GCH (Hertfordshire) Ltd

Queensway House

Inspection report

Jupiter Drive
Hemel Hempstead
Hertfordshire
HP2 5NP

Tel: 01442266088

Date of inspection visit:
18 October 2018
25 October 2018

Date of publication:
10 January 2019

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?	**Requires Improvement**

Summary of findings

Overall summary

Queensway House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
This inspection took place on 19 and 25 October 2018 and was unannounced.

Queensway House provides care and support to up to 80 people some of who live with dementia. At the time of our inspection 56 people were living at the service.

The home had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 staff told us at times there were not sufficient numbers of staff deployed and at times experienced delays when seeking assistance. Our observations on the day however did not support these views as we saw staff were attentive and responsive to people's needs. Care records were not consistently reflective of people's changing needs, however staff were aware of what support people required.

People felt safe at the service, staff had received relevant training on how to safeguard people and understood their responsibilities to report any concerns. Risks to people's safety and well-being were identified and managed to keep them safe from harm. Relevant pre-employment checks had been completed for all staff and safe recruitment practices followed. Medicines were stored appropriately, administered to people as the prescriber intended, managed safely and checked regularly. People lived in a clean and hygienic environment and were cared for by staff who followed robust infection control procedures.

People felt staff were well trained. Staff had attended relevant training to understand their role and spoke positively about the training they were provided with. Staff felt supported and had regular supervisions and appraisals. The registered manager was in the process of reviewing how people's consent to the care they received was captured in their care plans. Staff were aware of how to support those people who may have not been able to provide their verbal consent. People's nutritional needs were met and responded to when people were at risk of weight loss. The environment was undergoing a planned renovation and decoration.

People told us that staff were friendly and respected their privacy. Staff knew people well and were knowledgeable about people's individual needs and demonstrated a caring approach. People's privacy and dignity was promoted.

People received care that responded to their individual choices and promoted their independence. People and their relatives were involved in planning how people`s support would be delivered. People were

supported to pursue hobbies and interests. People were able to have visitors without restriction and able to see them in privacy. People were encouraged to provide feedback on the service they received and knew how to make a complaint. Their feedback was used to improve the quality of care they received.

People's care records were not always updated in a timely manner when people's needs changed. People, relatives and staff were positive about the registered manager and felt they were visible and approachable. Staff were encouraged to attend team meetings which were held regularly.

The provider operated systems that constantly monitored and reviewed the quality of care people received. The areas identified at this inspection as requiring improvement the provider took action to immediately address these. Notifications required to be sent to us were made in a timely manner.

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.

Some people and staff told us there were not always sufficient numbers of staff. Our observations were people's needs were met on the day in a timely manner.

People were protected from harm by staff who were trained and reported their concerns appropriately.

People's changing health needs were identified and managed safely.

People received their medicines safely as intended by the prescriber.

People lived in a clean, hygienic environment.

Staff were aware of how to keep people safe in the event of an emergency such as fire.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed and care and treatment was delivered in line with current legislation.

Staff had induction training when they joined the service and received ongoing training and personal development.

People's consent was sought prior to care being delivered. However when decisions were made in a person`s best interest, these were not always documented.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were treated in a dignified and sensitive manner.

Staff knew people well and listened to their views and opinions about their care.

People's privacy was respected and maintained.

Peoples confidential information was kept secure.

Is the service responsive?

Good

The service was responsive.

People contributed to their care plan based upon their view of their needs, wishes and independence.

Staff were aware of people's choices and preferences and delivered care accordingly.

People were supported to pursue activities and hobbies, and were part of a wider community.

People `s visitors could freely see them without restrictions.

People felt confident in raising a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People's care records were not accurately maintained.

Systems were in place to monitor the quality of care people received.

People were positive about the management of the service and felt the registered manager was approachable.

People's views and opinions were sought to improve the quality of the care they received.

Queensway 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.

This inspection took place on 19 and 25 October 2018 and was unannounced. On 19 October 2018 the inspection was undertaken by two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone using this type of service. On 25 October 2018 we spoke with people's relatives and reviewed information requested from the provider.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us about the service such as information from the local authority, and notifications submitted to us. A notification is information about important events which the provider is required to send us by law. We spoke with the local authority safeguarding and commissioning teams and asked for their views about the care provided at Queensway House.

We 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.

During the inspection we spoke with six people, seven people's relatives, nine staff members, the registered manager, two members of the providers senior management team and the provider themselves.

We reviewed the care records and risk assessments of five people who used the service to ensure these were reflective of people's current needs. We also reviewed additional information relating to the quality of the service provided to people and how this was monitored.

