Assured Care Services Limited

Tenby House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 2 and 6 October 2015 and was unannounced.

Tenby House provides accommodation and personal care for up to 32 older people with a variety of mental health needs; the majority of whom have been diagnosed with some form of dementia. The home also provides a short break and respite service. At the time of our inspection, there were 26 people in residence. Parts of Tenby House date back to the Edwardian era, but the home has been extended over the years, with the addition of more bedrooms and another lounge area. Communal areas include a large sitting room, dining room and access to gardens at the rear of the property.

The majority of rooms have en-suite facilities and all rooms are single occupancy. Tenby House is located close to the centre of Worthing and within easy reach of the seaside.

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.

People and their relatives felt that Tenby House provided a safe environment. Staff were trained to recognise the

Summary of findings

signs of potential abuse and protected people from harm. Risks to people had been identified and assessed and information was provided to staff on how to care for people safely and mitigate any risks. Staffing levels were sufficient to meet people's needs and were assessed appropriately. The service followed safe recruitment practices. People's medicines were managed safely and medicines were administered by trained staff. Staff were provided with advice and guidance on infection prevention and control.

Staff underwent an induction programme which included shadowing experienced staff. New staff followed the Care Certificate, a universally recognised qualification. Staff then went on to follow additional training and were encouraged to pursue additional qualifications relating to care. Staff received regular supervisions and annual appraisals. Group supervisions and team meetings were in place. Staff understood the requirements under the Mental Capacity Act 2005 and about people's capacity to make decisions. They also understood the associated legislation under Deprivation of Liberty Safeguards and restrictions to people's freedom. People had sufficient to eat, drink and maintain a healthy lifestyle. They had access to a range of health professionals and services. The design of the home met people's individual needs.

Care was provided to people by kind and caring staff who knew them well. People's spiritual and cultural needs were taken account of and they were supported to follow their religious preferences. People were encouraged to express their views and to be involved in all aspects of their care and treatment and staff supported them in this. People were treated with dignity and respect. At the end of their lives, people were supported to have a comfortable, dignified and pain-free death.

People received personalised care and care plans contained information about people's lives, including their personal histories. Relatives were involved in reviewing care plans with senior staff. There was a range of activities on offer to people, including quizzes, music, gentle exercises and arts and crafts. Other activities included visits from a therapy dog and musical entertainment. People could access the community with staff or were supported by their families or friends. There was a complaints policy in place and all complaints were dealt with in line with this policy. No complaints had been received recently.

People's views about the quality of the service were obtained informally, either from care staff or through the involvement of an independent consultant. Their views were fed back to the management and acted upon. Relatives were also asked for their feedback and overall this was positive. Staff were asked how they felt about the service through an annual survey. Staff felt supported by the management team and there was an open-door policy. A range of robust, quality audit processes were in place to measure the care and overall quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People and their relatives felt the service was safe. Staff were trained to recognise the signs of potential abuse and knew what action to take.

People's medicines were managed safely.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were sufficient numbers of staff and the service followed safe recruitment practices.

Good

Is the service effective?
The service was effective.

People were supported to eat, drink and maintain a balanced diet. They had choices of what they wanted to eat and special diets were catered for.

People had access to healthcare professionals and services to maintain good health.

People could personalise their rooms with things that mattered to them.

Staff received training at induction and other essential training which enabled them to look after people effectively. They received regular supervisions and annual appraisals.

Staff understand the requirements of the Mental Capacity Act 2005 and associated legislation under Deprivation of Liberty Safeguards and put this into practice.

Good

Is the service caring?
The service was caring.

People were looked after by kind and caring staff who knew them well. They were supported to express their views on how they wished to be cared for and were treated with dignity and respect.

At the end of their lives, people were supported in line with their personal wishes by caring staff.

Good

Is the service responsive?
The service was responsive.

People received personalised care and care plans provided comprehensive information and guidance to staff.

A range of activities was organised for people to participate in or they could go out into the community.

