







# Flightcare Limited Orchard Nursing

## 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	

### Overall summary

This was an unannounced inspection, carried out on 11 August 2015.

Orchard Nursing accommodates up to 31 people. The service provides single bedrooms, shared lounges and dining rooms and there are gardens for people to use. Parking is available directly outside the building and public transport links are close by.

The service has had a registered manager since August 2011. 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 last inspection of Orchard Nursing was carried out in May 2013 and we found that the service was meeting the regulations we reviewed.

Information and guidance in relation to safeguarding people from abuse or the risk of abuse was readily

# Summary of findings

available to staff. People were kept safe by staff who knew how to identify and respond to abuse. People felt safe and were confident about raising any concerns they had about their safety.

The recruitment of new staff was thorough and safe which ensured applicants were suitable to work in a care setting. Staff completed an application form, attended an interview and underwent a series of checks prior to them being offered a job.

Risk assessments were carried out and risk management plans that were in place showed what actions staff should take to minimise the risk of harm and injury to people. There were sufficient staff to meet people's needs safely. Medicines were safely managed and checks were undertaken to ensure the building and emergency equipment was checked regularly.

The service acted in accordance with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant people who lacked capacity to make specific decisions were protected and authorisation was sought before people were lawfully deprived of their liberty. People's consent was obtained prior to them receiving care and support.

Staff were supported within their roles and they received training relevant to the work they carried out, and the needs of the people who used the service. Staff told that they received a great deal of training and that they were always attending refresher courses to update their knowledge and skills.

People were offered a choice of food and drink and their dietary needs were understood by staff. Staff engaged with people whilst assisting them to eat and drink and they were patient in their approach. People who were at risk of malnutrition or who had specialist dietary needs received appropriate input from nutritional specialists and other relevant health professionals. The chef was knowledgeable about people's dietary needs and prepared the right food and drinks for people.

People spoke positively about the care they received and were supported by staff that had good knowledge of their care and support needs. Care and support was planned around people's choices and personal preferences. People were treated in a respectful and dignified manner and their care needs were met with kindness, consideration and patience.

People were listened to and involved in the planning of their care and support. People's likes, dislikes, cultural, religious and spiritual needs were taken account of. Care plans and risks people faced were reviewed regularly and updated to reflect any changing needs. People and their family members had access to a complaints procedure and they were confident that any complaints they had would be listened to and acted upon.

The environment aided the orientation of people living with dementia. Photographs, coloured doors and pictorial signs were used so that people could recognise parts of the service such as bathrooms, toilets and their bedrooms. Period items such as pictures and ornaments were located around the service to help stimulate people's memories and generate conversations from the past. Menus and activity programmes were available in picture format so that people could better understand them.

People, family members and staff spoke positively about the registered manager. They told us the registered manager was easily accessible, approachable and supportive. There was an open culture within the service and care was delivered in a positive environment.

Effective systems were in place to monitor and assess the quality of the service people received and to ensure that the service was safe. These included checks on care plans and medication and on practices such as infection control and health and safety. The service encouraged open communication with people who used the service, family members and staff. Surveys and regular meetings captured people's views and recorded actions taken by the service in response to them.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People felt safe living at the service and staff knew how to recognise and respond to allegations of potential abuse.

People received care and support from the right amount of suitably skilled and experienced staff.

Medication was managed safely and people received their medication on time.

Good



### Is the service effective?

The service was effective.

People's needs were assessed to ensure they could be met at the service.

Staff applied the law when making decisions for people who lacked capacity.

Staff had received the necessary training and support to enable them to effectively meet people's needs.

Good



### Is the service caring?

The service was caring.

People were respected and their privacy, dignity and independence were promoted.

Staff spoke about people in a caring way and they were patient and caring in their approach when providing people with care and support.

The service is accredited to the Gold Standards Framework which provides staff with specialist training in relation to end of life care.

Good



### Is the service responsive?

The service was responsive.

Care plans included people's preferences with regards to how they wished their care to be provided. Care plans were updated to include a change in people's needs.

People had all the equipment they needed to help with their mobility, comfort and independence and the environment aided people's orientation.

People had access to information about how to complain and they were confident that their complaints would be listened to and acted upon.

