Care Quality Commission

Treelands Home Limited

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Inspection report

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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 unannounced comprehensive inspection took place on 25 October and 2 November 2017. We last inspected the service in November 2015 when we rated the service as Good overall, with two breaches of the Health and Social Care Act 2008 and Associated Regulations. The breaches related to staff practice not being in accordance with the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. This was because some people who lacked capacity did not have their rights fully protected and had been subject to restrictions on their liberty for their safety and well-being without the proper processes being put in place. At this inspection we found that improvements had been made to staff training and understanding. The service now met the relevant requirements.

Treelands is a residential home registered to provide accommodation with personal care for up to 40 older people, some living with dementia. The service had a registered manager.

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 living at the service, their relatives and health and social care professionals gave us positive feedback about the service. One person said, "If all homes were like this one, there wouldn't be anything to worry about."

People said they felt safe living at the home. Staff knew how to identify signs of potential abuse, where and how to raise concerns and that these would be acted upon. Environmental risk assessments were undertaken but regular checks were not always undertaken. This left some people at risk of avoidable harm. Individual risk assessments were undertaken and records showed that appropriate measures had been put in place to minimise risks to people. Medicines were administered and stored safely.

An effective recruitment process made sure only suitable staff were employed to care for people.
There were sufficient numbers of staff on duty to support people. Staff received a thorough induction, training and ongoing supervision to enable them to carry out their roles. Staff felt well supported by management.

People were treated as individuals with dignity and respect and their consent was sought for care and treatment. Where people lacked capacity, the Mental Capacity Act 2005 and its code of practice was followed. Relatives, health care professionals and others were consulted and involved in best interest decision making. People received a varied diet in accordance with their own choices. People's health needs were met by a range of external professionals. Healthcare professionals felt confident that the service delivered good quality service.

People and their relatives praised the staff for delivering high quality care. Staff were described as friendly, kind and caring.

People had individual risk assessments and care plans and had been consulted along with their families. There was a programme of activities on offer. Family and friends were able to visit freely and visitors were made welcome.

There was a variety of systems in place to monitor the quality of the service. Prompt action was taken to remedy any shortcomings. External organisations provided support to improve systems.

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

The service was not always safe.

Some aspects of the environment were not routinely checked for safety.

People's individual risks were assessed and actions taken to reduce them as much as possible, whilst minimising restrictions on people's freedom.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

People were supported by sufficient staff to enable them to receive care at a suitable time and manner.

People received their medicines on time and in a safe way.

An effective recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Good

The service was effective.

People were well cared for by staff that had the knowledge and skills to carry out their roles.

Consent was sought from people for care and treatment decisions. Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and acted in accordance with them.

People were supported to access healthcare services. Staff recognised changes in people's health, sought professional advice and acted on it.

Is the service caring?

Good

The service was caring.

People had developed good relationships with staff who knew

them well and staff were kind towards people.

People were treated with dignity, respect and compassion. Staff protected people's privacy and supported them sensitively with their personal care needs.

People and their relatives were consulted and involved in decision making about care and treatment

Is the service responsive?

Good

The service was responsive.

People received personalised care which matched their individual needs.

People were offered a range of activities.

People knew how to raise concerns and complaints, which were dealt with promptly and effectively.

Is the service well-led?

Good

The service was well led.

The service had an open person centred culture with staff working well as a team.

People had confidence in the registered manager. People were consulted and their views taken into account in running the service.

The service had a range of systems in place to monitor the quality of care.

Systems were continually being improved to deliver better service.

Care Quality Commission

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 October and 2 November 2017 and was unannounced on the first day. The inspection consisted of one adult social care inspector and one 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. This expert was experienced in working with elderly people and those living with dementia.

Before the inspection, we reviewed the information we held about the service, which included the Provider Information Return. (PIR) This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications which related to deaths, accidents and incidents. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

Methods that were used included informal observation, examining records and speaking with people. We spoke with 12 people using the service, 9 relatives of people using the service, and 11 members of staff including the provider and the registered manager, care staff and ancillary staff.

We reviewed the care records of six people, three in depth and three partially to look at specific aspects of care. We looked at a range of other documents including medication records, three staff recruitment files, training records, minutes of meetings and duty rotas.