Complaints were investigated and responded to in line with the provider's policy.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

People were involved in developing the service and were encouraged to feed back their views on the quality of care they received. Their relatives were also asked for their feedback.

Staff knew and understood what was expected of them and were supported by management.

There was a range of audit processes in place to measure the quality of care delivered.

Tenby House

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.

The inspection took place on 2 and 6 October 2015 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. We spent time looking at records including seven care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with seven people living at the service and spoke with two relatives. Due to the nature of people's complex needs, we did not always ask direct questions. For some people, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the area manager, registered manager, deputy manager, administrator, dementia lead, three care staff and the chef.

The service was last inspected in November 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People said they felt safe living at the service and relatives also told us that their family member was looked after safely and protected from avoidable harm. Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff were able to name the different types of abuse, such as emotional, physical and sexual. One staff member said they would notice if people had changes in behaviour and would investigate further, to find out the cause. Another staff member said, "If we see something, any sort of abuse, we report it to the management". All staff said they would report any concerns they had to the registered manager or, failing that, to the area manager. They felt confident that appropriate action would be taken. The safeguarding policy was on display in the hall corridor and provided staff with contact numbers to call of the local safeguarding authority. We asked staff what they would do if they wanted to make a complaint anonymously and they referred to the whistleblowing policy. Staff said they would report any concerns to the management or to CQC.

Risks to people were managed so that they were protected and their freedom was supported and respected. One relative said their family member had suffered falls, but that these had occurred when staff were not present. They felt that risks were monitored and managed appropriately. Care records contained detailed risk assessments for people in areas such as falls, activities of daily living, skin integrity, moving and handling and challenging behaviour. These assessments identified and assessed the level of risk and provided information and guidance to staff on how to mitigate the risk. Risk assessments were reviewed monthly or sooner if needed. Accidents and incidents were reported appropriately and uploaded on to the provider's system on a monthly basis. The area manager would then discuss these with the registered manager. Reviews of the accidents and incidents log showed that appropriate action had been taken afterwards. For example, one person had sustained a series of falls. Upon investigation, it was decided to review their medicines and a new prescription was drawn up by the GP. This resulted in a cessation of falls for this person. A sensor alarm on the stairs ensured that staff were aware when people went up or down the stairs and could be monitored safely. Door protectors had been fitted to prevent people from accidentally trapping their fingers in the edge of the door. Environmental risk assessments had been completed and there were plans in place in the event of an emergency, such as power failure or fire at the home.

There were sufficient numbers of suitable staff to keep people safe and meet their needs and staffing rotas confirmed this. A relative told us, "They seem to be able to keep their staff. There is a turnover, but some staff stay a long time". Staffing levels were assessed based on people's individual needs and hours that staff needed to work were calculated based on a range of areas from delivering personal care to accompanying people to health appointments. Staff felt they had time to chat with people and could also take regular, allocated breaks. One member of staff said, "There's a big staff team, everything's covered. We work well together".

Safe recruitment practices were employed. Potential staff were pre-screened by a member of the administration team and, if considered suitable, would then be invited for a formal interview. Agency staff were rarely used. Before new staff were allowed to commence employment, two references were obtained, their identity checked and application made to the Disclosure and Barring Service, to ensure they were safe to care for people. Records confirmed this.

People's medicines were managed safely. We observed a lunchtime medicines round with the registered manager as she administered medicines to people. She wore a tabard to indicate that she was administering medicines and should not be disturbed. People were given their medicines and provided with a drink to swallow down any tablets. The registered manager waited patiently with people to ensure they took their medicines as needed. Medicines were administered from trolleys situated on the ground and first floor. Stocks of medicines were stored in a secure room dedicated for the purpose. Controlled drugs were stored in a separate locked cupboard in line with current legislation. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated legislation. We checked the stocks of controlled drugs and other medicines and stock levels tallied. Medicines were audited monthly and no errors were evident in the months we checked. Senior staff were trained in the administration of medicines. A new staff member said that they were currently being trained. They

Good

Is the service safe?

told us that they had shadowed, "Quite a few" medicines rounds and had progressed to administering medicines more independently, with trained staff on hand to observe and support.