Good

Is the service safe?

Our findings

The registered manager regularly reviewed people's needs and adjusted staffing where necessary. They told us there was ongoing recruitment in the home and that they had already recruited to vacant positions. They said, "There were 16 staff vacancies across the home, with 47 full time staff in post. There is a recruitment plan in place and there have been staff leaving due to the changes we have made and the disciplinary process." The registered manager demonstrated where they had increased staffing levels steadily on both day and night shifts since January 2018. This was continually monitored. A senior staff member said, "Since the [registered] manager [started], the standards have raised, and I think that some of them [staff] couldn't manage. There has been changes in staff, these are positive Some staff that worked here before the problems have now come back. Things are getting better and although we sometimes struggle to fill sickness or use agency [registered manager] will always help."

People and staff told us there were not always sufficient numbers of staff. Call bell records showed a small number of people experienced a delay at peak times between eight and twelve minutes in some examples. One person said, "I would say they seem a bit short staffed at times." A second person said, "Sometimes I think they are short staffed, they are not always quick to answer the call bell, but I have been here a long time and I have never seen anything that would make me feel concerned." The registered manager was aware of these delays and told she regularly monitored call bell response times.

One staff member said, "This is a good place to work, but staffing is a problem because we only have time for the essentials.". We did not find evidence to demonstrate that people's needs were not met however, the occasional lack of staff placed people at risk of not receiving care when needed., We observed several occasions where staff positively assisted people and spend time with people ensuring their needs were met.

Recruitment records looked at showed that relevant pre-employment checks had been completed. These checks included criminal records checks, written references and evidence of identity. Where agency staff were used, a profile of their skills, abilities and training, along with verification of their character had been seen. This ensured that staff employed were of sufficient good character to work with people using the service.

People told us they felt safe living at Queensway House. One person said, "I feel safe because I have got people around me that are there for me." One person's relative said, "Things have improved so much over the last few months. Before [person] wasn't safe and I visited a lot, but now I honestly feel [person] is safe so the time we spend together is quality time. Not because I am checking up anymore."

People were protected from the risk of harm by staff who knew how to identify abuse and report concerns. Staff were able describe what abuse was and actions they would take if they suspected a person was at risk. One staff member said, "Anything out of the ordinary like a bruise, injury or even a change in a person's mood I report to my senior."

Staff were aware of how to raise concerns anonymously following the whistleblowing procedure if they had

concerns regarding a staff member or manager. One staff member said, "If I saw something and couldn't go to the [registered] manager, then I would either raise as whistleblowing or come to you [CQC] or social services, I have all the phone numbers." This demonstrated that staff were also aware of local organisations they could raise their concerns with. Training records confirmed that all staff have undertaken appropriate training.

Where there had been incidents, accidents or safeguarding reviews, lessons learned from these was an area that had been implemented into team meetings and handovers and was being further developed. Staff spoken with were aware of recent incidents and actions arising from these, however this process required further development to embed in the daily practise.

Risks to people's health and well-being were identified and managed. We saw that staff completed a range of assessments to mitigate the risks to people in areas such as mobility, skin integrity, and risk of falls. For example, managers had been proactive in using sensor mats for when people were sat in their chair and moved to get up. They also looked at the chairs people used and where needed used raisers to increase the height of the chair, making it easier for people to get up. Staff told us both these interventions had reduced the numbers of falls and injuries for those at high risk of falls. Incident records we reviewed also confirmed this.

Staff spoken with were knowledgeable of people's health needs and were able to describe to us how they safely provided care to people. For example, when we observed one person transferred using a 'Bucket chair' we asked why the person was unable to use a hoist. All the staff spoken with were aware of the reasons why the person had to be moved this way, which was consistent with the information held in the hospital discharge records and the care plan. One person told us, "I had a fall at home and was admitted to hospital then I came here. I asked if I could have a walking frame, they provided it, I have had no falls here. I have a mat beside my bed [Connected to the call system], if I put my feet on it when I need someone they come quick." This showed that risks to people's safety and wellbeing were assessed and known by staff who supported them.

Staff had received training to administer medicines and their competencies were regularly checked. Staff maintained accurate records for the receipt and disposal of medicines. The room used to store medicines was well organised. Where people required their medicines to be given covertly staff had sought the advice of the GP, relatives and asked the pharmacist to authorise the use of covert medicines to ensure this was safe.