We sought feedback from six health and social care professionals who regularly visited the home and received a response from three of them.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from avoidable harm. A range of environmental risk assessments were carried out by the provider. However, we found that some aspects of the environment were not safe.

On the first day of the inspection a storeroom door had been left open with the key in the lock. This store contained food supplies but also contained some potentially hazardous chemicals. For example, a bottle containing chemical cleaner was found on the floor next to food supplies. There were three bottles of household cleanser which contained bleach stored on a shelf next to paper plates. Cooking oil was stored on the floor in the same room. As the door was left open, these bottles were potentially accessible to people with impaired ability to understand risk who might not recognise the danger to their health. The registered manager said they would ensure that in future the door was always kept locked and that cleaning materials would be stored separately from foodstuffs. On the second day of inspection we found that this was the case.

The service employed a dedicated, full-time maintenance person to maintain the building and equipment. A maintenance book was used to record any faulty items requiring repair. Staff were aware that it was their responsibility to report any issues.

However, on day one of the inspection we noticed that one window restrictor in a room on the first floor was broken, which meant that the window could be opened fully and the person living there might be at risk of falling from a height. We also found one fire door did not close properly. Both of these faults were remedied on the same day by the maintenance person. We also noticed a log burner in a fireplace which was surrounded by a cage. However the gate of this cage was not blocked and therefore could be opened by people living at the service, thereby exposing them to the potential risk of burning. Following feedback to the registered manager a locking mechanism was put in place to manage this risk. The provider accepted that some checking mechanisms were not always undertaken. The registered manager had already booked an external health and safety consultant to review and update all systems in order to prevent further omissions.

Staff undertook regular fire safety training and had received hands-on experience. Staff were able to explain how to move people to safety zones in the event of a fire.

Safeguarding and whistle blowing policies were in place. Staff were actively encouraged to challenge poor practice and raise concerns. Staff confirmed they had received safeguarding adults training and spoke with confidence about different forms of abuse and how to raise a concern. The staff induction booklet gave contact details of how to raise an alert or a concern. This meant that each member of staff had their own copy of the relevant phone numbers. However, there was an additional, out of date, address given which we were assured would promptly be remedied.
People said they felt safe living at the service. Comments included: "Oh yes my dear I feel quite safe here, we have the alarm bell." Relatives confirmed that they felt people were safe because risks were being assessed and well managed. For example, one person described how a relative "has a cushion which triggers an

alarm" which reduced the potential risk of a fall from their chair. On the first day of the inspection, we saw staff were closely monitoring the movements of one person who was not safe if mobilised. A member of staff had been stationed near to this person's chair in order to protect them from a potential accident. One relative told us "the safety is all right here... (Name) is quite safe here."

People had individual risk assessments completed, recorded and reviewed monthly or more frequently as required. For example, where people were assessed as being at high risk of falling, staff undertook regular checks of bedrooms at night. Bed rails with cushioned protection or 'crash mats' to prevent injury were put in place as appropriate to the person's assessed needs.

Each person had an individual personal evacuation and emergency plan (PEEP). At the time of the inspection these were stored in each individual person's room. The registered manager was considering keeping a copy in a folder near the fire panel so that people's needs could more readily be identified in the event of an urgent evacuation.

Accident and incidents had been reported appropriately and reports included details of when and where the accident occurred, whether any injuries had been sustained and if any first aid or medical treatment was required. An analysis of accidents and incidents was used to identify any trends or changes that could be made to prevent recurrence and reduce the risk of possible harm.

There were sufficient staff to meet people's care needs.

Staffing levels varied at different times of day according to need. For example, there were more staff on duty early in the morning when people required help to get out of bed, and fewer in the afternoon. During the day seven care workers were employed from 7 am to 2 pm. In addition there was one kitchen assistant, one cook and one cleaner on duty until 5 pm. From 2 pm to 9 pm there were six care workers on duty. From 9 pm to 7am there were two waking night staff.

