The Old Rectory Limited

The Old Rectory Nursing 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

We carried out an unannounced comprehensive inspection of The Old Rectory Nursing Home on 16th January 2017.

The Old Rectory Nursing Home is registered to provide accommodation with personal and nursing care for up to 31 people who live with dementia. The home is set within its own grounds with car parking facilities.

A registered manager was in place and was present during our visit. 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.

At the last inspection in April 2016, we asked the registered provider to display the ratings from the previous CQC inspection as failure to do this was a breach of regulation 20A. This visit found that this had been addressed with ratings now prominently displayed.

Prior to this inspection we received a concern about poor communication with relatives in relation to the changing needs of people and the availability of an access to records policy and procedure. We looked at those concerns as part of this inspection. We found evidence that relatives were contacted when events or issues occurred which affected their relations and this was confirmed by relatives we spoke with. We found that while an access to records policy was available; this needed to be reviewed as did other policies and procedures.

Relatives told us that they felt that their relations were safe living at the Old Rectory. Observations of care found that people were comfortable and relaxed with the staff team.

Staff demonstrated a good understanding of the types of abuse that could occur and the action that they needed to take in the event of harm occurring or suspected harm. Staff were aware of the whistleblowing process and of external agencies they could refer concerns onto. Staff also understood the principles of the Mental Capacity Act 2005. The best interests of people who did not have the capacity to make decisions were evidenced.
The premises were clean and hygienic with no hazards present which could present a risk to people who

used the service. Personal emergency evacuation plans (PEEPs) were available for each person in the event of them having to be evacuated in an emergency.

Risk assessments outlined the specific risks people faced in their daily lives. This enabled people to receive safe care and treatment.

Medicines were safely managed. All medication was safely secured and could be accounted for. The registered manager had processes in place to ensure that medication was administered safely.

There were sufficient staff on duty during our visit to keep people safe. Staffing rotas confirmed that these levels were maintained and this was confirmed by people who we spoke with. Recruitment records included all the necessary checks to ensure that people who used the service were supported by staff who were suitable to care for vulnerable adults.

Staff received training and supervision appropriate to their role. Staff also received annual appraisals which gave them the opportunity to discuss their practice and areas of future development.

The nutritional and hydration needs of people were taken into account with people being offered choice and support with eating and drinking. Risk assessments were in place to ensure that people were not at risk of malnutrition.

People who used the service were living with dementia. Whilst steps had been taken to orientate people within the building, we recommend that the registered provider refers to good practice guidance to ensure that the environment is fully dementia friendly.

People's privacy and dignity was promoted and they were supported in a discreet, friendly and respectful manner.

Care plans were available for all people. These were person centred and were reviewed regularly. They provided staff with the information they needed to meet the needs of people.

The registered provider employed an activities co-ordinator who sought to organise activities as well as work with people on a one to one basis. This enabled people who used the service to participate in activities which reflected their interests.

A complaints procedure was available. This meant that the registered provider adopted a transparent approach to the care provided. Relatives had not had to make a complaint about their relation's care.

The registered manager maintained a presence within the service and utilised part of their time in providing direct clinical support to people. This meant that the service could be managed to meet the needs of people who used the service.

Staff considered that the registered manager was approachable and supportive. The same view was held by relatives. The registered manager carried out audits on various aspects of the service to ensure standards of quality were being maintained and improved. Information was provided to people and their relations about the standards of care within the service and their views about the service were actively sought. Policies and procedures relating to the service were out of date and needed reviewing.

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.
Relatives told us that their relations were safe living at the Old Rectory.
The premises were clean and hygienic and presented no hazards to the people.
Safe recruitment procedures were followed.

Is the service effective?

Good

The service was effective.
People told us they had confidence in the knowledge and skills of the staff team.
The principles of the Mental Capacity Act were applied for people who lacked capacity to make their own decisions
The nutritional and hydration needs of people were met.

Is the service caring?

Good

The service was caring.
Staff were caring and promoted people's privacy and dignity.
People were treated in a respectful manner.
People were encouraged to personalise their personal living space.

Is the service responsive?

