Laudcare Limited

Stanshawes Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was unannounced. Stanshawes Care Home provides residential and nursing care for up to 45 older people. At the time of our inspection there were 39 people in residence. The service is registered for up to 48 people but shared rooms were being used by just one person. The building was two storey with a passenger lift and stairways to the top floor. None of the bedrooms had en-suite facilities.

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 and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were safe. The registered manager and staff team were all knowledgeable about safeguarding issues and protected people from harm. Where concerns had been raised previously, the registered manager worked with the local authority safeguarding team and made changes where these were needed. The staff team knew how to raise and report concerns if they witnessed, suspected or were told about any bad practice or abuse. All staff had received training in safeguarding adults. Medicines were administered to people safely.

Any risks to people's health and welfare were assessed. The care plans included instructions on how to reduce or eliminate the chances of injury. All the appropriate checks to maintain the premises and facilities had been completed regularly. Where people needed to be assisted to move, their moving and handling needs were assessed and a moving and handling plan was written.

Staffing numbers on each shift were calculated to ensure each person's care and support needs could be met. Staff were provided with regular training and were supported by their colleagues and the registered manager to do their jobs.

The registered manager and the staff team were aware of the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were asked to give consent to care, support and treatment. Where people lacked the capacity to do this, staff worked within best interest decision making procedures.

People were satisfied with the quality of the food and drink provided. Food and fluid intake was monitored where risks of weight loss or dehydration had been identified. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

People were looked after by staff who knew of the importance of having good relationships. Staff spoke well about the people they were looking after. Feedback from relatives was consistently positive and the staff team were described as caring and friendly. People's privacy and dignity was maintained. People were involved in making decisions about their care and support. Families were included where this had been agreed upon.

People received the care and support they needed and were encouraged to express their views and opinions about how they wanted to be looked after. When people's care and support needs changed their care plans were adjusted. People and their relatives were listened to if they were unhappy or had comments to make. Actions were taken where appropriate in order to improve the service.

The registered manager provided good leadership and management for the staff team and there was an open culture in the home. Feedback from people who lived in the home, relatives, the staff team and health and social care professionals, was seen as important and used to make positive changes. There was a real commitment to keeping people at the heart of everything they did. There was a programme of quality checks in place to ensure the standard of service provision and care remained good. Where improvements were identified, actions were taken and checks made to ensure the improvements had been implemented.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they were safe. Staff were aware of their responsibilities to safeguard people and to report any concerns they had.

The service followed safe recruitment procedures to ensure only suitable staff were employed. The number of staff on duty ensured people's care and support needs could be met.

Any risks to people's health and welfare were assessed and then well managed. All appropriate checks were completed to ensure the premises and facilities were safe. Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were trained and well supported. They had the necessary knowledge and skills.

People's rights were properly recognised, respected and promoted. Staff sought consent from people before helping them and where people lacked capacity, they followed best interest processes. The service was meeting the requirements of the Deprivation of Liberty Safeguards.

People were provided with sufficient food and drink and supported to eat and drink where needed. People were supported to access the healthcare services they needed.

Is the service caring?

Good

The service was caring.

People were looked after in the way that they wanted and the staff took account of their personal choices and preferences. People were involved in making decisions about their care and support.

People were treated with dignity, kindness and respect. The staff team provided the support they needed but encouraged people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received the care and support they needed. Staff responded to changes in their needs and adjusted their plan of care.

A programme of activities for people to participate in was in place and links had been established with local schools and other local facilities.

People were listened to and any comments they had were acted upon.

Is the service well-led?

Good

The service was well-led.

There was an open culture within the service where the views and opinions of people living in the service, relatives and the staff team were seen as important.

The registered manager provided good leadership and management of the staff team. Regular audits and checks were carried out to monitor the quality and safety of the service.

Stanshawes Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

When we inspected the service in January 2014 we found there were two breaches of legal requirements. These were in respect of infection control and prevention procedures and the assessment and monitoring of the quality and safety of the service. The provider wrote to us and told us what action they had taken to address these breaches and when they expected to have made the improvements by.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who had experience of using this type of service. Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications the provider had sent to the CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We looked at the action plan the provider had sent us following the last inspection. In this they told what improvements they planned to make to rectify the breaches.

We contacted health and social care professionals who were involved in the care of people who lived at Stanshawes. We asked them to tell us about their views and experience of the service. We have included their comments in the main body of the report.

