WCS Care Group Limited

Westlands

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?	Outstanding

Overall summary

The inspection took place on 5 and 6 May 2015 and was unannounced. The service was meeting the regulations at our previous inspection in July 2013. We were confident the provider continued to meet the regulations because they had kept us informed of changes and important events and had responded to our requests for information promptly and effectively.

The home provides accommodation and personal care for up to 41 older people, or older people living with dementia. Thirty five people lived at the home at the time of our inspection. Each of the three floors of the home was organised as a separate household, which meant people had access to communal rooms and facilities of a size many people would be familiar with.

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.

Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns. The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks.

There were enough staff on duty to meet people's physical and social needs. The registered manager

Summary of findings

checked staff's suitability to deliver personal care during the recruitment process. The premises were regularly checked to ensure risks to people's safety were minimised. People's medicines were managed, stored and administered safely.

Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff until they knew people well. Staff received training and support that ensured people's needs were met effectively. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, to improve people's experience of care.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No one was subject to a DoLS at the time of our inspection. The manager ensured that best interest decisions, for people who lacked capacity, were made after discussions with their representatives or families and other health professionals.

Risks to people's nutrition were minimised because people were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs and staff understood the importance of helping people to maintain a balanced diet.

Staff were attentive to people's moods and behaviour and understood when to implement different strategies to minimise people's anxiety. Staff ensured people obtained advice and support from other health professionals to maintain and improve their health or when their needs changed.

People and their relatives were involved in planning and agreeing how they were cared for and supported. Care was planned to meet people's individual needs, abilities and preferences and care plans were regularly reviewed.

The provider's quality monitoring system included regular checks of people's care plans, medicines administration and staff's practice. Accidents, incidents, falls and complaints were investigated and actions taken to minimise the risks of a re-occurrence.

People who lived at the home, their relatives and other health professionals were encouraged to share their opinions about the quality of the service. The provider and registered manager took account of others' opinions to make sure planned improvements focused on people's experience. The provider worked with partner agencies, who were specialists in the field of dementia care, to ensure people received the best possible care and support.

The provider had implemented innovative technologies to minimise medicine errors and obtain prompt health care advice. People could access a virtual health advice service, which reduced the time it took to relieve any anxiety about their health.

The provider's philosophy, vision and values were understood and shared across the staff team and resulted in a culture which ensured people were supported to maintain their purpose and pleasure in life.

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. Staff understood their responsibilities to report any concerns about people's safety and to minimise risks to people's health and wellbeing. The provider assessed risks within the home and took action to ensure people lived in a safe and comfortable environment. People's medicines were stored, administered and managed safely.

Good

Is the service effective?
The service was effective. Staff had the skills and experience to support people effectively. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's preferences, allergies, nutritional and specialist dietary needs were taken into account in menu planning and provision of choices. People were referred to other healthcare services promptly to minimise the risks of ill health.

Good

Is the service caring?
The service was caring. Staff knew people well and understood their individual and diverse preferences. Staff were kind and compassionate towards people. Staff respected people's privacy and dignity and supported people to maintain the relationships that were important to them.

Good

Is the service responsive?
The service was responsive. People and their families were involved in care planning and their preferences, likes and dislikes were understood by the staff. Staff supported and encouraged people to maintain their interests and friendships and participate in community events. The provider responded effectively to people's complaints and took action to improve the quality of the service.

Good

Is the service well-led?
The service was well led. The provider used traditional and innovative methods in partnership with experts in care, to understand the experience of people who lived at the home. Staff understood and supported the provider's vision, values and ethos to ensure care was centred on people's individual needs. The quality assurance system, which included regular assessments of people's individual risks, ensured accurate information was used to minimise risk and improve the quality of care.