Good

The service was responsive.
The individual needs of people were planned for.
Activities were provided to people who used the service.
A complaints procedure was in place although no complaints had been received.

Is the service well-led?

Good

The service was well led.

People told us that they knew who the manager was and that they thought the service was well led.
The registered manager adopted an open and transparent approach.
The views of people were sought enabling comments to be made on the quality of the service provided.
The registered manager maintained audits which enabled an on-going commentary on the service to be gained.

The Old Rectory Nursing 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 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 16th January 2017 and was unannounced. The inspection team consisted of one adult social care inspector.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at five care plans and other records such as two staff recruitment files, training records, policies and procedures, quality assurance audits and complaints files.

We spoke with the Local Authority Commissioning Team. They had no concerns about the service. We checked to see if a Healthwatch visit had taken place. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. Healthwatch last visited in April 2016 and had no concerns.

We spoke with four visitors, three members of staff and the registered manager. We spoke with five people who used the service. The nature of their disability was such that it was not always possible to get direct views on the quality of their care. As a result, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We toured the premises to check that standards of hygiene and decoration were being maintained.

Good

Our findings

Relatives told us that they considered their relations to be safe living at the Old Rectory. They told us "I feel relieved that [relation] is safe living here and I have no concerns". Another relative told us "I visit every day and can leave knowing that [relation] is safe and being looked after.

The nature of the disability of people living at the Old Rectory was such that they were not always able to give an account of their experiences of the care they received. As a result we could only use observations to assess how safe they felt with the staff team. Throughout our visit, people appeared relaxed and comfortable with the support they received from the staff team. Staff were seen by people as a point of reference where they could get assistance. People who used the service were willing to allow staff to help them.

Risk assessments were carried out for each person. These considered risks people faced in relation to their nutrition, falls, skin integrity, manual handling and the environment. Appropriate plans were put in place to manage any identified risks and they were reviewed on a monthly basis.
Accidents were reported when they occurred and recorded appropriately in accident records and daily records. Any falls were audited on a monthly basis to ensure that any patterns or trends could be identified to prevent re-occurrence.

Staff on duty during our inspection included the registered manager, two nurses, care assistants, activities co-ordinator and other ancillary staff such as domestic staff, kitchen, laundry and maintenance staff. Staff rotas were available outlining similar levels of staff on other days. The registered manager told us that they now had the full complement of staff and that they no longer had need to use agency staff. This had contributed to continuity of support for people. Observations of care practice noted that when people required assistance, staff were always available to respond to them and that there were sufficient staff available to keep people safe. Relatives told us that there were always staff around to offer help throughout the day and night.

The premises were clean and hygienic throughout. The registered provider employed domestic staff who were present on the day of our inspection. Domestic staff were observed cleaning the main areas of the building. Personal protective equipment (PPE) was available throughout the building with sanitisers, soaps, aprons and gloves available in key areas such as toilets and bathrooms. PPE was also available in bedrooms for use when assisting people with their personal care.
Care staff used protective items when serving meals or supporting people with their personal care. Domestic

staff did the same when cleaning. There was a pleasant smell throughout the building. A list of tasks for domestic staff was available relating to specific cleaning schedules that required attention. These were recorded as completed when actioned. All cleaning materials were locked away when not in use. One person had spilled a drink in their room. Domestic staff quickly responded in ensuring that this was cleaned up as soon as possible.

The premises were safe from any hazards All sluice rooms were locked and the laundry and kitchen could only be accessed by a coded lock. These were in place as such areas may have presented hazards to people who used the service. People were supported to move either independently or with support through the building safely and in line with their own preferred activities.

A maintenance member of staff was employed by the registered provider. It was this person's role to ensure that any repairs or ongoing maintenance required to the premises was addressed. During our visit, the maintenance staff tested call alarms in people's bedrooms. Prior to carrying out the tests care staff were alerted to them taking place so they would not be distracted by these tests. Call alarms were accessible to people and were occasionally used during our visit. Best interest decisions had been made in respect of the availability of call alarms for all people. A process had reached a conclusion in line with a person's capacity as to whether they were able to use call alarms. Where it had been identified that a person was unable to use the call alarm, a sensor mat had been placed in their room. This alerted staff of the person's movements, for example if they had got out of bed. These were in place for people who were at risk of falls. These were checked regularly to make sure they worked effectively. During our visit, fire officers visited the service and conducted a check on fire detection systems.