During the inspection we spoke with 13 people who lived in the service, nine relatives and 12 staff members (including the registered manager and regional manager). We looked at six care records, five staff recruitment files, training records, staff duty rotas and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People said, "I feel safe here", "I have my call bell and I can always call for help. The girls always place it on my table before they leave the room" , "I definitely feel I am safe" and "I have a mat on the floor and when I step out of bed it alerts the staff. They come and check I am managing ok on my own". Relatives we spoke with said, "I really feel my relative is safe", "Everyone is very kind and caring. My husband seems very content and he would not be if there was anything wrong" and "My mother is very well looked after. She would tell us if she wasn't being well looked after".

Staff received safeguarding training as part of the mandatory training programme that had to be completed. Training records evidenced that all staff were up to date with their safeguarding training. Staff had a good awareness of safeguarding issues and would report any concerns they had about people's safety to the registered manager or the nurse in charge. They referred to the provider's whistleblowing policy (policy on raising confidential concerns). Staff knew what constituted abuse and how they might recognise if a person was being harmed. Whilst some staff knew they could report safeguarding concerns directly to the South Gloucestershire Council safeguarding team, the Police or the Care Quality Commission, others had to be prompted. The providers safeguarding policy was kept under regular review and next due in January 2017.

The registered manager had previously completed safeguarding adults training with the local authority and had a good understanding of safeguarding issues. There had been one safeguarding alert and investigation completed in the last 12 months. The issues were raised during a health care funding review meeting. The outcome of this was that measures were put in place to remove the risks and the registered manager worked well with the investigation to make improvements.

Staff files were checked to ensure safe recruitment procedures were followed. Each of the files we looked showed that appropriate pre-employment checks had been completed. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. For nurses, their registration with the Nursing and Midwifery Council was checked. Where required, checks were made of a prospective employees right to work, before any offer of employment was made. These measures meant people using the service were not looked after by unsuitable staff.

As part of the care planning process risks assessments were completed for each person. Standard ones were completed for all in the respect of the risks of malnutrition and the likelihood of developing pressure ulcers, the likelihood of falls, continence, the use of bed rails and moving and handling tasks. Room profiles (moving and handling plans) were written for people who needed help to move or transfer. These listed the specific equipment required and the number of care staff to undertake any task. Other risk assessments and plans were person-specific, for example where there was a risks of choking. We asked about the individual emergency evacuation plans for each person. Whilst the service had prepared a list detailing each person, their room number and general information about their mobility, the list lacked detail. The list was kept in the grab bag by the fire panel (PEEP's) and was updated at least weekly. The service gave us their reassurance they would look at reviewing the information to include the support the person would require

in the event of the building needing to be evacuated.

Checks of the premises, facilities and equipment were undertaken regularly. There was a programme of weekly, monthly, quarterly and six monthly checks. These included checks of the hot and cold water supply, the fire safety equipment, electrical equipment, nurse call bell system and moving and handling equipment. The records were shared with us and showed they had all been completed as scheduled. The registered manager maintained an oversight that these checks had been completed. This ensured that the premises and all equipment remained in good working order.

The service used a 'care homes equation for safe staffing' tool to calculate the number of staff required to be on duty at any given time. Each month the dependency score of each person was reviewed and rated as high, medium or low needs. Shifts were covered with a mix of trained nurses and care staff. There were also housekeeping staff, a maintenance person, activities staff and an administrator to meet people's daily living needs. There were two trained nurses on duty during the day and one overnight. Staff felt the number of staff on duty each shift were sufficient, but there had been occasions when they were maybe one staff member short. This was usually due to last minute sickness where cover could not be arranged. In the last year there had been 15 members of staff leave the service, about a quarter of the total number of staff. During the same time period, 27 new staff had started. There were currently a couple of staff vacancies including that of deputy manager. The service would only use agency staff as a last resort. Any vacant shifts were covered by in-house staff taking extra shifts, or bank staff. People were therefore looked after by staff who were familiar with their needs and preferences.