Some people living with dementia had found it difficult to take their medicines as prescribed. Rather than immediately deciding that people should be given their medicines in a covert way, that is without people knowing, the provider had looked at an alternative. Where people became anxious or refused to take their medicines on a regular basis, their GP had been consulted. A review of their medicine, in some cases, had resulted in the medicine being changed slightly so that people only had to take it once a day, instead of two or three times. This had worked well. Two people were, however, given their medicines covertly and a best interest meeting had been held to arrive at this decision. A best interest meeting is where a decision is made on the person's behalf and is attended by the person's relatives, healthcare professionals and staff. Where medicines were given covertly, the risks had been weighed up and assessed and these were recorded in the care plan.

There was advice and guidance for staff on infection prevention and control on the main noticeboard in the hall corridor. People's laundry was kept separately and soiled linen was laundered in red alginate bags at a sluice wash setting. Staff wore personal, protective aprons and gloves when delivering personal care or supporting people to eat. We observed the registered manager washed her hands between administering medicine to people.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Two relatives said that they visited their family member on different days at different times in the week. They said that this enabled them to meet a variety of staff and that they knew every member of staff really well.

The majority of staff had achieved a National Vocational Qualification at either Level 2 or 4 in Health and Social Care. Pre-employment days were organised for potential new staff which involved shadowing experienced staff and chatting with people. These pre-employment days enabled management to assess new staff capabilities and helped new staff to have a good understanding of what the job entailed. On commencing employment, staff were required to complete the Care Certificate covering 15 standards of health and social care topics. We were told that staff would complete the Certificate within 12 weeks of commencing employment. One new member of staff told us that they completed, "A little bit every day" and were working towards completion. New staff completed an induction programme which included shadowing experienced staff. A member of staff confirmed this and told us that they had spent the first two weeks shadowing another member of staff. They added that their priority had been getting to know people and staff.

All staff were required to complete essential training in a range of areas such as moving and handling, emergency first aid, fire marshalling, infection control, health and safety, nutrition with dementia, understanding dementia with person-centred care and challenging behaviour. Training was refreshed as required and the staff training plan confirmed that all staff were up to date with their training. Some training was delivered face-to-face by trainers and some was on-line training which staff could access freely. There were opportunities for staff to undertake additional training or qualifications. A member of staff confirmed that, "Training's very good" and went on to describe the training they had received and how this had supported them in their role.

Staff received regular supervisions, usually three per year and an annual appraisal, with senior staff or the management. The staff supervision matrix showed that supervisions were not completely up-to-date for some staff. However, group supervisions also took place and records confirmed this. For example, one group supervision had been held on infection control and notes recorded what needed to be achieved by staff and actions arising. Team meetings were held for staff every quarter with separate meetings held for care staff, senior staff and kitchen staff. The last meeting for senior staff held in July 2015 showed that issues such as handovers, staff on call, care documents, medicines, policies and procedures were discussed. Actions arising as a result of the team meeting were minuted.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice. People had been assessed in their capacity to make decisions by a member of staff who was knowledgeable and skilled in this area. Capacity assessments had been undertaken following a discussion with the person, if they were able, and their relatives. Following this, applications had been made to the local authority under the Deprivation of Liberty Safeguards (DoLS) legislation. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Parts of the home, including the front and back doors, were only accessible through coded keypads. Where people had been assessed as lacking capacity to make a particular decision, then a best interest meeting was held. This is where people's families, professionals and staff get together to make a decision on the person's behalf. For example, a best interest meeting was held for one person relating to their capacity to communicate when they were in pain. As a result, a decision was taken to apply patches to their skin to alleviate pain.