We observed the administration of medication. A portable medicines trolley was used to store medication and this was taken round the building as the medication round progressed. The nurse administering medication wore a tabard indicating the task they were doing and that they were not to be disturbed. This meant that the nurse could concentrate on ensuring that people received the correct medication safely. When the nurse needed to enter people's bedrooms to administer medication, the trolley was locked. Medications were administered in a supportive and helpful manner with drinks being provided to enable people to safely swallow tablets.

When not in use the medication trolley was stored in a locked room. This room remained inaccessible to people so that their safety was maintained. The clinical room contained a refrigerator that was used the store medicines that required storing at a lower temperatures. The temperature of the refrigerator was checked throughout the day and recorded.

Medication administration records (MARS) for each person were appropriately signed once medicines had been taken. These records included a photograph of each person and a reference to any known allergies that they had. This meant that the people could be given the correct medication safely. Records included reference to the amount of medication that had been received by the pharmacy supplier. Records were also maintained relating to those medications that were no longer needed and had to be returned to the pharmacy supplier. Other records related to the use of topical creams. These are creams such as painkillers or creams used to maintain people's skin integrity. Records were maintained indicating when they had been applied as well as a body map outlining the exact place on people's bodies to best promote their health. Some people had been prescribed controlled medication. These are prescription medicines which are controlled under the Misuse of Drugs Act 1971.All controlled medication was separately stored and audited along with other medicines.

No one living at the Old Rectory managed their own medication. Two people required medication to be

administered covertly. This decision had been made as a best interest's decision as they lacked the capacity to understand the consequences of refusing medication. Guidelines were in place for nurses administering medication as to how these medicines could be covertly administered in a safe manner. General guidelines were available for nursing staff on how to manage medication generally with reference to their own professional accountability as registered nurses.

A safeguarding procedure from the local authority was available as well as the service's own process for reporting any concerns. In addition to this a whistleblowing procedure was available for staff to raise concerns about care practice within the service. Staff demonstrated a good understanding of the types of abuse that could occur as well as the system for reporting these to senior managers within the service and the local authority. Staff were very clear about how concerns about care practice could be reported to external agencies such as the Care Quality Commission or the Local Authority. Staff told us they had received safeguarding training and this was confirmed through training records.

Recruitment files included checks on the suitability of people to work with vulnerable people. These included references, health declaration form and disclosure and barring check (DBS). The DBS is designed to ensure that staff do not have criminal cautions or convictions that could impact on the role they had applied for. All DBS checks had been obtained before each member of staff came to work at the Old Rectory. Evidence of the identity of staff was available and interview notes with scoring on each question were available to better assist the registered provider in making recruitment decisions. One person who had recently been recruited told us that the recruitment process had been fair and thorough.

Good

Our findings

People's relatives told us "Staff are brilliant"; they are good at what they do". They told us that they were happy with the food provided, "I can come in everyday to help my relation with their lunch and the food is always well cooked".
People who lived at the Old Rectory were living with dementia. The registered provider had sought to provide signage for people to assist them to find key areas such as bathrooms and toilets. Individual bedroom doors had pictures and photographs of things of interests, past and present that related to the person to help them identify their bedroom. These included their past employment, sporting or leisure interests. While the registered provider had taken steps to better orientate people, we recommend that good practice guidance such as The Alzheimer's Society or Kings College be used to assess the effectiveness of the wider environment to meet people's needs. This is raised to ensure that people who used the service could fully orientate people in line with their communication needs.

Staff told us that they received training in mandatory health and safety subjects as well as training relating to specific needs of people such as dementia awareness. Further training had also been completed by registered nurses in relation to their clinical practice. A training matrix had been completed for 2016 and this carried on into 2017. There was evidence that the registered provider had sought to identify external training that would be relevant to the training needs of staff. Further training had been completed by staff in relation to safeguarding and the Mental Capacity Act. This meant that people who used the service were being supported by staff who were trained to meet their needs.