People were able to remain responsible for their own medicines if they had been assessed as able to manage safely and their GP agreed. At the time of our inspection each person was assisted by the nurses with their medicines. Medicines were re-ordered on a four weekly basis to ensure they were always available and there robust procedures in place for checking in new supplies. Each person had a printed medicines administration record (MAR). Where handwritten entries had been made on the MAR, these were countersigned by a second member of staff. Discontinued medicines were clearly marked through, signed and dated. Where people were prescribed creams or ointments, a topical medicines record chart was kept in their bedroom and the treatment was applied by the care staff. Appropriate records had been kept.

All medicines were stored safely in a locked room. A medicines refrigerator was available for those medicines that required cold storage and appropriate arrangements were in place for storing controlled drugs. Room and fridge temperatures were checked each day. There was a weekly audit of the controlled drugs. There were plans in place to provide a second treatment room/medicine storage area for the downstairs area as part of the refurbishment plans for the service.

Good

Is the service effective?

Our findings

People and relatives said the service was effective. Comments we received included, "We are impressed with the home. Dad gets the exact help he needs", "The staff are superb and I could not be better looked after", "The nurses are so kind and know what I like" and "Absolutely brilliant".

Staff received the training and support they needed to ensure they did their jobs effectively. Each staff member had a regular one-to-one supervision meeting with a senior member of staff. In addition group supervision meetings took place. We saw examples of 'instant supervision' recordings where the registered manager had addressed issues of work performance that did not meet expectations. Staff received an annual appraisal and during these any training and development needs were discussed and planned.

All staff had a programme of mandatory training to complete. This included fire safety, moving and handling, food safety, safeguarding adults and children, equality and diversity and infection control. A computer based training system was used to deliver this training. At the time of our inspection the service had an overall 97% compliance with their training programme. The training matrix showed 89% of the staff were up to date with their deprivation of liberty whilst medicines, fire safety, moving and handling and pressure ulcer prevention were between 96 and 100%. In addition to the mandatory training, there had been sessions on dementia awareness and the Mental Capacity Act 2005.

New staff had an induction training programme to complete at the start of their employment. They initially worked with an experienced member of staff and were supported by a 'care coach' to settle in to their role and complete the programme. The induction programme was in line with the Care Certificate and had to be completed within a 12 week period. The Care Certificate was introduced for all health and social care providers in April 2015 and ensured care staff were prepared for their day to day role.

Nurses completed additional training and this included syringe driver training, tissue viability, first aid at work and dementia awareness. The nurses were also being supported to meet the conditions of registration with the Nursing & Midwifery Council and the re-validation process. Care staff were expected to complete qualifications in health and social care (diploma) at least at level two. Senior care staff were expected to have or be working towards a level three diploma. This meant the staff team had the relevant skills to meet people's needs. The registered manager told us how they had placed information about one person's medical condition in their care file so the care staff could have greater understanding of how to look. This was because care staff had requested additional information to have a better understanding of the person's needs.

Staff completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. The registered manager told us a training session had been arranged and was led by the DoLS assessor from South Gloucestershire Council. Staff knew what to do if a person lacked mental capacity and how best interest decisions should be recorded.

During the inspection we heard people being asked to give consent and to make decisions about things that

affected their daily lives. Examples of this included, where they sat, whether they wanted to be assisted back to their bedroom and want they wanted to eat. An assessment of each person's mental capacity assessments was made in respect of all aspects of care and daily living. The assessments were reviewed when there were changes in the person's needs. Where people lacked the capacity to make decisions best interest decisions were recorded having been made with other key people (family members, GP or other health care professionals).

The registered manager was knowledgeable about the MCA and DoLS. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. This legislation sets out an assessment process that must be undertaken before a deprivation of liberty can be granted. At the time of this inspection, two DoLS authorisations were in place and due to be reviewed in April 2017. A further 12 DoLS applications had also been submitted to the local authority but these had not yet been processed. The registered manager was aware CQC needed to be notified when the outcome of the applications were known.

Each person's nutritional needs were assessed and monitored on a monthly basis. The chef and kitchen staff were informed when people were losing weight and fortified foods were provided. People's body weights were checked on a monthly basis, increased to weekly where this was necessary. Where people had specific needs, for example the risk of choking or poor teeth, their eating and drinking care plan detailed the care and support they needed. Food and fluid records were kept where a person's eating and drinking needed to be monitored.

The chef and kitchen staff were informed of people's specific dietary requirements. Specific dietary information, preferences and allergies were all written on the white board in the kitchen and updated as often as necessary. There was a rolling four weekly menu plan in place but this was in the process of being reviewed. Two hot meal options were served at lunch time each day however there were also a number of other options. The chef met with all new people to the service about the food they liked to eat.