Some healthcare professionals and staff felt that there were not always enough staff available. One healthcare professional said: "There are not many carers… you need to look around for them." A second one described staffing levels as "satisfactory". One member of staff said;
"The thing that could be improved here is the staffing".
Another member of staff described the afternoon period between 4 pm and 8 pm as "stretched" and a third member of staff said "staffing is the biggest problem… Afternoons seem to be the worst time… we need more staff in general".

In response to the above, the provider had undertaken a detailed observation and monitoring of the afternoon and evening period. This had identified a need to increase numbers of staff on shift during 5 pm to 8 pm. This was based on the number of people who required assistance in getting ready for bed. This showed that the provider was seeking to ensure staffing levels were adequate on every shift.

Any gaps in staff rotas were met by existing staff working extra shifts, rather than agency staff who were rarely used. This meant that people benefited from continuity of care from staff who knew them. The registered manager said "Agency staff don't know our residents so it's too impersonal."

People using the service and their relatives said there were enough staff on duty.
Comments included: "It does seem adequately staffed, there is usually three or four on at all times." And "they are never understaffed, although it gets busy at bedtimes, but usually there's always one or two carers

in the main lounge."

During the inspection call bells were answered promptly. People's needs were being met in a timely way and there was no sense that people were being rushed. Staff had time to engage with people at their own pace.

Recruitment processes were effectively and safely managed.

People's medicines, including those requiring additional security, were managed and administered safely. Staff responsible for the management and administration of medicines had been trained and their practice was monitored by the registered manager. Medicines were securely stored in individual locked cabinets in each person's bedroom. Medicine Administration Records (MAR) were completed accurately and documented each person's medicines and any allergies. The service used a monitored dosage system provided by local pharmacist on a monthly basis. Colour-coded sealed packs were used which matched the colour coding of the MAR charts. This reduced the risk of any medicines being taken by the person at the wrong time. During the inspection we saw staff administered medicines in a calm and unrushed way, ensuring people received the support and explanations they needed.

On the first day of inspection we found gaps in one record for one person for a medication which should have been given the previous day, but had not been documented. It was established that this was not a medicine error, but a recording error. They then dealt appropriately with the member of staff concerned. We were told that MAR sheets were normally audited weekly by the registered manager. There was a room set aside for use by nurses and for additional medicine storage. This contained a communal medicines fridge. The temperature of the fridge was monitored and recorded daily to ensure it remained within the safe recommended range. Additional secure storage was available here for those medicines which required additional security.

One healthcare professional said: "(medicine administration) seems to be fine from my observations. They do seem to have good processes in place."

Good

Is the service effective?

Our findings

At the last inspection in November 2015 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the need for consent and the assessment of people who may be at risk of being deprived of their liberty. The provider sent us an action plan detailing the actions they would take to ensure improvements were made. At this inspection we found improvements had been made.

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).

Since the last inspection the registered manager had implemented a programme of staff training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).
The individual staff training matrix for 2017 showed that the majority of staff had now received training relating to the MCA and DoLS. The registered manager and most staff were aware of the importance of consent and had an understanding of the MCA and DoLS. Staff were able to describe how to ensure people's legal rights were protected.

Some people using the service were not free to leave and were under constant supervision. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving relevant professionals and other people who knew the person well. Relatives confirmed they had been involved in the process. Best interest decisions were clearly recorded. Where people who lacked capacity were dissuaded from leaving the service on the grounds of their own safety, a Deprivation of Liberty Safeguards application had been made to the local authority. Several other DoLS applications had been made relating to specific decisions and the service was awaiting authorisation. Clear records were kept of these pending applications.This meant the service was acting to protect people's legal rights.

During the inspection staff asked for people's consent before care or support was given, for example, during the administration of medicines. People using the service and their relatives confirmed they were asked for consent. For example, one person described how when she received personal care the staff consulted her. "They say to me, how is this?"

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff had undertaken training in areas such as infection control, fire prevention, health and safety, moving and handling, nutrition and hydration, first aid, medicines management and safeguarding adults. Many staff had completed more specialised training in order to meet the specific needs of the people using the service such as dementia awareness and end of life care. Staff

said they had received training and support to be able to competently carry out their roles. They confirmed that they were offered the opportunity to undertake nationally recognised accredited training. Several staff had completed NVQ in level II or III. They said they received regular ongoing supervision from the registered manager who often worked alongside them.