Good



### Is the service well-led?

The service was well led.

The service had a registered manager. Staff and family members described the manager as supportive and approachable.

The leadership of the service was inclusive and promoted an open culture.

Good



# Summary of findings

There were effective quality assurance systems which helped to ensure people received safe and effective care and support.

# Orchard Nursing

## 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 11 July 2015 and was unannounced. The inspection team consisted of two adult social care inspectors 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.

Before the inspection we reviewed all of the information we held about the service. This included a Provider Information Return (PIR), which we received before the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We

reviewed notifications that the registered provider had sent us since the last inspection and information we received from members of the public. Prior to the inspection we contacted commissioners of the service and Healthwatch for information about the service and they raised no concerns with us.

During our visit we spoke with 11 people who used the service, eight visiting relatives and 10 members of staff who held various roles, including care staff and ancillary staff. We also spoke with the registered manager, the deputy manager and the quality assurance manager for the service. We looked at five people's care records and observed how people were cared for. We toured the inside and outside of the premises including people's bedrooms. We looked at staff records and records relating to the management of the service.

We carried out a number of Short Observational Framework for Inspectors (SOFI) including over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people using the service who could not express their views to us.

# Is the service safe?

## Our findings

People told us they felt safe. People's comments included; "I could not feel safer. The staff are always around and if we need anything we just ask," "I'd tell someone if I was worried or upset" and "I do feel safe here. I think there's enough staff. They don't take too long to come when you buzz them. They give me my medicine when it's time. My room is kept nice and clean", Relatives commented; "When I go home from here I have no worries. I know the staff look after her [relative] and keep her safe" and "It's fantastic here, it makes me feel better to know that she's [relative] safe and well looked after here".

People were protected from abuse or the risk of abuse. Staff told us they had undertaken safeguarding training and records confirmed this. A staff member told us "Safeguarding is one of the first training sessions new carers need to complete and we get regular reviews and updates." All staff had access to the registered providers safeguarding policy and procedure and copies of those set out by the relevant local authorities. Staff were familiar with the procedures for reporting actual or suspected abuse and they told us they would not hesitate to report any concerns they had. Staff described the different types of abuse and the signs which may indicate abuse had taken place. Their comments included; "I would definitely report anything I thought was abuse, without hesitation" and "I'd report it straight away". Potential safeguarding incidents which had occurred at the service had been referred to the relevant agency for investigation and the registered manager had worked in partnership with the agencies to ensure people were protected from further abuse.

All parts of the service were clean and hygienic and people who used the service moved around freely and safely. Staff had easy access to personal protective equipment (PPE) which they used appropriately. For example, when providing people with personal care, handling soiled laundry and when serving food. Hand cleanser/sanitizer and paper towels were provided in all toilets and bathrooms and hand washing instructions were displayed above all hand basins. Rotas which were displayed on the back of doors in bathrooms, toilets and people's bedrooms showed cleaning had been completed on a regular basis. Sluice rooms and store rooms were secured which helped ensure the safety of people who used the service. There were appropriate bins situated around the

service for the disposal of domestic and clinical waste and systems were in place to ensure all waste was safely removed from the service. Infection control audits (checks) were regularly carried out across the service and records of them were kept. An audit carried out at the service by the local authority's community infection control team in February 2015 showed the service achieved a score of 99.39 per cent.

People received their medication on time and medication, including controlled drugs was managed safely. Medication was administered by nurses who had completed up to date training in relation to the task and they had access to current policies and procedures and other related guidance. Senior staff completed regular medication audits at the service and an annual audit was carried out by the local authority's community medicines management team. The last audit carried out by the community medicines management team took place in February 2015 and the service achieved an overall score of 26 out of 30 which meant in general good practice.