All festivals were celebrated and people had recently been able to join the Christmas party. A full Christmas meal would also be served on Christmas Day and people's spouses were invited to join their loved one. Birthdays were celebrated with their own special birthday cake and served along with afternoon tea.

People made positive comments about the meals and said they had choice of what to eat. We received negative comments from the family of one person whose needs were to have a pureed diet. They were unhappy that on some days the presentation of the meal was not up to the standard of other days. We mentioned this to the chef who agreed they would address this with the specific member of staff.

We spent a period of time watching what was happening during the meal time in the ground floor dining room. People were asked what they wanted to eat and were served with their choice of food. The staff were on the whole attentive and provided assistance as required. However, we did note there was some care staff to care staff 'personal' conversations being carried on. Those who needed assistance with their meals were provided with help in a sensitive manner. The member of staff sat next to them and conversed with them throughout the meal. We noted that other people were chatting away with their dining companions and staff interacted with them as necessary. People were asked if they had enough to eat and if their meals were alright. Some people had their meals cut up and drinks were provided in a variety of different glasses, tumblers and mugs.

Each person was registered with a GP practice with the majority being with the one practice. The allocated

GP from this practice visited on a weekly basis and saw those people the nurses had identified as needing a GP visit. Nurses also requested home visits whenever people were unwell or when people had asked to see their doctor. Feedback we received from the GP practice was, "The staff know the patients well", "I have no concerns regarding the way in which people are cared for" and "The standard of care is good and any instructions I leave are followed".

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The home worked alongside community and hospital social workers, occupational therapists and physiotherapists in order to make sure people were well looked after. During the inspection the service received visits from one GP, an occupational therapist and the tissue viability nurse. They told us, "We are always called in appropriately", "The nurses are very pro-active and identify promptly when additional treatment options are needed" and "When I visit to see my patients, the nurses have everything planned so I know who needs to be seen". One person told us, "I get to see my GP whenever I need to". One relative commented that the staff "did a very good job of chasing up a dental appointment recently".

Good

Is the service caring?

Our findings

We asked people if they were happy with the care they received. They said "Everybody is so friendly here", "They treat me very well" and "You can talk to the carers and the staff, that makes me feel good". Relatives and other visitors said, "Always very kind here and a good atmosphere", "Staff always help with my relative" and "You cannot fault any of the staff" and "This home is really lovely, people seem to be much better cared for than other homes we go to".

The registered manager kept a 'compliments' folder and said they always ensured that feedback was shared with the staff team. Comments we took from a sample of the cards included, "Thank you for all your kind care for X and support for us (the family)", "Very expert care" and "Thank you for the care and attention the staff showed to Y". One relative had thanked the staff for the kind care despite, "Z being difficult at times and not very nice, due to their frustration". Thank you cards and letters were also displayed on noticeboards throughout the home.

Staff spoke about people in a kind and respectful manner and told us about the different ways people liked to be looked after. People received care and support that took account of their life history, likes, preferences, needs, hopes and goals. The relationships between staff and people receiving support consistently demonstrated dignity and respect at all times. Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. The registered manager told us one person who did not like to wear a lot of clothes had been provided with a moveable screen across their doorway to respect their dignity. Staff addressed people in an appropriate manner, generally by their first name. Each person's preference was discussed during assessment and recorded in their care plan. All staff completed a training module in equality and diversity to ensure they provided support that took account of individual's specific wishes.

We observed numerous examples of positive and meaningful interactions between people and the staff members looking after them. People appeared happy and contented. We heard staff having conversations about getting ready for Christmas, how the person was feeling, and asking about family members. One person said they were worried about their husband and the staff member agreed to telephone them, in order to put the person's mind at rest. We observed people being assisted with their meals, activities and moving from one place to another. The staff had a kind and caring approach. We heard staff sharing humour with one person – they told us this was a daily occurrence and the person "perked up" during the banter.

We observed staff knocking on bedroom doors before entering the room. This demonstrated the person's right to privacy was respected. People were able to have a key to their bedroom door if they wanted to affording them further privacy and security. Lockable storage was available in the bedrooms enabled them to keep their personal possessions safe.