Comments from staff included; "It's very good for training here." And "We get loads of training… New people (staff) work alongside experienced people on each shift to help them learn."

The registered manager had a responsive approach to learning. For example, if they spotted staff needed additional learning on a specific topic, they would promptly enrol them on an appropriate course of learning, saying, "If there's a problem, I'm trying to get the training people to come straight in." New staff were given an induction booklet which contained some questions on key topics such a safeguarding and whistle blowing on which they were later tested by the registered manager.

People using the service, their relatives and health and social professionals expressed confidence in the skills and knowledge of the staff team. Comments included, "(Relative) told me today that we could not have chosen a better home for (name). She said that the staff are always very cheerful and cannot do enough for (name of resident). (The relative) has total faith in their ability to care for (name of resident) and said they have a good understanding of what has happened and what support to offer."

On the first day of inspection we noticed that there were insufficient drinks and an absence of jugs of squash or juice available in bedrooms and lounges. However, this was noted by the registered manager as an oversight and had been improved by day two. On the first day of inspection a menu was displayed in the dining room noticeboard giving only one choice for lunch. We were informed by the cook that everyone who wished to eat in their own room was asked individually whether they would like the main choice or whether they would like a different option, such as a salad. We were told that although it was not displayed every day there was always a choice of meal. People we spoke to who lived at the service confirmed this.

People's dietary needs and preferences were known to the chef and staff. The cook kept a record of people's needs and allergies. People who required a special diet, such as vegetarian were also offered an alternative meal which suited their diet. Where people required support to eat their meal, the staff were respectful and unhurried in their approach. People identified at risk of malnutrition had their weight monitored weekly, and any record of weight gains or losses was managed proactively. For example, fortified drinks and regular snacks were offered.

People said that they enjoyed the food on offer at the service. Comments included: "The food is excellent here…if you want any more you only have to ask." One relative said "(name) is always telling us how lovely the food is… It's all freshly made". A visiting health care professional said "(Name) needs a lot of support regarding nutrition and the home is aware and making sure that they are drinking and eating enough, which is helping them to stay well, so the staff are prompting and overseeing everything in this area."

People had access to health and social care professionals to meet their needs, for example GPs visited weekly; the community nurses also visited regularly. Other visiting professionals included social workers, the community psychiatric nurse; speech and language therapist (SALT) and chiropodist. People's health care needs were recorded in their care plans along with instructions for staff to monitor and meet individual needs. For example, one person had received a visit from an optician which had resulted in an operation which had dramatically improved their vision. A relative praised the service for the way in which they worked with healthcare services to control pain being experienced by their relative; "(Name) pain is monitored and

well controlled. If there is a problem they don't let (name) just lie there… The nurses are called in regularly."

Good

Is the service caring?

Our findings

The atmosphere in the home was warm, friendly and relaxed. People were clearly comfortable with the staff who seemed to know each person well and treated them with kindness and compassion. For example, one person was given a baby doll to cradle as this helped them to feel calm. Staff worked with people in a patient and gentle manner. For example, when one person complained about being cold, a member of staff went to fetch additional clothing and helped the person into it. Another person who was distressed was comforted by a member of staff who said "don't worry, I'm not going to leave you."

People were able to exercise choice. For example, some people had been able to bring pets with them, such as a cat. Privacy was maintained by staff. For example, personal care was delivered in private and when staff assisted people with personal care they acted discreetly.

People using the service, their relatives and professionals were all positive about the care and support provided by the staff team. People living at the service said: "the staff are all so bright and caring…the care here is fantastic." And "the carers are 100% good…They're a great lot here, very friendly. If I want anything they do everything just perfect."

Relatives said they always felt welcome at the home and that staff were always friendly towards them. People visiting the home during the inspection were very positive about the level of care offered. Comments included; "(staff) are very caring, you just couldn't fault them, they are always very friendly." Another visitor said "the carers are very good, they look after (name) well." When asked whether staff were respectful and treated people with dignity, one person replied "Yes I think so, yes, they are very polite." Family members confirmed that they were consulted and involved in decision making about their relative's care.