Staff had received training to recognise the signs of what might constitute challenging behaviour. Physical restraint was not used. A member of staff described what they would do if they witnessed a person exhibiting behaviour that might challenge. They told us, "We try and take them to their rooms, chat with them until they calm down a bit. We offer them a tea or coffee".

People were supported to have sufficient to eat, drink and maintain a balanced diet. One person told us that they, "Like living here and I like the food". The main dining room was not large enough for all people to have their meal

together. However, many people chose to eat their meals in their room or had it served to them in the lounge area. The main meal of the day was served at lunchtime and the menu for the day was posted on the dining room wall. The menu also showed pictures of food so that people could easily understand what choice of food was on offer that day. On the day of our inspection, people had the choice of fish and chips, ham and mashed potato or eggs. People chose what they wanted to eat on the day and were shown the food when it was served. They were then asked whether their original choice was still acceptable.

Suppers consisted of a hot lighter meal, soup or sandwiches. Alternatives were available to people if they did not like what was on offer. Special diets were catered for, for example, vegan, and diabetic or for people with cultural differences. Some people had been assessed by the speech and language therapist as requiring their food to be pureed, because of difficulties with swallowing (dysphagia) or because they had problems with chewing. Special equipment was used to assist people with eating. For example, plate guards to prevent spillages or special bowls that could be affixed, to prevent them from sliding on the table.

People's risk of malnourishment had been assessed and, where required, advice had been sought from healthcare professionals. Care plans confirmed this. Some people were prescribed food supplements to augment their calorie intake. The chef said that they used ingredients such as cheese, full fat milk and cream to supplement people's diets; smoothies were also popular with people. The cook said, "It's really, really busy, but I have a kitchen assistant to help". The Food Standards Agency had awarded a rating of 5, which is the highest rating. Menus were planned on a seasonal basis and the chef said that they could assess whether people liked particular meals or not by the amount of food left on plates at the end of the meal. Roast dinners had proved very popular with people and a roast was served three times a week. One person told us that their favourite food was a roast. The chef told us they were not constrained by budget so fresh meat, fish and vegetables were always used. Freshly made home-baked cakes or fruit were available to people with their afternoon tea. Drinks were freely available, as were snacks between meals. People could also have a snack and a hot drink just before they went to bed.

People were supported to maintain good health and had access to healthcare services and professionals as needed. The member of staff who was the dementia lead told us that they would often lead on discussions and liaise with the GP, for example, if people had problems taking their medicines. The dementia lead was a qualified mental health nurse and liaised with the living well with dementia team, to support people effectively according to their mental health needs. Another member of staff said, "If someone is unwell, I would report it to the manager". Where people had needed dental treatment and were unable to see the dentist in the community, two dentists and a dental nurse had come from a local dental clinic to assess and treat people. A chiropodist visited every six to eight weeks and people were also seen by a visiting optician or audiologist, as required. On the day of our inspection, we met very briefly with a GP who had come to visit. He said, "All is good at Tenby House". Visits to healthcare professionals, or other involvement, were recorded in people's care plans. A hairdresser also visited the home regularly.

People's individual needs were met in the design of the home. A relative told us that, "They are always decorating, making it nice". A collage of pictures had been made, including people's name, which depicted people's likes and interests and were placed in frames on the door of their bedrooms. If they wished, people could bring their own furniture when they were admitted to the home. Many people had photos and items on display that were of personal interest. The corridors on the ground floor of the home were in the process of being redecorated. The registered manager said that when this had been completed, they planned to have pictures on the walls showing different eras, which people could relate to or talk about. The home was going through a period of refurbishment and all works had not been completed at the time of our inspection.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff and our observations at inspection confirmed this. One person said, "It's very good, they're very nice", and added, "I cannot fault them", referring to staff. She confirmed that she only ever had female staff care for her, which was her choice. People were looked after by kind, warm and friendly staff who cared about their well-being. One person said that staff helped them with, "Washing and keeping clean" and added, "I think they are good staff here". Relatives confirmed that their family member was offered a choice in the way they were cared for. One relative said, "Choice is always offered, but [named family member] may not always understand". They went on to say, "Staff are all friendly and the way they always talk to Mum is nice". One member of staff said, "When you're working in care, you get attached to everyone. It's like a second home". Another member of staff told us, "You can tell how people are feeling because they tell you".