From our conversations and observations it was evident staff had built up trusting relationships with the people they were looking after. This was apparent in the relaxed and confident manner people interacted

with the care staff. We also noted that visitors to the home, whether they were relatives, health or social care professionals or visitors from the church, were welcomed in to the home.

The service has a system in place where each day there was a 'Resident of The Day'. On this day the person was visited by the chef and asked for feedback about the meals provided and any changes they would like to see. Their bedroom was given a more thorough clean and nursing and care staff reviewed their care plan and risk assessments with them. This enabled people to express their views and make decisions about their care, support and treatment.

People were supported to make advance end of life care decisions and to have a say about their care support and treatment. Decisions to not be resuscitated in the event of a sudden deterioration in their health were made in consultation with them (where possible), their relatives, the GP and the nurses. We suggest the registered manager review the relevant documentation in people's care files to make sure, where the form was completed during a hospital stay, it is signed and agreed by the GP. Relatives we spoke with whose loved was at the end of their life said, "We cannot fault the standard of care Mum is receiving. The staff are so kind and supportive of us and we have been told we can visit at any time".

Good

Is the service responsive?

Our findings

We asked people if they felt the service was responsive to their specific care and support needs. They said, "I like living here. I wish I hadn't resisted going in to a home for so long. I am so well looked after", "I get everything I want and need", "If there was something I was not happy with I would know who to speak to" and "The staff help me whenever I need support". Relatives made positive comments about the way their loved ones were looked after. They said, "I cannot fault a thing. Mum is so happy" and "I believe the staff do genuinely care for everybody".

People's care needs were assessed prior to being admitted to the home to make sure Stanshawes Care Home was an appropriate place for them. During this process the assessor would determine that the staff had the required skills and experience to look after the person and any specific nursing equipment was available. The assessment was used as the basis for the person's personalised care plan for each person.

The assessments covered all aspects of a person's daily living needs and included details about people's likes and dislikes and what was important to them. The plans provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, managing continence and wound care management where required. In those plans we looked at we found there was a detailed account of the person's needs with clear instructions on how those needs were to be met. We saw good examples of person specific care planning. For one person who was hearing impaired, there were specific instructions about the television. We checked to see that the instructions had been followed and they had. In another person's plan there were specific instructions on how to care for health-related appliances.

Care reviews were held at regularly intervals involving the person, relatives where relevant and other professionals. Generally this was on a monthly basis however could be undertaken sooner if a person's needs changed significantly. Where people's needs had changed the service had made appropriate referrals to other health and social care professionals for advice and support. Two health care professionals told us they had been contacted by the staff because of changes in people's needs, in order to tap in to their expertise The person was encouraged to express their views and have a say about how they were looked after during these reviews. These measures ensured the support provided continued to be in line with the person's specific needs.

At the time of the inspection there was one full time activity person in post. The service was in the process of recruiting an additional member of staff. The activity organiser told us they had attended an activities workshop and had looked at the importance of maintaining relationships with the community and life-story work. The weekly activity programme consisted of movies and music sessions, bingo and baking, the BBC Sunday church service and visits by the hairdresser. The 'good news team' visited the home every five weeks and either chatted with people and if the person wanted, prayed with them. A non-denominational church service was also held on a five weekly basis. One person told us, "I am a very quiet person, I do not want to take part in the activities but I am always told what is happening, in case I change my mind". Another lady told us they had their nails painted and added, "I have never in my life worn nail varnish and I like it. My hands look really nice". We were told there was a minimal budget allocated by the provider for the

organisation of activities and many of the activities only happened because of the goodwill of the staff team.

The activity organiser told us for the last four years children had visited from the local school and had sung to people. Trips out from the home were seen as important in order to keep people part of the local community. The home did not have it's own minibus but used the local community transport service. There had been a recent outings to a garden centre and shopping trips.

People and relatives we spoke with said if they had any concerns or complaints they would feel comfortable about raising these with either the registered manager or one of the nurses. People were also encouraged to express their views and make comments about things during their care plan reviews, when they were 'resident of the day' and during resident and relative meetings. These meetings were held on a three monthly basis and we looked at the minutes of the last two meetings. We saw there was feedback regarding food and ideas for future activities. The registered manager or nurse in charge of the shift, did a walk-about of the home each day. They used a tablet computer to record their findings, spoke with people and staff and recorded comments made.