A visiting health care professional said "The carers are very helpful…they do what is needed straightaway." Another professional said "(name) has been very well looked after… As have their family. (Treelands) have supported both their new resident and her family impeccably."

One member of staff said "We are all like one big family here." Another one explained that the service went out of its way to include relatives in activities such as bonfire night celebrations, saying "Families are always welcome here. The Christmas party is out of this world." Staff were sensitive to the needs of those without immediate family, saying "We try and make people with no relatives feel part of our big family."

People's wishes had been discussed with them and they had been involved in decisions about their care. Treatment Escalation Plans (TEP) were in place, which recorded important decisions about how individuals wanted to be treated if their health deteriorated. This meant people's preferences were known in advance so they were not subjected to unwanted interventions or admission to hospital at the end of their life, unless this was their choice.

One person was receiving end of life care at the time of the inspection. We observed that their condition was monitored regularly by staff. Staff visited the person frequently, providing comfort, repositioning and food

and fluids. Medicines were given as prescribed to reduce any unwanted symptoms, such as pain.

Good

Is the service responsive?

Our findings

People received personalised care and support. Their care and support was planned with them and the people who mattered to them where possible. Each person had a care plan, which described their health needs, mental capacity and preferences about how they wished to receive their care. Staff were knowledgeable about each person's health needs and preferences. They confirmed they had the guidance they needed to meet people's specific needs.

One social welfare professional praised the service for their responsiveness saying: "(the registered manager) had a thorough grasp of (name's) care needs and if anything did more than expected… (to help them settle in)" They went on to describe the ways in which this had been achieved, which included finding out about the person's likes and dislikes. They continued; "(name) has not fallen since being in the home and I am aware that the manager is monitoring this area of care…and will be prepared to put in sensor equipment…so there is ongoing assessment of this issue."

People were asked to give their consent to engaging in activities. This was evidenced in their care plans.

People confirmed that they were asked about activities they would like to participate in. One person expressed dissatisfaction saying "I do want to do things, but there's nothing to do. I wouldn't mind a bit of gardening or just going outside for a walk." Another person said she would also like to go outside into the garden for a walk but would need support. "So it just doesn't happen."

The service had employed an activities coordinator for about nine years on a part-time basis. The registered manager told us that they recognised the needs of their residents had changed in recent years. They now had many more people living with dementia. In response to this, a new activities coordinator with a specific interest in dementia was employed to work full-time.

The new activities coordinator had been researching specific ways to engage people living with dementia in meaningful activity. At the time of the inspection they were in the process of speaking individually to each person about their previous life and their interests in order to compile a "This Is Me" record. This was to ensure that people received personalised support in undertaking whatever activities suited them best. At the time of the inspection she had only been able to offer individual consultations to about one quarter of the people living at the service.

The coordinator had created a new weekly timetable of activities. This included tabletop gardening, floor-based games such as skittles and visiting musicians. One-to-one sessions were also offered to those people who chose to stay in their rooms. These included hand massage and reminiscence therapy.

On the first day of inspection we saw that only four people were engaging in an activity with the activities coordinator. Some other people were seen dozing in their chairs for extended periods. One person complained of being bored. Others were engaged in reading or chatting to their visitors, either in the communal lounge or in their own rooms.

People we spoke to in their own rooms confirmed that they were very happy to be there and engage in their hobbies such as reading or watching television. On the second day of inspection we observed a one-to-one consultation which the person clearly very much enjoyed.

The activities coordinator explained that they were new in post and were still developing the role. They were very aware of the need to look for ways to involve other people living at the service in meaningful activities, such as gentle exercise. They had created a menu of ideas for individual sessions and were keeping records of who enjoyed doing what.This should ensure that more people were able to engage with meaningful activities.

Relatives and one healthcare professional referred to a successful musical cabaret event which had taken place before the inspection. This event had engaged most people living at the service and there were plans to offer similar events in future. The relative of a person who had participated in the cabaret and had really enjoyed the nostalgia reported to the staff: "You've made my Mum a different person."