Outstanding

Westlands

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 5 and 6 May 2015 and was unannounced. The inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 10 people who lived at the home and one relative. We spoke with four care staff, the cook, a domestic assistant, the registered manager, the deputy manager, the deputy director of operations and a member of the board of directors for the group of homes. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people living at the home were not able to tell us in detail, about how they were cared for and supported, because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home because there were always staff around. Two people told us, "The staff come if I ring the bell", which they said made them feel safe. A relative told us there were always enough staff to support people, whenever they visited.

We saw there were posters around the home which informed people and their relatives about the provider's safeguarding policy and procedure and listed contact details of other agencies they could speak with if they had any concerns. Care staff told us they had training in safeguarding and knew what to do if they had any concerns about people's safety. Care staff explained the signs they looked out for, and the actions they would take, if they thought people were at risk of harm. One member of care staff said, "If I were to see signs, such as, marks, bruises or someone appeared uncomfortable with staff, I would tell the care manager."

Care staff told us they felt supported to challenge other staff's practice, if they were concerned that people might feel disrespected. A member of care staff told us, "I can point out or explain to staff if their words could be misunderstood by people." Care staff told us they were confident that the provider's whistleblowing policy was effective. Two care staff told us the manager had taken appropriate action to investigate their concerns, when they had raised these in the past. A member of care staff said, "It was sorted out. The manager deals with issues." Records showed that the manager had not needed to make any referrals to the local authority safeguarding team and no concerns about people's safety had been reported to us during the previous 12 months.

In the three care plans we looked at we saw the manager had assessed people's individual risks and written a plan to minimise these where they were identified. For one person who was assessed as at high risk of falls due to their reduced mobility, their care plan stated that two staff were needed to assist the person to mobilise with specialist equipment. For another person who was at risk of not recognising their own needs, due to their confusion, their care plan guided care staff to speak clearly in short sentences and to support them in making decisions.

We saw staff were observant and aware of people's individual risks. We heard care staff remind one person of the possible consequences of not wearing their slippers and reminded another person of the possible consequences of walking without assistance. Staff offered to take preventative action, such as fetching one person's slippers and the other person's walking frame for them. Care staff told us they monitored people's needs and shared information about any changes in their abilities at handover. A member of care staff told us, "We record how they've been, what they've eaten, any concerns." Records showed the manager and deputy manager monitored the handover records so they knew when people's risks changed and they updated the preventative actions for staff in the care plans.

People and relatives told us there were enough staff to meet their needs. The manager checked people's needs and abilities and scored each person's level of dependence. The provider's 'dependencies analysis tool' was used to decide how many staff were needed to support people safely and according to their needs. We saw there were enough staff to answer call bells promptly and for staff to spend time supporting and engaging with people individually. Care staff told us there were enough staff and that bank staff covered unexpected staff absences, which meant people received consistent care from staff they were familiar with.

The deputy director of operations showed us the records of the checks they made on staff's suitability to work at the home to minimise the risk to people's safety. They told us, "No-one can start without sign off by an operations manager. Staff are checked as fit for role, meeting the job description criteria, consent and right to work, two references from previous employers and a check with the Disclosure and Barring Service." The DBS is a national agency that keeps records of criminal convictions. The staff records we looked at showed that all the checks had been made and any remaining risks were assessed by the operations manager and legal team. The deputy director of operations told us, "Sometimes we can't employ people if they do not pass our checks."

The provider minimised risks to people's safety by completing risk assessments of the premises and taking action to minimise the risks. Records showed the provider had contracts with external specialists to test and maintain essential energy supplies, the lift and the fire alarm system. The manager's checks included checking that the taps ran at the recommended temperatures and that equipment,

Good

Is the service safe?

such as hoists, beds and bed rails, were regularly tested and repaired when needed. Records showed that all care staff signed to say they had read the risk assessments, so they all understood their responsibilities. A member of care staff told us, "There is an external supplier to check the hoists, the housekeeper checks the slide sheets, belts and the sizes and we report maintenance issues to the housekeeper." Care staff told us repairs and maintenance issues were resolved promptly.

