book but an explanation was easily found because the registered provider had in place corresponding records with a clear audit trail in place. Staff reported to us improved communications with the pharmacy and felt the ordering and delivery of the medicines were accurate.

We checked on the Medication Administration Record (MAR) and found these were up to date. We looked at people's topical medicines; these are prescribed creams to be applied to people's skin. MAR records for people's topical medicines were found in people's rooms. Staff had been assessed as competent to apply people's topical medicines. We found there were body maps in place to give guidance to staff to what and where to apply people's prescribed topical medicines. At the end of each shift the senior carer or the nurse on duty was required to check the MAR sheets and sign to state topical medicines had been applied. This meant there were checks in place to ensure people were given their prescribed creams.

Staff had had drug administration competency training and were able to describe to us how they gave people the correct medicines discarded spoilt medicines, and administered covert medicines and homely medicines. This meant staff who administered people's medicines had a good knowledge of procedures.

We found the service had risk assessments in place and these were relevant to identifiable issues appropriate to individual people who used the service. For example where people were at risk of falls their risk assessments described what actions were required by staff to reduce their risk of falling. The service also had in place risk assessments for the building and other incidents such as heatwave, scalding and physical attacks on staff. These demonstrated the registered provider understood the complexities of home management and had put in place actions to mitigate the risks.

Accidents and incidents were recorded electronically for the registered manager to review. We found the staff had recorded these on the electronic system and they were immediately transferred to the registered manager to review. The registered manager then reviewed each incident and where necessary took action to reduce the likelihood of reoccurrence.

In November 2016 Abigail Lodge received an infection control assurance visit from the local Infection Control team. We saw the team had recommended a number of minor actions to reduce the risk of the spread of infections. The registered manager had begun to address the recommendations in the action plan. We found communal areas of the home to be clean and tidy. There were mattress checks in place and the registered manager had taken action to replace mattresses where necessary.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can 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).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw the service had capacity assessments in place; people's best interests had been discussed with relatives and other professionals. Staff were trained in the MCA and DoLS and applications had been made by the registered manager to the appropriate supervisory body to seek authorisation to deprive people of their liberty.

In the pre-admission assessment the registered provider asked the person, "Do you agree to this assessment being carried out," and "Do you understand the reason for the assessment." This meant before the person had entered the home the registered provider had in place questions relating to the person's consent about being assessed. We looked at the issue of consent in the home and found where people were unable to consent a best interests decision had been made. For one person it meant they were given their medicines covertly. The staff had consulted with their GP and family members to agree this was the best course of action to taken. For another person a capacity assessment had been carried out by the staff in relation to bed rails. Again consultation had taken place to ensure the use of bed rails was the safest option. This meant the service understood what action to take if people did not have the capacity to consent.

People and relatives we spoke with told us the staff were well trained. Staff employed by the service had undergone an induction. We looked at staff files and found most staff had undergone an initial two day induction. The registered manager showed us the registered provider's new induction programme for staff and told us it was being implemented in the service. The new induction programme included staff being trained over a number of weeks and checks in place to ensure they understood their job role and were competent to carry it out. Staff confirmed with us they had undergone an induction to the service.

We saw the registered manager had in place a training matrix which demonstrated which staff had received training and when training required updating. The registered manager was able to keep a track of staff training and if it was up to date.

We looked at the support provided to staff and found that they received support through training, supervision meetings with their line manager and appraisals. A supervision meeting takes place between a staff member and their line manager to discuss any concerns they may have, review progress and identify any training needs. We saw the manager had held group supervision meetings whereby groups of staff came

together to discuss and learn from specific issues.

At our last inspection we found the arrangements in the home for blood glucose monitoring did not follow a clear pattern and people were putting people at risk of inappropriate treatment. The registered provider had taken the decision that the Care Home Assistant Practitioners (CHAPs) would no longer carry out people's blood monitoring. We found this was now carried out by the nurse. This meant one person monitored people's bloods and gave them the correct dose of insulin when required. Staff had also received training in diabetes.