Supervision records were available as well as a plan for supervision sessions to be held during the forthcoming year. These included annual appraisals for staff. Other forms of supervision included meetings with nursing staff, care and ancillary staff. Staff confirmed that they received supervision every six weeks yet considered that the manager's approach was such that they could be approached if they were any urgent issues to be raised in between supervision sessions.

A structured induction process was in place. One member of staff had been recruited very recently and was able to confirm that the induction process had enabled them to settle into their role quickly. The induction process included a period of orientation around the building and shadowing care practice. Nursing staff underwent a period of being shadowed whilst administering administration and then being supervised in this task until they were competent to do this on their own. The induction process for care staff was linked to The Care Certificate. The Care Certificate is provided by the Skills for Care Organisation and is the start of the career journey for care staff and is only one element of the training and education that will make them ready

to practice. The induction process included mandatory training in health and safety topics and safeguarding vulnerable adults.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

All people who lived at the Old Rectory had had a deprivation of liberty order approved by the local authority. This was to reflect the fact that a coded lock system on the front door had been installed to ensure that people were not at risk of leaving the building unescorted and hence compromising their safety. In addition to this, the capacity of all people had been assessed. There were situations where people had been assessed as not having capacity and needed assistance in making decisions in respect of key areas of their lives such as medication and the use of bedrails. In these instances, there was evidence that a process had been undertaken in line with the MCA to ensure that decisions had been reached in people's best interest and these were available in people's care records. Staff had received MCA training and they gave us a good account of what this entailed and how the rights of people could be best supported.

Care plans outlined the nutritional needs of people and included an assessment of any risks people faced from malnutrition. These were reviewed each month and people's weight was being more frequently monitored in line with their individual assessment. Some people required diabetic diets and this was outlined in their care plan as well as in menu planning and records of food provided. Further information was outlined as to whether people needed meals to be cut up or softer diets presented.

Lunchtime was a relaxed occasion. Dining facilities were limited in the building with only nine people being able to use the main dining room at any one time. This did not appear to adversely impact on people who used the service. Other people either chose to have their meals in lounge areas or in their bedrooms. People were actively able to choose which area they had their meal and we observed this in practice. We did not observe people requiring direct assistance with eating although staff did ensure that people who required it had their food cut up or received a soft meal.

Menus were available and on display within the dining room. Meals provided and alternatives available were also verbally passed onto people. The registered provider employed a cook and kitchen staff. The cook was knowledgeable about the nutritional needs of people who used the service. The kitchen was a well-equipped facility. A care plan was in place which provided staff with guidance on how to support people with certain behaviours which caused them anxiety and stress and could present as negative behaviours to others. The plans directed staff on the use of diversion techniques and communication methods to help the person become less anxious and more settled. Communication profiles which were in place for people included key words used to express a particular emotion or feeling. This enabled staff to better meet the needs of people.

Good

Our findings

Prior to this inspection we received concerns about the level of communication between the staff and relatives in respect of any significant changing needs. We looked at those concerns as part of caring.

Relatives told us that they felt that the staff adopted a caring attitude to the people they supported. They told us "They [staff] are marvellous" and "They are very kind". Relatives told us that they were relieved that their relation was receiving such a "good quality of care". Another relative told us "I am here every day and they let me be involved, it is like one happy family" and "I can leave here knowing my relation is being looked after well". People added "They always tell me if there has been a change in my relation's health."

A concern received since our last visit related to communication provided to relations, in particular, when their relative received end of life care. No one at the time of our visit was receiving end of life care so it was not possible for us to assess this on this inspection. There was evidence in records that where communication between the service and relatives took place, this was recorded with details of the discussion held.

Staff spoke to people in a caring and dignified manner. Positive interactions were observed including staff sharing a joke with individuals and attending to individual requests in a friendly and helpful manner. Staff anticipated the needs of people, for example, one person's footwear had become loose and the person was in danger of tripping and falling. Staff discreetly assisted this person while they were sitting down to avoid any risk of falling. Staff were able to spend time with individuals chatting about subjects that were of interest to them. The opportunity for staff to sit with people on a one to one basis was observed throughout our visit.