A member of care staff who was trained in medicines administration, showed us how they stored, administered and managed people's medicines safely. We saw medicines were kept in a locked cabinet in each household. Medicines were delivered in biodose pots, with the person's name, the name of each medicine and the time of day it should be taken, clearly recorded on the lid. The pots included all the prescribed medicines in one pot and were colour coded for the time of day they should be taken, to minimise the risk of errors.

The two medicines administration records (MAR) we looked at included the person's photo and a list of their medicines, which matched the biodose pot. The member of care staff told us they checked that all the medicines listed were included in the pot, before they offered it to the person, and they signed the MAR sheet once they saw the person had swallowed them. The member of care staff told us, "If a person declined their medicines, I would phone their GP for advice and share that information at handover."

Records showed that only trained staff were responsible for administering medicines on each shift and that care managers checked that medicines were administered according to people's prescriptions every day. We saw the monthly checks of medicines management included a count of all the medicines in the cabinet, checked against the records, and a record of the reasons that unused medicines were returned to the pharmacy. The deputy director of operations told us the implementation of the biodose system had reduced errors in medicines administration, as planned.

Good

Is the service effective?

Our findings

People told us they received the care and support they needed. One person told us, "It's not home but it's next best." A relative told us the staff supported their relation effectively and they trusted the staff's judgment.

Care staff told us their induction programme included reading the policies and procedures, attending training, meeting the people who lived at the home and shadowing experienced staff. Staff told us they felt prepared and supported when they started working at the home. Staff told us, "You have to get to know the people, it's your job to know them" and "I know my responsibilities and boundaries."

Records showed that all staff attended training that supported them to meet people's needs effectively. Care staff told us they had time to attend training and were encouraged to reflect on their learning and practice. A member of care staff told us, "We are observed in practice and get feedback." Staff attended regular one to one supervision meetings and annual appraisal meetings. One member of care staff told us, "They ask how we feel and I get feedback from the management team. I feel supported." Another member of care staff told us, "The managers are always about. They say well done and thanks. They recognise when you have done a good job." Staff were offered opportunities to develop their career through promotion to senior roles and by studying for higher level health and social care qualifications.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Care staff understood the requirements of the MCA. We saw staff asked people how they wanted to be cared for and supported before they acted. We saw that staff respected and supported people's right to balance risks with maintaining their independence.

The registered manager ensured that people or their representatives were consulted in planning care and support. Two people's care plans included mental capacity assessments that showed they did not have the capacity to sign their consent to care. Both of the care plans had been signed by the person's representative to say they were involved in discussions about how the person should be cared for. A relative told us they had been involved in discussions about their relation's care plan and had signed the record.

The MCA and DoLS require providers to submit applications to a Supervisory Body for authority to deprive a person of their liberty. The registered manager understood their responsibility to comply with the requirements of the Act. In the care plans we looked at, we saw the manager had checked that the person was not being deprived of their liberty and any restrictions were the least restrictive option to keep them safe. No one was deprived of their liberty or was subject to a DoLS at the time of our inspection.

People told us the food was good and they had a choice of meals. One person told us, "They don't make me eat anything I don't like." A relative told us the menus were available to visitors too, which assured them their relation was offered meals they liked. The cook told us menus were based on a nutritional analysis, and there was a choice every day. They told us they followed the provider's four-weekly, seasonal menu, as the basis for menu planning, but they were able to change the menu to meet people's preferences. They explained they had 'Westlands Wednesdays' meetings with people who lived at the home to talk about the meals and ask people for their suggestions. The cook told us, "We do a Westlands' special to keep the choice local", which meant people were offered meals of their choice.