People received their medicines in accordance with the prescriber's instructions. We checked people's medication administration records (MAR) and found these were complete with no errors or omissions. Physical stocks tallied with records demonstrating people had received their medicines when required. People's preferences and allergies were clearly recorded, and a review of people's medicines, particularly those to manage behaviours that challenged others were regularly carried out.

People told us that staff assisted them with their personal care using appropriate personal protective equipment. We observed that staff used aprons and gloves when assisting people. The home was bright, clean and presentable. People told us they lived in a clean environment. One person said, "I always find it clean and looked after, there are no smells or anything like that, it's clean."

Staff spoken with were aware of how to evacuate people in the case of a fire. Regular fire drills and checks were made of fire equipment with external companies carrying out necessary maintenance and safety checks when required. Staff were aware of how to store and manage oxygen safely when used in the home,

and robust policies were in place to guide staff around this.

Good

Is the service effective?

Our findings

People told us staff supported them with their care and support needs. One person said, "From what I see the staff seem very skilled." One person's relative said, "I visit regularly and think the staff, including the agency ones are on the ball and well trained. [Registered manager] is always watching and I have seen them step in to teach staff where they think they need help."

Staff confirmed they completed an induction programme, during which they received training relevant to their roles. Staff told us they had their competencies observed and assessed in the work place and received regular training and updates in a range of subjects, such as moving and handling, safeguarding adults, administration of medicines and infection control.

Senior staff were supported to develop their roles with support and training which had led to promotion and development. One staff member said, "I started last year as a care assistant and have been supported with training to now be a senior. I have just completed my level two diploma and feel very supported by the [registered] manager." Development of champion roles was ongoing. This was enhanced training provided to staff members in key roles, such as moving and handling, safeguarding and end of life care. These staff members would then act as a mentor for other staff offering support and guidance to colleagues. Due to the departure of staff, some champions were not in place, but the registered manager was working to find replacement staff and was due to commence their training shortly.

Staff told us they received regular supervision with their line managers and were able to discuss matters relating to their work performance or concerns about particular people, and also any personal issues that affected them. Staff felt supported and told us they could always find a member of the management team who would support them.

We observed throughout the inspection staff obtaining people's verbal consent prior to assisting them. Staff clearly explained how they wished to assist people and waited for them to respond. Where people declined and were not ready or did not wish to be helped, then staff acknowledged this and returned later. One person said, "They do ask permission before they do anything for you, they don't just take your cardigan off they ask if they can, they are respectful."

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 to 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had completed MCA and DoLS training that helped them understand issues around capacity and supporting people effectively with decision making. We saw that written consent had been obtained from

people relating to the support they received. However, although appropriate MCA and DoLS assessments and applications had been completed, they were not always well documented with rationale to support the decisions made. This did not affect the decision made, for example to use bed rails to keep people safe, but did not document whether other less restrictive options were considered, or if the views of relatives close to the person had been consulted.

People were supported to have a balanced diet. We saw tables were nicely laid with condiments, napkins, cutlery and flowers. The dining room was sociable and relaxed and staff were able to eat their meal with people they supported. People were offered a range of healthy home meals and alternatives were offered if people did not like the food on the menu that day. Staff were seen to visually show people the choices on offer for lunch, enabling people who found it difficult to make or recall their choices of what they wanted to eat. However, in the upstairs dining room we observed people did experience a delay when requesting to leave the dining room."

Staff were observed to offer people clothes protectors and people were supported to eat independently where they were able to. Where they were not able staff assisted them in an unhurried manner, offering gentle encouragement to get people to eat. People were provided with drinks at lunch time and throughout the day, and a range of healthy snacks and home cooked cakes were available.

Staff had recorded specific dietary needs people had, such as allergies, soft or pureed meals due to swallowing difficulties or preferences due to cultural reasons. Kitchen staff were made aware of these dietary needs and prepared the meals accordingly. For example, people with a pureed meal had their lunch served using moulds to make the food more visually appealing. People with specific cultural needs, such as eating specific types of meat had this provided to them.

Kitchen staff were aware of people at risk of weight loss and offered a range of foods to support weight gain. The chef regularly reviewed people's weights with staff, and regularly spoke to people to gain a better understanding of their likes and preferences to support their weight. The kitchen staff spoken with were aware that they played a key role in maintaining people's health and physical wellbeing.

People's health needs were met by a range of external health professionals. Care plans addressed people's health needs and records confirmed that people were supported as appropriate to make and attend health appointments. A range of health professionals visited to support people such as district nurses, chiropodists, speech and language therapists and dieticians. Health professionals spoken with told us when they visited staff were prepared with the relevant information about people`s health needs along with the required documentation. One person said, "If you need to see a doctor they will call one. Or they might think you're not well and do it themselves, they pick up on things like that. They have taken me to the hospital as well for my appointments. I had my feet done yesterday, and got these new glasses earlier from the optician."