Following our inspection, the registered manager had consulted individual people living with dementia about the new approach to activities. They said "I've been getting really good feedback about the one-to-one's…and the "This Is Me book…they love that…we found out some really interesting things about people's early lives". This was a good example of the service being responsive to changes in the needs of people living there over time.

The activities coordinator explained that there was a plan to create a safe area of the garden by closing it off with a fence. This would then enable people to walk outside safely and undertake some gardening.

A complaints procedure was in place and people said they knew how to make a complaint if necessary. People were reminded in the residents' meeting how they could raise a concern or complaint and these were minuted. People said they would speak with the registered manager or a member of staff should they have any concerns. All felt sure any concerns would be listened to and resolved. One person said, "We always see someone who's in charge, either the manager or (name). It's quite good really, they listen to what you say."

Health and social care professionals confirmed they had not received any concerns or complaints about the service from people they visit.

The PIR showed that three complaints had been received by the service since the last inspection. The registered manager confirmed during the inspection what action had been taken and that they had been resolved to the satisfaction of the complainants.

The PIR showed that 14 compliments had been received from relatives in the year March 2016 to March 2017 thanking all staff for their care and support. Comments included, "Treelands undertook from the start to provide every necessary level of care, a promise that they faithfully and affectionately fulfilled."

Good

Is the service well-led?

Our findings

People and their families said they were very happy with the atmosphere and the quality of care provided at Treelands. One relative said "(the registered manager) is on top of it. (Name) knows who everyone is and what ails them and seems to really care."

There was a culture of open communication, working as a team and ongoing learning and development. There was a clear management structure, where the provider developed good relationships with families. Many people had lived there for several years. The registered manager had been in post for some years having worked their way up from a position as a care worker. There was a feeling of pride in developing a high quality service and mutual respect among the team. The registered manager praised staff for the quality of their teamwork saying, "they are superb…they pull together." The registered manager felt very supported by the provider: "If I need anything, it's there. I get all the support I need from (name of provider)…(name) has always been there for me."

Staff said they felt well supported by the management team. Comments included "if you go to (the registered manager) with a problem, it sorted out. (Name) always comes right back to you." and "(the registered manager) treats everybody well. I wouldn't be afraid to go and speak to (name) about anything." And a third member of staff said "there's a good team spirit here. You can go (into the office) at any time. They never say you can't go in."

Staff practice was monitored on a daily basis and any issues arising were tackled promptly with further training being provided as required. We saw examples of this during the inspection. The service had a whistleblowing policy and encouraged staff to raise concerns. Staff confirmed that regular supervision and appraisal took place. If and when required, disciplinary procedures were used to maintain high standards by care staff.

The views of people living at the service was sought by means of regular quarterly residents' meetings which were minuted. Items discussed included people's food preferences and ideas for social activities. Changes implemented included an addition to the menu of lasagne by request. In June 2017 everyone was consulted on an individual basis about any personal concerns. This was to ensure that people who did not attend the meetings also had an opportunity to raise any issues.

The registered manager used a wide range of quality monitoring systems to continually review and improve the service. This included a monthly review of care records, weekly checks of medicines administration records, moving and handling equipment, infection control measures, safe storage of chemicals and keys, and timely response to call bells. Findings were recorded with a date set for action required and a further date for completion which was also monitored.

The management function was well supported with effective administration records. For example, a colour-coded graph had been devised which graphically illustrated where and when falls were occurring in communal areas. This information was analysed to identify causation and effective remedies put in place.

The changes resulted in a dramatic improvement and a reduction in falls from an average of 20 per month down to 6 per month in one particular area of the home. This was a good example of effective quality assurance monitoring leading to an improvement in the quality of the service.

The registered manager was always looking for ways to improve the service by modifying or developing systems. For example, a new one-page summary form had been created to meet the needs of visiting health care professionals. This gave key essential information all held securely in one place for ready reference. This enabled more time to be spent with the individual person and less time spent looking for information in individual folders.

The service had relevant policies and procedures in place to guide staff on issues such a safeguarding, whistleblowing and health and safety. The manager had notified the Care Quality Commission (CQC) promptly about significant events. The website had recently been updated and met the requirements.