At lunchtime we saw food looked and smelt appetising and saw people became more alert at the smell and sight of the meal. One person did not want either of the meals on the menu, but the cook made them an omelette in accordance with their preference. The cook told us, "Making choices is a fun activity at tea time." Care staff told us people did not always remember what they had chosen, so they offered them the choice again at the time. We heard staff offering people a choice at lunchtime and checking that people received the support they needed. For example, one person had their soup in a cup, to minimise the risk of spilling it and another person had a plate guard around the edge of their plate, to enable them to eat independently.

Care plans and daily records included information about people's allergies, special dietary requirements and likes and dislikes. The cook told us, "Senior care staff tell me about new people's' needs and preferences, which might be Halal or gluten free, for example." For people who were

Good

Is the service effective?

assessed as at risk of poor nutrition, staff monitored their daily food and fluid intake and their weekly weight. A member of care staff told us, "We record how they've been, what they've eaten, any concerns and we ring for a GP." Records showed people were supported by specialists in diet and nutrition to ensure they were encouraged to eat a balanced diet which met their needs.

A relative told us the staff supported their relation to maintain their health. They told us, "[Name] has seen the doctor since they moved in, and has been to outpatients. They are pushing the GP for a hospital appointment." People's care plans included information about their health conditions and contact details for their GPs and specialists, which meant staff knew which health professional to contact for advice and support. Records of people's daily living showed they saw doctors, district nurses, speech and language therapist and mental health nurses when they needed to. Staff kept records of the health professionals' advice and monitored the outcomes of following their advice, so they knew which actions were effective.

The provider was trialling a system of live health care advice via the internet with voice and video, 24 hours a day, seven days a week. The system was portable, which meant people could speak with the health care professional independently and confidentially from the privacy of their own room. The deputy director of operations told us the system had resulted in a decline in visits to the accident and emergency services and people were supported to maintain their health with minimum disruption to their daily lives.

Good

Is the service caring?

Our findings

People told us they liked living at the home because the staff were fun and were kind to them. One person told us, "I didn't want to live in a home, but I love living here now. I am very happy." Another person said, "I am getting to know the routines. They are nice people." A member of care staff told us, "The staff are genuine in their caring."

All the staff told us the most important thing was to get to know the people who lived at the home so they could support them in the way they preferred. We saw staff knew and understood people well. Staff offered people comfort, reassurance and a distraction when they appeared anxious. We saw people were less anxious after staff had spent time with them. Staff understood people who were not able to communicate verbally and supported them with kindness and compassion.

People's care plans included a personal profile, entitled, 'This is me', as promoted by the Alzheimer's Society. The profile included a brief history for each person and details about their cultural and religious preferences, likes and dislikes and named the people who were important to them. For one person who had specified a religious belief, there was guidance for staff about the important aspects and artefacts relating to the religion. Staff told us they had training in equality and inclusion so they understood the importance of supporting people's diverse needs. A member of care staff told us, "It is about the people's values. They have always got a story to tell."

People told us staff listened to them and supported them as much as they wanted. During our inspection we heard staff checked that the person wanted to be supported before each interaction. Records showed that people were asked for their views about how they were cared for when they reviewed their care plans. Relatives were encouraged to share their memories of their relation with the creation of 'memory boxes'. The memory boxes gave people a real memento of their lives and enabled staff to understand what was important to people.

Most people were not able to tell us whether they were involved in planning their care, but records showed that people's relatives were involved. A relative told us they had chosen the home for their relation and had been invited to explain their relation's preferences. In two of the care plans we looked at, we saw relatives had been involved in the discussions about care. There was a poster in the hallway with information about the local advocacy service, which showed the manager understood the importance of people having an independent representative.

A relative told us they visited whenever they wanted to and felt welcome. One relative told us, "I could sit in the conservatory to visit if I wanted to be in a quieter space." We saw visitors were encouraged to feel at home, and made cups of tea for their relation and themselves. Staff treated people with dignity and respect and recognised the value of people as individuals. Care staff told us, "It's important to think of their feelings. It's where people live and where we work" and "I'm in their space. I don't want to intrude."

Good

Is the service responsive?