Staff maintained the privacy and dignity of people. Staff knocked on bedroom doors at all times before being invited to enter. One person had entered a bedroom and the person in that room was not happy with their presence. Staff intervened in a respectful way to ensure that the person's privacy was maintained and their wishes respected.

People were encouraged to be as independent as possible in their daily lives. Many people were able to move through the building independently. Others relied on mobility aids and these were available to them at all times. People were able to maintain their independence through decision making and were given choice by the staff team. This included choice in assistance with meals, drinks and any activity people wished to do.

Information was given to people verbally. Staff would ensure that people were aware of anything that was relevant to them. This included what was available for lunch that day, making people aware that they would be receiving a visitor that day or activities on offer. Other pictorial information was available to people advising them, for example, of activities that would be taking place or meals to be provided. Staff spent time talking to people about events such as recent birthdays they had had or trips out with their families.

Staff interactions with people who used the service also included explanations of how people were to be supported once consent had been given. Staff explained to people how they would be supported and why this was to be done. People responded to this by seeking staff members out if they needed assistance with anything. Staff remained a point of reference for people who used the service.
People's rooms were personalised with items which were important to people such as photographs and pieces of furniture which people brought from their previous home. Signs and photographs were located on the door of each person's room. These displayed leisure activities relevant to them, pictures of people as they were when they were younger or past occupation. People had full access to their rooms when they wished. Some people preferred to stay in their own rooms and this decision was respected.

A confidentiality policy was in place and staff had signed this to acknowledge their understanding. Any requests made to staff from people which involved issues of a personal nature were responded to in a quiet and discreet manner.

Good

Our findings

Relatives told us that the staff responded quickly to the needs of their relations. They also confirmed that any changes to their relation's health were relayed to them. They were aware that a care plan was available yet were happy with the level of communication provided to them without the need to refer to care plans.

Prior to people living at the Old Rectory, an assessment information form and a care plan was obtained from the agency referring the individual to the service, such as Local Authorities or hospitals. This information was available in the care files we looked at. In addition to this, the registered provider completed their own initial pre-assessment form which summarised the main health and social needs of each person. This was then translated into an assessment form which went into more details about all aspects of needs that people had in their daily lives.
Care plans were developed on the basis of assessments carried out and covered identified needs and how they were to be met. These were person centred and reflected the specific needs of each person, for example, if there had been a change in their health needs or whether they were at risk of social isolation. Other people had the potential to display behaviour which put themselves and others at risk. In each situation, care plans offered an approach staff should take in order to assist in this and each approach was unique to the needs of each person.

Care plans were clearly written with evidence of review. This review took place monthly and identified if any changes to the needs of people had occurred. This enabled any changes in people's needs to be met. Daily records which were maintained for each person provided an account of the progress of individuals during each day as well as evidencing that care plans were followed. Daily records also provided evidence that significant others involved in people's support had been contacted to ensure that their needs were met. Further documentation provided evidence of checks made on individuals at night.

Care plans demonstrated that other social needs had been taken into account. Part of care plans focussed on social isolation and the risks faced by people that they could become socially isolated living at the Old Rectory. A balance was maintained between people preferring to enjoy their own company and them not becoming too withdrawn from activities provided.

People received the care and support they needed with their healthcare. Evaluations of care plans and daily records provided evidence that the health of people was monitored on a daily basis. Where other healthcare agencies such as doctors were needed to assist with these, clear records were available indicating which healthcare professional had been involved and the outcome of this intervention. One person's care plan had

been changed in relation to a health condition which they had recently been diagnosed with. There was evidence the persons care plan had been updated following diagnosis, For example it outlined the action staff needed to take to ensure the was kept comfortable and so that they received appropriate treatment. Evidence was available outlining that relatives had been informed of the condition and how it was to be treated. Evaluations of this care plan were put into place until such time as the condition passed and this person's health improved.