During the last inspection we raised concerns about the building and how it had been adapted to meet people's needs. We saw the registered provider had made improvements to the building to assist people moving around the home. The service had received the standard required to become "Dementia Accredited" by the registered provider. The registered manager told us this included delivering training to staff to ensure they were more aware of people's dementia care needs. We spoke to staff who told us they had undergone simulated activities in their training to replicate how people with dementia experience their environment. One staff member said, "I got very frustrated." Another staff member said they had learned more what it is like to have dementia. We observed staff talking to people with dementia type conditions, they listened and spoke to the person about what they were talking about, and only when people became disorientated did staff step in and suggest an alternative. This meant staff had the communication skills to work with people with dementia type conditions.

There was evidence that other health professionals had been contacted appropriately for example SALT team, dietitian, tissue viability nurse, respiratory nurse, challenging behaviour team and CPN. This meant the home was addressing people's health needs with other professionals. We saw where people had developed additional health needs the service made referrals to the GP or utilised the services of visiting health practitioners to check out people's health needs.

Handover records were informative and handover for all staff was held at the beginning of shifts. A shift report was completed by staff which included information about people with any new infections or pressure damage, GP visits with outcomes and medicines supply issues. This meant the senior care staff in the home and the managers had an overview of what was happening in the home each day. One relative confirmed the staff communicated well with them and said, "The carer's told me immediately." This was in relation to an incident which had occurred in the home

We checked the menu during the inspection. One relative said, "The meals are nice and [person] likes fish and chips and Sunday dinner, [person] can eat okay even though they don't have any teeth". Another relative thought that the meal time choice "Is poor" and "The quantity and quality could be better." There was a consensus amongst the people we spoke with they would have liked more fruit to be served. The choice for one day was chicken and leek or liver and bacon. The catering staff told us broth or scrambled egg was available if people did not like what was on offer. The desert was ice cream or a pudding with custard. We asked what was given to the people diagnosed with diabetes. One staff member said, "We had diabetic custard for them. I'll just pop down and see chef for some". We observed people enjoying their meals and staff prompted people to eat.

We looked at people's hydration preferences and saw one person preferred milk. We saw they were in bed and had a glass of milk within easy reach. This meant staff were meeting people's drinking preferences.

Everyone who used the service was being weighed monthly or weekly. This was documented using the Malnutrition Universal Screening Tool. We spoke with staff members who demonstrated they were aware of

people's weight and dietary needs. We found these were appropriately managed and the nutrition charts used in the home were informative of people's food intake. No one in the home was gaining or losing excessive amounts of weight. We saw staff had referred some people to dieticians who had been prescribed food supplements for people. This meant action had been taken to avoid the risks associated with malnutrition.

Good

Is the service caring?

Our findings

People were complimentary about the staff during the inspection. One person said, "Staff are lovely" and " Staff are always available when needed." Another person we spoke with said, "Staff are kind to me." Another person said, "Some are better than others." One relative told us "I'm always made to feel welcome when I come in." Another relative described three staff in particular as being, "Really special." They went on to tell us the actions the staff take to make their relative happy. Two relatives gave us the name of one carer, one relative said, ""." She makes certain the men are always shaved". We found relatives valued the relationships they had with staff and expressed confidence in them.

Three visiting professionals spoke with us about the staff. They told us the staff understand people and know them "Very well". One of them told us they were impressed with a senior carer who, "Genuine cared." All agreed the staff were friendly.

During the inspection we found all staff to be helpful. In our discussions with them we found them to be knowledgeable regarding the people who use the service and to have a caring attitude. They told us about people's likes and dislikes, and knew how people liked to be cared for. We found staff reactions to situations were immediate and responsive giving choice and allowing and promoting independence.

The registered manager told us they had tried to hold relatives meetings to involve them in the home but had found attendance was poor. Information was displayed in the home including a "Resident's Charter" which explained to people what they could expect from the service.

People's care plans gave staff guidance on how to promote each person's independence. For example they described the kind of assistance people needed for dressing so they could do as much as possible for themselves. We saw staff seek permission to support people when they thought they needed additional help.