All medication was stored securely when not in use. The temperature of the medication room and medication refrigerators was monitored and recorded daily to ensure medicines were appropriately stored and remained effective. A record was kept of all medicines received into the service, medicines returned to the pharmacist and medicines which were destroyed. Each person who required medication had a personalised medication profile and a medication administration record (MAR) which were appropriately completed. Medication profiles displayed a recent photograph of the person which helped staff confirm their identity, when administering medication. Profiles also included details of the person's GP, known allergies, how people communicated pain and any individual advice for administering medication. For example, one person's profile recorded that they were at risk of choking. Some people were prescribed PRN medication, this is medication which is given when required. Guidance for the use of PRN medication was available and appropriate records were in place for individuals confirming the use of PRN medication, for example pain relief. Where appropriate people were asked if they required any pain relief and the 'Abbey Pain Scale' was used for people who had difficulties communicating. The Abbey Pain Scale is an observational assessment tool used to measure pain in people who are unable to communicate.

## Is the service safe?

Risks people faced in relation to the environment and their care and support were assessed. Plans were in place to manage identified risks and they instructed staff on how to minimise the risk of harm to people. This included risks associated with falls, use of bedrails, nutrition and moving and handling.

Staff had received training in topics of health and safety including fire awareness, first aid and infection control and they were confident about dealing with an emergency situation. Emergency equipment such as first aid boxes and fire extinguishers were located around the service and staff knew where to locate them. Equipment had been regularly checked to ensure it was intact and safe to use. Each person had a personal evacuation plan PEEP and a continuity plan was in place for the service. These provided staff with instructions and guidance about how to respond in an emergency such as in the event of a fire, flood or breakdown of essential equipment at the service.

People's needs were met by the right amount of skilled and experienced staff. Staffing rosters for the four weeks prior to our visit showed there had been a consistent amount of

staff on duty throughout the day and night. Each shift was led by a suitably qualified and experienced member of staff and people told us they felt safe with the staff. There was always a staff member available in communal areas of the service and staff regularly checked on people who occupied their bedrooms.

Staff were recruited in line with the registered providers recruitment and selection policy and procedure. Recruitment records for five members of staff who held different roles, including a nurse, care assistants and ancillary staff showed that the process for recruiting staff was thorough and safe. Applicants had completed an application form and attended interview and as part of this they provided details of their previous employment history, training and experience. References were obtained and Disclosure and Barring Service (DBS) check was carried out in respect of applicants prior to them starting work at the service. DBS checks are carried out to check on people's criminal record and to check if they have been placed on a list for people who are barred from working with vulnerable adults.



# Is the service effective?

## Our findings

People told us they had received all the care and support they needed and that they had confidence in the staff team. People's comments included; "The staff are very good at what they do and they certainly know me well", "The doctor's always in and out, he was in last week to see me. The girls don't take a chance any problems they are straight on the phone", "We can choose what time we get up and go to bed. If you want to sleep in you just stay in bed". Family members told us they had confidence in the staff team. One family member said, "She's [relative] fully dependant on the staff, and I'm fully confident that they do look after her very well".

Each person had their needs assessed prior to admission to the service or within 48 hrs in the case of an emergency admission. Need assessments which were carried out by other health and social care professionals were also obtained and held in people's care files. This information helped to decide if a person's needs could be met at the service and it was used to develop people's care plans. A family member told us "Before she [relative] came in they did an assessment and I was involved at all times, they asked me lots of questions which was good".

Do not attempt resuscitation (DNAR) authorisations were in place for some people who used the service and they had been completed in line with requirements by the person's GP. The DNAR authorisation form had been placed at the front of the person's care plan as recommended and staff were aware of those people who had a DNAR in place. A member of staff told us, "If a resident goes to hospital, we send the DNAR with them". Short term care plans were in place for people where required, for example, when a person was prescribed a course of antibiotics and where a person required pressure relief.

Appropriate referrals for people had been made as required to external services such as the falls team, dieticians and community mental health teams. People were supported to access primary health care services including GPs, dentists, opticians and chiropodists.

Relatives told us staff were knowledgeable about people and how to meet their specific needs, including any medical and healthcare needs. One family member told us their relative's health had deteriorated and that they were reassured that staff were able to cope with the

deterioration and continue with their relative's care. Another family member said they were confident that staff were able to tell if their relative required medical intervention because they had received specific training around their relative's health condition.