An activity co-coordinator was employed by the registered provider. Our last visit found that activities provided to people had improved. This improvement had involved providing information on activities, evidencing activities through the display of photographs of activities and the experiences of relatives. The provision of activities continued to meet the needs of people. A board was on display including photographs and artwork made by people living at the service. The board also provided forthcoming dates of interest for each month and how these were to be celebrated. The activities co-ordinator spent time with people during our visit on a one to one basis chatting to them. They also spent time preparing for up and coming events for people who used the service, such as birthdays.

A complaints procedure was available. This outlined the process for making a complaint and how it would be investigated. Complaints records were maintained but no complaints had been received by the service since our last visit in April 2016. We had received a concern since our last visit to the service in April 2016. We discussed this with the registered manager. There was no evidence that the registered provider's complaint procedure had been used to raise this concern. The registered manager was aware of the details of this. Compliments received were available for staff to refer to. These included cards and letters thanking staff for their efforts. We observed a visitor providing staff with a verbal compliment on the "marvellous" work they had done with one person.

Good

Our findings

Prior to this inspection we received concerns about the process for accessing records we looked at those concerns as part of well led.
Relatives of people who used the service told us "The manager is really good" and "We have had no problems since my relative came to live here". People told us that the registered manager made themselves available and that they maintained a presence within the service.

A breach of regulation 20A had been identified at our last inspection. This was because the registered provider failed to clearly display at the service outcomes of performance assessments including the rating given by CQC following the previous inspection. This meant that people who used the service, their relatives and others were not provided with up to date information about the quality of care provided and other agencies' views on standards of care. The rating for the previous visit in April 2016 was now prominently displayed for people to refer to. Other information such as our previous inspection report and other information on visits conducted by agencies such as Healthwatch were also accessible for people to read.

A concern had been raised with us since our last inspection about the lack of availability of the registered provider's access to records policy. This meant that the care of people was not fully transparent. During this inspection the registered providers policies and procedures were made available to relatives and others involved in people's care. This included an access to records policy and procedure. Policies and procedures covered others matters such as health and safety, safeguarding, whistleblowing and staff conduct. These had not been recently reviewed to ensure that they included up to date information about current legislation and current good practice. The registered manager told us that this had been identified and the documents would be reviewed in the near future.

The registered manager had become registered with us in December 2016. They had worked previously in the service as manager from the time of our last visit before being registered. They had also worked as a registered nurse in the service for a number of years prior to that. Staff rotas indicated that the registered manager was on duty most days and discussions with them saw them dividing their role between direct clinical practice with people who used the service and their responsibilities as the manager of a regulated service.

Staff were positive about the registered manager's approach. They felt supported and the involvement of the registered manager with hands-on support enabled them to be aware of the needs of individuals. They considered the manager to be approachable. They considered that improvements had been achieved since

the registered manager had started their role.

Our records indicated that the registered provider informed us of any incidents that adversely affected the health of people who used the service or significant events. These included deaths of individuals as well as notifications that deprivation of liberty orders had been approved by the Local Authority.

The registered provider sought to gain the views of all those connected with the service. Staff meetings with care staff, nurses and ancillary staff took place as well as meetings with people who used the service and their relatives. Questionnaires had been sent out in 2016 for people to comment about the quality of care provided and these had been positive. The registered manager had sought to comments and suggestions from people with suggestion boxes and invitations for suggestions located for people to refer to.

The registered manager had conducted on-going audits of key areas of care within the service. These included audits on the quality of care plans, medication processes, accidents and quality assurance audits. These were carried out monthly. Where care plans required updating, for example, the details of what was required was recorded with an accompanying date of completion. Medication audits included details of stock checks and nurse practice in administration. Accidents outlined what accidents had occurred each month, the action taken and whether there were any patterns or trends that could identify these happening again.
A general quality assurance audit was conducted. This related to issues such as environmental checks, low level safeguarding referrals made, notifications to the Care Quality Commission as well as any health issues such as weight loss, pressure ulcers or infection control issues. All audits provided a commentary on what needed to be done and were marked off as completed.

Other checks were available including a maintenance log sheet of repairs that had been done, domestic cleaning schedules and auditing of personnel records. There was evidence that the registered manager met with the registered provider on a regular basis to feedback issues affecting the quality of the service.

The registered provider had placed the certificate on registration on display. Appropriate insurance cover was in place for the service.