People's needs were supported with regard to their religious and spiritual beliefs. One person was visited by representatives from their faith every month. Another person received Holy Communion. For some people, input by priests was important especially as they reached the end of their lives, for example, being anointed and receiving Last Rites.

People were supported to express their views and were actively involved in making decisions about their care and treatment as much as they were able. One person confirmed this and said, "It's a lovely home and that's right. There's only one thing that bothers me, I have to be good and behave myself!" They then added, "I'm only playing" and, "If my mum was alive and I had to put her in a home, I wouldn't get better than this". Relatives confirmed that they were involved in making decisions about their family member's care and that they reviewed the care plan with the registered manager.

Staff said that they would, "Encourage people to make decisions and promote their independence, things like brushing their own teeth, showering and dressing". Another member of staff said that people did make day-to-day choices, that they could get up when they wanted to, for example. A third member of staff said, "You just have to see everything from their point of view. Some people have little understanding of knowing what's happening – it can be frightening. Explain what you're doing and reassure them".

People were usually treated with dignity and respect. We observed staff knocking on people's doors and asking if it was all right to come in, before entering. However, we saw people were routinely provided with disposable clothes protectors at mealtimes and some staff were affixing these to people without always asking whether they wanted them or not. We fed this back to the registered manager at the end of our inspection who said they would follow this up with staff.

People were supported at the end of their life to have a private, comfortable, dignified and pain-free death. There were a few people at Tenby House who were receiving palliative care. We observed staff caring for people in an extremely sensitive and gentle way. One person's room had a peaceful atmosphere and classical music was playing softly in the background, as staff helped them to eat their lunch. The dementia lead was in the process of discussing people's end of life care needs with their relatives. They told us they talked about how people would have wished to be cared for, prior to them developing dementia – what would the person have wanted? As staff supported people at the end of their lives, they too were emotionally supported by more senior staff.

Good

Is the service responsive?

Our findings

People received person-centred care that was responsive to their needs. The essence of being person-centred is that it is individual to, and owned by, the person being supported. One person said that they preferred to remain in their room for most of the day and that they ate all their meals on their own. They said, "I am a bit of a loner" and that staff respected their need to be alone. A relative told us that staff would come in to their family member's room and read magazines to them and added, "They take Mum out into the garden in the summer". Relatives were encouraged to visit at any time.

Care plans contained detailed information about people and included their personal histories. Staff confirmed that they read the care plans and one staff member told us, "That's the first thing I did" when they commenced employment. A new member of staff said, "I'll meet [named person] and have a lovely chat. I get to know a bit about him and then look at the care plan. I observe people as well". Senior care staff wrote up care plans and risk assessments and they were also keyworkers to people. Keyworkers co-ordinate all aspects of people's care. The registered manager referred to keyworking and said, We're the ones who do the monthly care plans. Care staff write up about daily care, clothing, etc., and report back to the keyworker who liaises with families". The management had liaised with families to find out what was important to people, including their individual preferences, interests and aspirations and these informed the care plan. Staff also talked with people about what mattered to them. People chatted with us on the day of our inspection and talked enthusiastically about their lives, wartime experiences and families. The provider was in the process of changing from paper-based care plans to an online version. Management thought that care plans, using this new online version, would enable easier access by staff in reading care plans, reviewing them monthly and updating them as required. Care plans were reviewed monthly and there was information and assessments on all aspects of daily living. Daily records were completed by staff and provided detailed information on people and how they had spent their day and what kind of mood they were in. These daily records were referred to as staff handed over to other staff between shifts.