New staff completed an induction programme during which time they shadowed more experienced staff and completed a range of training. Induction training consisted of topics such as safeguarding, health and safety and dementia awareness. Staff received appropriate support and supervision and they felt well supported in their role. Staff had one to one supervisions with their line manager and an annual appraisal to assess their performance and any training and development needs. Staff told us they found these sessions useful and that they gave them the opportunity to discuss their strengths and needs in terms of practice and professional development. Regular staff meetings also provided an opportunity for staff to discuss their work, and to share ideas for improving the service.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The registered manager and staff had completed training in relation to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and they had access to the provider's policy and procedure in relation to MCA and DoLS. Where people did not have the capacity to consent to decisions about their care, the registered manager followed appropriate guidance. Mental capacity assessments had been carried out to demonstrate that people were not able to make specific decisions for themselves and involved other relevant people to come to a decision about what was in the person's best interests. A DoLS authorisation was in place for a number of people who used the service and a DoLS application had been submitted for a number of other people. Appropriate documentation was in place in relation to the DoLS authorisations and pending applications. Staff knew which people were subject to a DoLS authorisation and they understood what a DoLS meant for the person and what their responsibilities were for implementing it.

People's rights were protected in relation to decision-making and staff had a good understanding about obtaining people's consent and ensuring people's legal rights. Staff sought people's consent before providing care



## Is the service effective?

and support. For example, staff knocked on bedrooms doors, waited for the person to agree before entering their room, explained to the person why they had come to their room and what they proposed to do, before continuing with the task.

People's dietary needs were assessed and a care plan was in place as required for people who were at risk of poor nutrition and hydration. Any advice sought from dieticians and speech and language therapists (SALT) were included in care plans and where appropriate people's food and fluid intake was monitored. The chef held information about people's dietary needs and they prepared appropriate food and drinks for people. For example, high calorific meals and drinks were provided to people who were at risk of weight loss and low sugar foods and drinks were provided for people living with diabetes. Other risks associated with eating and drinking, such as the risk of

choking had been identified and managed. Staff understood people's dietary needs and provided people with the support they needed. People were provided with regular meals and drinks of their choice. A menu with a choice of meals for the day was displayed on a notice board in the dining room and people had access to a selection of drinks and snacks in between main meals. Jugs of juice and beakers were available in the lounges, dining areas and in people's bedrooms. During the morning and afternoon staff walked around the service with a drinks trolley and offered people snacks and a choice of hot and cold drinks. Suitable beakers were provided for people whose needs required them and staff provided people with prompting and assistance. Staff had undertaken training in supporting people with their nutrition and they showed a good understanding of this.

# Is the service caring?

## Our findings

People told us that they felt valued by the staff and that they were patient, thoughtful, kind and caring. People's comments included; "The girls here are like family to me, could not do more for me, fantastic", "They're all lovely I could not speak highly enough of them" and "The staff are lovely, they're very kind. They talk to me respectfully and listen to what I say. I don't feel patronised." Family members commented; "The carers are kind and caring. They're really nice people, keep her [relative] clean and look after her" and "She's [relative] treated as an individual, they all are, and with dignity. I saw a new face today [staff] and the first thing she said to me was hello, which shows good customer service."

The atmosphere of the service was friendly, calm and relaxing. Staff regularly enquired how people were and asked if they needed anything. Staff chatted and shared banter with people who used the service and their family members and people appeared to enjoy the interactions. One relative told us, "Staff are really friendly and happy" and another family member said "They always make us feel welcome and offer us a cup of tea".

Care records included information about people such as; family and employment history, religious and spiritual beliefs, hobbies and interests and preferred daily routines. This information helped staff generate discussions of interest and develop positive relationships with people. People spoke freely with the staff and discussions which took place showed staff had taken time to get to know people. Family members told us that staff knew their relatives well. A lot of staff had worked at the service for a number of years and had established trusting and positive relationships with people.

Staff were patient, courteous and polite towards people. Staff sat close to people when chatting with them and they explained to the person what they were about to do, for example, prior to assisting people with their mobility. Staff also sat close to people whilst assisting them to eat and drink and they encouraged people to eat independently. Staff addressed people in a friendly and respectful tone and they smiled throughout the interaction.