Our findings

People told us they were happy at the home and that staff supported them to live their lives in the way they preferred. One person told us they liked their room and could go to bed when they wanted. They told us, "Not a lot" could be done to improve their life as they were happy with the life they led.

People's care plans were detailed and explained their needs and abilities, with guidance for staff to ensure people were encouraged to be as independent as possible. Care plans included information about people's history, preferences, interests and preferred pastimes. We saw people were supported to maintain their individual interests, such as painting and craftwork.

The provider had implemented a programme of fitness and wellbeing events, with dedicated recreational staff, so that people who did not want to pursue an individual hobby were offered alternative pastimes. The programme 'Our Organisation Makes People Happy', (Oomph), offered five hours of interactive events every day. The deputy director of operations explained the purpose of the programme was to, "Play, make their day, be there and choose your attitude." During our inspection, we saw a group of people taking part in a patchwork quilt making session and other people playing cards and dominoes with staff. In another communal lounge we saw people taking part in a knitting and music session. The music was from the 1950s and people were singing along, shaking pompoms and enjoying the party. We saw the impact of the programme was to create a community within the home for people who were not able to maintain links with their previous communities.

A relative told us, "I haven't seen [Name] engaged in activities, but she would join in if she wanted to. There are always magazines and the radio is on, or the TV with subtitles" and "There is an activities plan in [Name's] room." The deputy director of operations told us that activity planners showed the one-to-one activities people did with staff if they did not want to join in group events.

People were protected from the risk of social isolation because the provider adopted innovative solutions to enable people to engage in their hobbies and maintain relationships with their families. The provider had introduced a computer and software programme that was tailored for each person to use independently, or with support from staff or relatives, according to their abilities. They told us this was part of their 'living well with dementia' programme. The computer included an interactive touch screen and 'My life' software, which was set according to each individual's personal profile of preferences and skill level. The programme knew each person's interests, hobbies, favourite film stars and made suggestions for films to watch or games to play, based on their preferences, and enabled people to video teleconference with their friends and family.

People were encouraged to complain in order to improve their experience of care, and were given the chief executive's telephone number as a 'hotline' for complaints. A relative told us they were given a brochure, which included the complaints policy and procedure, when their relation moved in. The provider told us there had been four complaints in the previous 12 months and they were all resolved within 28 days, resulting in improvement action plans. A member of care staff told us, "There is a complaints procedure. We used to get complaints about the laundry, but now we have a new tagging system and a seven day laundry service. Now there are no complaints about the laundry." This demonstrated how the provider responded positively to complaints and used them to improve the quality of the service.

Outstanding ☆

Is the service well-led?

Our findings

People told us they were happy with the quality of the service and they were able to make their opinions about the service known. A relative told us they were confident that any suggestions they made about improving how their relation was cared for, would be welcome and acted on.

The provider encouraged people, their relatives and other health professionals to share their opinion about the quality of the service, through questionnaires, household meetings and freepost comment cards. Records showed the provider shared their analysis of the feedback across all the homes in the group, so all staff could understand what others thought of the quality of the service and consider how they could improve. A member of care staff told us, "We have floor meetings and can put ideas forward."

The provider's system for obtaining feedback from people who were unable to communicate verbally, was to observe and map people's state of 'wellbeing', using a tool promoted by specialists in dementia care. Registered managers from other homes in the group conducted regular mapping observations and made recommendations for improvements. Following the most recent wellbeing mapping, the registered manager had agreed an action plan. This included coaching care staff to the Alzheimer's standards of care, such as 'staff to have an upbeat mood and cheerful presence'.

The provider engaged with external agencies, such as Age Concern, to conduct expert-by-experience observations to understand how people who could not communicate verbally might perceive the quality of care. Records showed that the provider had taken action to implement the expert's recommendations, which included increasing the hours for the fitness and wellbeing (Oomph) staff and reviewing and refurbishing the environment to be more dementia friendly.