The home had engaged other professionals to review the behaviour of people who challenged the service. We saw the staff approach was to distract people and quietly guide them away from the areas which were causing their behaviour to become elevated. Staff displayed patience towards people and promoted the well-being of other people in the home by ensuring individual needs were met. One relative told us their family member was, "Screaming and hallucinating at home- it's such a bonus that they are now relaxed and quiet". This meant the staff approach helped people to remain calm.
During our inspection we observed staff giving explanations to people about what was going to happen next. For example when it was mealtimes or when people needed a change of clothing. We saw people were clean and well dressed. We did not observe any actions by staff which compromised people's privacy and dignity needs. All personal care was carried out behind closed doors.

We carried out observations of staff interaction with each other and with the people who used the service. We found the staff working as a team and people were not hurried along. For example we observed one person wanted to go outside. A more experienced staff member supported the person with less experience

to show them what to do and how to ensure the person was kept warm when they left the building.

The registered manager demonstrated an understanding of the need for advocacy. We saw the service had access to an advocacy service. Two people in the home had been allocated an independent mental capacity advocate (IMCA). An IMCA safeguards the rights of people to make their own decisions. People's relatives also had acted as natural advocates and the staff had listened to relatives about people's needs and wishes.

Staff understood confidentiality. They worked alongside the inspection team to protect people's records whilst we carried out the inspection. People's records were stored in locked cabinets.

At the time of our inspection there was no one on end of life care. However we looked at the compliments and the thank "Thank you" for the care they had provided for someone nearing the end of their life.

Good

Is the service responsive?

Our findings

One relative said, " I've never had to make a complaint" They told us they felt they could talk to the (registered) manager about anything ". We saw the registered provider had in place a complaints policy and complaints information was displayed in the home. Where complaints had been received by the service the registered manager had carried out a full investigation of the complaint, and had addressed each of the complaint individually. They had written to the complainant with an explanation of events and given an apology when required, as well as stating what actions they had taken to avoid a repeat of the incident. This meant the registered manager took people's complaints seriously and was responsive to each aspect of the complaints.

We saw that before people moved into the home their needs had been assessed to ensure the service could meet their needs. Care plans had then been written to give guidance to staff on how to care for each individual person when people had made the transition into the service. We found the care plans we looked at demonstrated the service delivered person centred care. This meant they focused on people's personal needs.

The care plans included information on people's environment, nutrition/ diabetes, communication, personal hygiene, sleeping, pain, social needs and medicine requirements. We looked at people's plans for people who had greater nursing needs and found detailed guidance for example on catheter care or colostomy care. For one person who had frequent falls there was documentation with causes and body maps and risk assessments. Their dependency rating was up to date and it was noted discussion had taken place with other health care professionals resulting in the prescribing of a long term antibiotic to prevent reoccurring infections. When one person had a fall prior to the inspection the registered manager had reviewed the incident and agreed to look into whether a referral to the falls team was appropriate. We found this demonstrated the service was proactive in meeting people's needs.

We found all personal care was documented in an individual file for each resident and these were located in in people's bedrooms. Since the last inspection the files contained documents relevant to each person. These were signed off at the end of every shift to ensure people had been provided with the care pertinent to them. This meant people received daily care to meet their needs. If a risk was found to a person in their care plan the service had put in place a risk assessment. The assessments were in date and followed the care plans in a logical manner. All of the care plans were up to date and reviewed monthly.

We saw staff maintained individual progress reports and observed staff maintaining the records through our inspection. This meant people's records were continually being updated.

People had in place emergency health care plans (EHCP) and Do Not Attempt Cardio Pulmonary Resuscitation (DNARCPR) documents. The UK Resuscitation Council states, "The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly." We saw these had been completed by the community matron in conjunction with the staff in the care home and people's family

members and were up to date.

We looked at the activities carried out in the home. Staff had supported a person's love of music by bringing in their organ, which in turn had provided musical entertainment for some people living in the home. We spoke with the activities coordinator who demonstrated to us the activities which they offered to people who used the service. We saw they had run outings for people. One relative said, "They have attempted to take [person's names] to Chester le Street and have been to Sunderland and Beamish." We saw the notice boards displayed the activities for the day, although the activities coordinator told us they do not always work out as people wanted to do other things.