People's privacy and dignity were respected. People told us that had chosen to spend time alone or join others in communal areas and that staff always shut doors and

closed blinds when they received support with personal care. We met with one person who was being cared for in bed and we were asked politely by staff to leave the person's room whilst they assisted the person to reposition. We were also asked politely to leave a lounge whilst another person was transferred into an easy chair by the use of a hoist. A relative told us that was common practice as they had also been asked to leave the lounge when people were transferred by use of the hoist. This demonstrated respect for people's dignity. Care plans contained information about how each person would like staff to support them with personal care to preserve their privacy and dignity. This included people's preference about whether they liked to be supported by male or female staff.

People were involved in the development and reviewing of their care plans and they made decisions about their care and support. One person said, "I tell them which way is best". Relatives told us staff listened to people and respected their opinions. One relative told us, "They always involve me and keep me up to date". Care plans contained information about people's expectations, wishes and preferences with regards to their care and these were taken into account. Care plans also included people's preferred methods of communication and how staff should communicate with people in a way they understand.

Care plans included information about people's level of independence for various tasks and how staff should support people to maintain this. People's independence was promoted in various ways. For example, where people were able to self-care staff encouraged and supported this. Staff gave supportive prompts and gentle reminders to people who required it, rather than taking over. One person liked to carry out small tasks around the service, such as dusting and setting tables and the person confirmed that staff supported and encouraged this.

The service is accredited to the Gold Standards Framework, an evidence based training and support system for services providing care to people at the end of their lives. This helped staff to ensure that the care they provided at the end of people's lives was based on best practice. Staff told us they had become more confident in supporting people and their families in a caring, compassionate way that

## Is the service caring?

preserved their dignity and comfort. Staff told us how they assessed pain for people who were not able to communicate verbally by using evidence-based assessment tools.

# Is the service responsive?

## Our findings

People told us they received all the care and support they needed and that staff responded well to any requests they made. People's comments included; "I never stop talking to the staff, different ones come in every day to see if I'm alright, and if I need anything they get it", "Staff talk to me a lot", "I sit in the lounge and when I want I ask someone to take me back to my room" and "I watch my telly. They've all offered to take me out in a wheel chair. I might go next week".

Each person had a care plan for their assessed needs and they were regularly reviewed to ensure they were relevant and up to date. People and/or relevant others were involved in the development and reviewing of care plans, which gave them the opportunity to contribute to the care and support they received. Care plans were person centred and provided staff with clear guidance about how to meet people's needs. People's spiritual, cultural and diverse needs, likes, dislikes, wishes and preferences were recorded. Preferences people expressed included; daily routines such as what time people liked to get up each morning and when they liked to retire to bed. Assistance people needed with everyday tasks, their mobility and communication were also included in their care plans.

Staff were knowledgeable about people's needs and they had a good understanding of them. One person said, "I get up every morning at 6:30. It's part of my routine, they know it". Relevant staff had access to people's care plans and shift handovers, involving key members of staff took place daily as a way of keeping up to date with people's needs. Daily records which were kept for each person showed they had received and were offered all the care and support they needed and that staff had responded appropriately to any concerns they had about a person's health or wellbeing. A member of staff told us, "I would recognise if a person's needs changed and I would tell the manager". Charts were completed as required for people who required any aspect of their care monitoring, for example, positioning, falls and behaviour. Records were maintained of the contact people had with other services and any recommendations and guidance from healthcare professionals was included in people's care plans.

People had the equipment they needed to help with their mobility, comfort and independence. People who required them had specialist beds and chairs and people were transferred by use of wheelchairs, hoists and standing aids in accordance with their care plans. Handrails were located around the service to aid people's mobility and bathrooms and toilets were fitted with raised toilet seats and specialist bathing/shower aids.

The service employed an activities co-ordinator who was responsible for organising and facilitating both group and one to one activities. The activities co-ordinator held information about people's preferences with regards to activities and they maintained records of activities which people had taken part in. Activities included, sing a longs, film shows, arts and craft and light exercises.

The environment aided the orientation of people living with dementia. For example, bedroom doors were painted in different colours and pictorial signs were used to identify toilets and bathrooms. Each person had a photograph frame hung on the wall next to their bedroom door. The frames which displayed past and present photographs of people and their family members were used as an aid to help people locate their bedrooms. Also located around the service were period items and pictures to stimulate people's memories and generate conversations from the past. Menus and activity programmes were available in picture format so that people who had difficulties reading could understand them.