Good

Is the service well-led?

Our findings

People and relatives did not make any direct comments about the management and leadership of the service but said, "I always see the manager about when I visit", "I think this is a well managed home. I would recommend to others" and "This was just one of the homes I visited when I was looking for a place for mum. We were very impressed with Stanshawes and have not been disappointed".

The registered manager has worked at Stanshawes Care Home since 2013 and been registered with CQC since 2013. The registered manager was working towards achieving a level five leadership and management qualification. There had been up until recently a deputy manager in post but they had left. The provider was in the process of looking to recruit a new part-time deputy.

The registered manager provided good management and leadership for the staff team and was well respected by the staff team. There was an open culture within the home with a commitment from all staff to make people's lives as good as possible. The registered manager said the staff team "know what I expect of them" and when we asked staff about this they agreed with the statement. The manager's office was located centrally short distance from the main entrance area and on the whole their door remained open at all times. This meant they had a good understanding of the day to day activities. Each day they were at work they walked the floor, spoke to people and staff on duty and checked the premises were safe. The registered manager was supported by other nearby home managers, a regional manager and the staff team, in providing a well managed service.

A 'flash' meeting was held each morning and attended by the registered manager, nurses, the activity organiser, maintenance, the chef and housekeeping staff. This meeting was used to update staff on any changes in people needs, organise which people needed to see the GP and identify which person was 'resident of the day'. In addition, daily handovers were taking place between shift changes. A handover is where important information is shared between the staff during shift changeovers. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach.

Staff meetings were held on a regular basis. These may be for the whole staff team, night staff or the housekeeping and catering staff. Clinical governance meetings were scheduled every two-three months. The December 2016 meeting had discussed person-centred care and dignity in care homes and in September the agenda had been in respect of infection control and personal hygiene. Examples of other topics discussed include nutrition, managing falls and risk assessment.

The registered manager submitted a weekly update to the regional manager and reported on any accidents and incidents, safeguarding events, health and safety issues, complaints, staffing issues and issues regarding people's care. The registered manager attended regular meetings with other home managers and the regional manager. These measures ensured the provider was aware of how the service was being run and enabled the sharing of good practice and solutions to any events that had occurred.

The home had a programme of audits and quality checks they were expected to complete. A food safety and kitchen audit had been completed in November 2016 and a number of areas for improvement had been identified. The registered manager told us what action had been taken to remedy those shortfalls. A quality dining audit had looked at the dining experience for people, food presentation and quality, refreshments and the hospitality service. One comment made as a result of this audit was in respect of there being no facilities for visitors to make their own hot drinks. Arrangements were already underway for a hot drinks machine to be installed in the ground floor lounge/dining room. Examples of other audits completed were health and safety, the management of medicines, nutrition and care documentation. Full quality audits were completed on a six monthly basis but revisited by the regional manager on at least a monthly basis to check on progress.

The registered manager was aware of when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. The CQC used information sent to us via the notification process to monitor the service and to check how any events had been handled.

All accidents and incidents were entered on to an electronic record system. At the end of each month the home manager follows up on each report and can analyse the number of falls or the number of events for a particular person. All accidents and incidents would be analysed to identify triggers or trends so that preventative action could be taken.

A copy of the complaints procedure was displayed in the entrance area and stated that all formal complaints would be acknowledged, investigated and responded to. Information was also given to people about the complaints procedure in the home's brochure. The service had a management of feedback policy and this covered complaints, concerns and compliments received. This stated the provider was committed to dealing with any issues that arise quickly and effectively as possible. In the last 12 months Stanshawes Care Home had received two formal complaints. The records kept showed these had been dealt with in accordance with the complaints procedure. Each of the complaints were about different issues but actions had been taken to prevent a reoccurrence of the issue. The registered manager said they used information from complaints to review their practice. All complaints were recorded electronically which meant head office were also able to monitor they were handled correctly.

The registered manager told us they had used an independent agency to complete a survey in September 2016. This was to capture the views of people who lived in Stanshawes Care Home, relatives, the staff team and health and social care professionals involved with the service. However no results were available as yet. One relative we spoke with told us they had completed a survey form "a while back". They also referred to the tablet computer which was located by the main entrance and knew they could provide feedback at any time. The registered manager told us that all feedback, however it was delivered, was used to reflect on what they were doing and look at ways to do things better.