The provider had responded to the quality of care recommendations by implementing 'values' training for all staff, which the chief executive planned to deliver personally, because it matched the organisation's values and philosophy of leadership. The deputy director of operations told us all staff signed a code of conduct which included, "Park the personal, choose your attitude and it's ok to laugh, it makes people's day." The provider showed their appreciation of staff signing up to the values and code of conduct by introducing a staff benefits scheme with discounts at national retail and leisure outlets.

Care staff told us, "I am very happy here. I like working here because the people and the staff are great" and "It's really good here, it's teamwork." The provider had introduced a requirement for registered mangers to regularly work alongside care staff, kitchen and housekeeping staff, so they could gain an in-depth understanding and appreciation of all staff's contribution to the service, to set realistic improvement actions where required. Care staff told us the seniors and management team were supportive and good role models. One member of care staff told us, "I have clear responsibilities, role and accountabilities and a mentor."

Care staff told us they felt well informed because the four-weekly household meetings and shift handover management system were thorough. Records showed staff updated a risk management log at the end of each shift, which enabled the registered manager to assess risks per individual, including risks to their nutrition, mobility, physical and mental health.

The handover management system ensured the registered manager monitored that senior staff had checked food and fluid charts were up to date, that medicines were administered safely and all household safety checks were completed satisfactorily. Records showed staff names, responsibilities and breaks and the duty and on call managers. The deputy director of operations told us, "We always know who worked on which household per day. We know whether people ate well, drank well and any concerns. There is no guessing, we know it's accurate. Information is checked and matches care plans, daily records and monthly reviews."

A member of care staff showed us how the daily records were summarised monthly, which informed the monthly review of care plans. They told us, "I evaluate the daily records, anything unusual or re-occurring, and highlight it and carry it over to the summary and unit meeting." Household meeting records included information about each person by name, per care plan section and their dependency scores, notes, medicines, falls and visits by other health professionals. A member of care staff told us, "If you are off for a couple of days, you can find out about GP visits or falls. You can check the care diaries too."

Outstanding ☆

Is the service well-led?

The registered manager kept us informed of important events that happened at the home, in accordance with the legal obligations. Records showed the registered manager analysed accidents, incidents and falls. The analysis included an investigation by name, the location, time, date and an accident prevention summary. Records showed staff were reminded about the actions they should take to minimise the risks of a re-occurrence, for example, to ensure walking frames were named and close to people's chairs.

The provider's workforce development plan included classroom training, working in partnership with the local commissioners and registration with the Age Care Chanel. The learning initiatives enabled staff to sign a dementia pledge, to engage with the local authority's 'Care fit for VIPs' standards, to attend evening courses in dementia care with relatives and to access 50 on-line training films at work and at home. A member of the board of directors told us, "The Alzheimer's society offer seven courses in dementia and a learning plan. Two thirds of staff signed up in the first two weeks."

The member of the board told us the board received monthly performance reports and a quality sub group of the board inspected the home every year. They told us, "We have done the laundry and the food and this year it is the activities. We need to see and understand for ourselves. We started on Oomph and I will check how it is received. We look to those who don't socialise and find out what they would like instead." The board member told us they had received training on the fundamental standards and could access the same training as the staff, which enabled them to understand and measure the impact of staff training. They told us, "I see good interaction between managers and staff and the people have confidence."

In the provider information return (PIR), the provider had told us about their plans for improving the quality of the service. At the time of our inspection, we found that that actions had already been taken to implement the plans. The provider had measured the impact of staff's training and of the recent innovations and had already seen improvements in the quality of care. They told us one impact of the Oomph programme had been a reduction in falls and the introduction of medicines being administered in a biodose had reduced errors. The remote health care advice, which enabled people to speak with healthcare professionals promptly and confidentially, had minimised any anxieties about their health and had resulted in a decline in the number of visits to accident and emergency.