The registered provider had a complaints procedure which was made available to people who used the service and others. The procedure clearly set out the process dealing with a complaint, including who is responsible for investigating complaints and the timescales for responding. People and their family members told us they knew about the complaints procedure and that they would complain if they needed to. People were confident that their complaints would be listened to and acted upon. A family member told us "I've no complaints, but if I did I wouldn't hesitate to tell them".

# Is the service well-led?

## Our findings

People who used the service and their family members told us they thought the service was well managed and they spoke positively about the registered manager and the deputy manager. Their comments included; “They do a really good job. Everything is great here”, “Really approachable” “The manager is absolutely fantastic, she comes in all the time. She is really interested” and “We are kept up to date, they communicate very well”.

Staff felt there was a supportive an open culture at the service and that they felt able to discuss anything with the management team. Staff comments included, “I think the manager, and the deputy manager are both fantastic, they always want to help and you can talk to them anytime” and “We have meetings a lot and if anyone comes up with a new idea they will try it and see how it goes”. The registered provider had a whistle blowing policy and procedure which staff were familiar with and felt able to use with confidence.

Family members told us the service was well run and leadership was always visible. One family member commented on the continuity of staff and the leadership, which had enabled them and their relative to build a positive relationship with staff and management. Staff told us the manager knew all of the people who used the service well. The service had a hierarchy of management with clear responsibilities and lines of accountability. Staff knew who was responsible for each aspect of the care they provided, for example who the clinical leads were.

Family members told us they felt included and involved in the running of the service. They had been invited to residents and relatives meetings which provided them with the opportunity to discuss how the service was run. They told us the management were very good at keeping in touch with them and that they received regular updates regarding events at the service.

The registered provider carried out surveys to gather people’s feedback about aspects of the service including daily care, staff and food. They did this by sending out questionnaires to people who used the service and their family members. Completed questionnaires were returned to the registered provider’s central office where they were analysed and the results were forwarded onto the registered manager. We looked at the results of a survey carried out in January 2015 and saw that people

consistently fed back that each aspect of the survey was satisfactory, good or very good. Results of surveys, which included any negative comments and the manager’s response, were published and displayed near to the entrance of the service for all to see. Improvements were made to the service as a result of the feedback people gave. For example, the laundry system and quality of activities at the service were improved.

Family members said the service had a culture of continuous improvement and that the provider was always striving to provide a better service for people who used it. Family members told us “They work hard at making things better” and “I see improvements all the time”. One family member said they would recommend the service to others. Staff felt that the service was always improving and that they were asked their opinion about how things could be improved. Staff also told us that they received constructive feedback from the management team to help them provide better care.

The registered provider used the Gold Standards Framework to support them in providing high-quality care to people at the end of their lives. During supervision sessions the management team discussed with staff their roles and responsibilities and shared information on good practice and monitored how well they followed guidance. Staff also underwent regular competency checks to gauge their knowledge in relation to training undertaken. Managers also used supervision to monitor the culture of the service by giving staff the opportunity to discuss their working relationships with colleagues and people who used the service.

A range of checks and audits were carried out across the service as a way of ensuring people received safe and effective care and support. This included checks on care plans, medication staff performance, infection control practices, the environment and systems and equipment. Audit tools clearly identified what was needed to improve the quality of the service provided, who was responsible for any actions and timescales for completion. Further checks were subsequently undertaken to ensure actions had been completed within the required timescales. Checks had also been carried out recently by the community medicines management and infection control teams. The service achieved high scores following both these visits. Some minor areas for improvement which were identified had

## Is the service well-led?

been completed prior to our inspection. This meant that the registered manager responded promptly to feedback and used it to improve the service. Any actions that were identified from audits were completed promptly.

A system was in place for reporting and recording accidents and incidents which had occurred at the service. The reports were regularly analysed to look for any trends and

patterns and to explore ways of learning. The registered manager had notified CQC promptly of significant events which had occurred at the service. This enabled us to decide if the service had acted appropriately to ensure people were protected against the risk of inappropriate and unsafe care.