People were given choices about the food they ate, what they drank, where they preferred to be in the home and if they wanted to spend time in their bedroom. We saw recorded in people's care documents the things people liked to do. People's care records demonstrated staff had recorded individual interests. This included for one person listening to their radio. We spoke to the person who confirmed they liked to do this and had their radio next to them whilst sitting at the dining table. Other people liked to watch their favourite TV programmes in their rooms whilst others enjoyed going out.

The service had in place relevant information collated together should a person need to attend a hospital on an emergency basis. This meant medical staff would have a ready supply of information available to them before they began to treat the person.

People were protected from social isolation as relatives were welcomed into the service. We found some relatives visited every day and were encouraged to be involved. They told us staff made them feel welcome in the home. Staff gave people the option to be in the communal lounges where there were other people around them and we observed staff chatting to people throughout our inspection.

Good

Is the service well-led?

Our findings

One staff member said, "I have been here a long time and am finding the whole home so much better and all the staff work together and help each other out." Another staff member said, "The standards of care are higher now than when [the registered] manager started three months ago but things can still be improved." "One relative said, "I feel things have settled down now we have the new manager who seems very nice and is doing a lot and making the home." Another relative told us the new manager had started lots of new things and everything was becoming more settled.

There was a registered manager in post. The registered manager was able to give us a good account of the service. They provided us with all of the information we needed, and it was organised and easy to follow. It was evident they understood the requirements of CQC and had submitted all of the required notifications. We also saw the home had displayed the last CQC inspection rating. This meant the service was meeting the registration requirements. The registered manager told us the service had worked to improve the rating and they were hoping to demonstrate the service had improved during this inspection.

The registered provider had a vision and values in place. These were displayed in the reception area of the home. One of the values was respect. The registered provider stated, "We treat residents and others as we want to be treated, with courtesy and dignity; showing respect in the way we communicate; involving and including people, respecting differences sensitively and professionally." We observed staff demonstrating the values in their treatment of people with dignity and respect.

We saw the registered manager carried out daily walk around of the service. They explained to us on their days off this was delegated to another member of staff. They described to us where they found things needed doing they could arrange a fix there and then. If they could arrange for things to be fixed we saw the service scored 100%. On some occasions arrangements for repairs needed to be put in place.

We noted the registered manager had questioned staff practices and made changes to the home to improve the service. For example the registered manager explained to us they had noted people were being given thickened fluids by staff which were of differing consistencies. Thickened fluids are used to help people avoid choking. They had introduced competencies for staff to assess and support staff in thickening people's drinks.

We saw the registered manager chaired staff meetings where they raised issues about the standards of care and what staff needed to do to improve the care in the home. The registered manager had also provided coaching sessions to staff. For example they had coached staff in the use of the Waterlow assessment. This assessment supports staff to understand the risks to people's skin integrity. This meant staff had been given additional support by the registered manager and who had demonstrated.

The registered provider had in place a continuous system of feedback. People, their relatives, professionals and staff were able to give feedback at any time using an electronic system via a point in the reception area or using handheld electronic devices. We asked the registered manager at what point is the feedback

collated to look at trends over a given time. The registered manager said the feedback is ongoingly reviewed and actions taken as the feedback is received. They sent us information to show between 7 September 2016 and 7 December 2016 the combined result of 340 pieces of feedback give the home a scoring of 84.77%.

The staff surveys showed staff were broadly positive about the home; 58.82% of staff strongly agreed with the statement "I trust my manager to do the best for me and the home, the remaining 41.18% agreed. This meant staff had faith in the manager to lead the home.

The registered provider also had checks in place to ensure the home was meeting their required targets. For example the regional manager was required to track different aspects of the home on a monthly basis. This included checking if everything in the home had been tracked, if daily walk arounds had been completed, if people's dining experiences had been reviewed and if comments or feedback by the home had been responded to. From the regional manager assessments they had written the home was going from "Strength to strength."

The service had an up to date statement of purpose, this is a document which tells people and their relatives what they can expect from the service.

We saw the service had community links in place. These were with other professionals. We found GP's, community nurses, chiropodists and opticians frequently visited the home. Partnership working was in place with the Speech and Language Team and local care managers.

At the last inspection we found people's records were not up to date or accurate. We found the service had made improvements to people's records and they were now accurate and up-to date. The registered manager had put in place systems to check if records were up to date.