A range of activities was organised on a daily basis and a noticeboard provided information to people about what was on offer. We recommended the use of pictorial references which would make this information more accessible and understandable for people living with dementia. Photos of people were also on display and these showed the different activities that they had engaged with and which they had clearly enjoyed. Following recent feedback from relatives about the lack of activities, the service had engaged the services of an activities co-ordinator. On the day of our inspection, the activities co-ordinator was encouraging people in a discussion about wartime reminiscences, especially the food and rationing. We observed the co-ordinator talked and engaged with the group as a whole. When people appeared disengaged, the co-ordinator knelt down next to them and talked with them individually. Magazines were available for people to have a look at and there was a music centre in the main lounge which people could listen to. A relative referred to their family member and said, "She loves anything to do with music and singing and always joins in – she loves that". Entertainment and activities were also organised and delivered by other individuals or groups. For example, a therapy dog had proved popular and a lady brought in their i-Pad and used this to support conversations and reminiscences with people. Other activities available to people included arts and crafts, music, quizzes and gentle exercises. People were also able to go out into the community, either with staff or with family or friends.

Complaints were explored and responded to in good time. The provider's complaints policy was on display. It stated that complaints were acknowledged within five days and resolved within 28 days. The registered manager told us that people were given a copy of the complaints policy when they came to live at the home. A relative said, "I normally talk to [named registered manager] about things" and that any issue was resolved to their satisfaction. The provider also evaluated complaints as part of their audit process. No formal complaints had been raised within the last year.

Good

Is the service well-led?

Our findings

As much as they were able, people were actively involved in developing the service. Residents' meetings had been organised in the past, but these had not proved a successful way of engaging people or of obtaining their views about the service. Instead, care staff encouraged and supported people to express their views on a one-to-one basis. In addition, an independent consultant met with people individually and talked with them. In this way, people were able to say how they felt about things, for example, on the range of activities offered and the menu choices. Based on people's verbal feedback, suggestions were then looked at and changes made as appropriate. As a result of people's feedback, the menu now incorporated three roast dinners a week.

Relatives were also asked for their feedback and the last survey was sent out to 28 relatives. Of the responses received, five relatives described Tenby House as, 'very good', four as, 'good' and three as, 'fair'. The relatives' survey had highlighted the lack of activities for people and an activities co-ordinator had been employed to address this. One relative told us, "We have been really pleased and the care has been marvellous". Surveys were sent out to relatives every six months. The area manager felt that there was open and transparent communication between relatives and the management and said that relatives could even contact them over the weekend if they wanted to.

The registered manager demonstrated good management and leadership. Staff felt supported by the management team. One member of staff said, "Staff are very supportive. [Named registered manager] is great and will help where she can" and added that the area manager was, "Really nice and always asks if I need anything". Another member of staff told us, "I've no problems with management and everyone is very easy to speak to". There was an open-door policy and the registered manager, deputy manager and area manager were all engaged with people and staff on a day-to-day basis. They were readily available to people and staff and there was no hierarchical approach to the structure of the management team and staff.

Staff were encouraged to feed back their views about the home. They knew and understood what was expected of them and there was good communication at all levels. A staff survey was undertaken annually and the last survey was completed at the end of 2014. Positive results overall had been fed back.

A range of robust audit processes was in place to measure the quality of the care delivered. Audits had been drawn up in areas such as medicines, accidents and incidents and maintenance. The accidents and incidents audit included an analysis of how each accident or incident report was written up, further training that was needed for staff to write these up properly and preventative measures that were needed. The maintenance audit reviewed the room risk assessments that were done each month and the maintenance log. Progress was measured and any outstanding maintenance work was reviewed. The management employed the services of an independent consultant who provided a monthly audit along the same lines as CQC, under 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well led', together with key lines of enquiry. Where actions had been identified, the management had put plans in place to address these.

The registered manager said she was proud of, "Having that bond with the residents" and that a challenge was, "Getting everything done – paperwork is the biggest challenge".