The environment was spacious and well laid out, ensuring there was enough room to meet people's support needs. Themed areas such as a café were popular meeting spots for people and relatives. Refurbishment work had been started in the home with a cinema and extended dining room. When people moved in they were able to choose colours and decorations for their room which the maintenance staff then completed prior to moving in. The dementia unit had undergone refurbishment and further work was planned on the lower floor. Although work had been completed, parts of the home continued to be drab, uninviting and lacking a homely feel. The registered manager and provider were aware of this and had plans in place to continue to develop the home. The design of the home however did support people's varying mobility needs allowing full access, and enabled people to remain as independent as they could. A lift ensured

people were able to move between floors to access all areas of the home.

Good

Is the service caring?

Our findings

People told us that staff were kind, and caring towards them. One person told us, "Staff are very caring and because I like to stay in my room they will always knock before coming in. That's very polite of them. They are very gentle when washing me because I have this injury to my shoulder, there is no rushing; they do things in a slow manner."

Staff knew people well and were familiar with their daily needs and routines. Staff knew and respected people they were caring for and took time to understand their preferences and personal backgrounds. People, and their relatives told us they felt staff listened to them and that their views mattered. Staff took time to communicate clearly with people, ensuring they got down to make eye contact and spoke clearly. One person said, "I have not come across anybody that wasn't nice to me, they will pop their heads round the door to ask if I am ok. They get to know people because they take the time to communicate with us that's how they know what we like and don't like. They are friendly from morning till night, I don't know how they keep it up they must be tired, they do a great job." A second person said, "I have never come across anyone rude, they are all lovely people. I can wash myself and dress myself, but they know I won't always do it, so they will always chase me up to have a shower or a shave. They care you see, if they didn't they wouldn't bother."

People's privacy and dignity was maintained. Staff were seen to knock on people's doors before entering. Staff called out to the person as they entered the room, and they ensured doors were closed when personal care was provided. We observed one person became agitated and argumentative with staff whilst partly undressed. Staff were quick to put a screen round this person to protect their dignity, and were then heard to listen to the person and help to settle them. Staff got the person a cup of tea and biscuits, gently prompted them to dress, and sat with them to understand what had upset the person so much. Within 10 minutes this person was seen to be contently sat talking with staff much happier and more relaxed.

People appeared comfortable in the company of staff and interactions between staff and people were friendly and relaxed. Interactions observed were meaningful and staff knew what was important to people. People were well dressed and groomed, their hair was clean and styled.

People were able to choose whether they wanted a male or female member of staff to assist them and this was respected. One person said, "Both a male and female carer were present in my room. I said, don't be offended to the male carer, but I prefer this lady. The male carer said, I totally understand I am not offended and left, he totally put me at ease in my choice."

People told us they could meet their visitors in private and were supported by staff to maintain contact with their relatives. One person's relative said, "I work shifts so I'm never visiting the same times or days. I know I could come first thing on a Sunday morning or last thing on a weeknight and would be welcomed."

People's care records were stored safely and securely and staff were aware of the importance of both, confidentiality and also protecting people`s personal information. We observed that when staff were

discussing people, they did so away from others and in a manner that meant they could not be overheard.

Staff ensured people were given information about external bodies, community organisations and advocacy services that could provide independent support and advice to them. We saw that where needed, the registered manager had involved advocacy services in decisions relating to people's care.

Good

Is the service responsive?

Our findings

People told us the care they received was focused on them and centred on their levels of independence, choices and how they wanted to live their own lives. One person said, "The way they care for me day to day depends on how I feel and how I am. My independence changes daily, so they change how they care for me daily."

Staff had a good knowledge of what was important to people which enabled them to provide care in a way that was appropriate and personalised to the person. Staff were able to tell us about people's personal history, individual preferences, interests and aspirations to help ensure people had as much choice and control as possible. People's needs were reviewed as part of resident of the day process. This allowed staff to spend time to discuss care with relatives and people, ensure tasks such as their weight had been recorded and review key areas of their care. It also enabled people to have a favourite meal given, favourite activity provided and have their bedroom spring cleaned once a month in addition to the routine cleaning.

People were able to join in a range of group social activities or be supported on a one to one basis. We saw positive examples of both taking place. During the inspection we observed staff and people playing musical instruments and singing along together. All looked to be engaged and enjoying the activity, which was well attended. The home had use of a minibus which they used regularly to take people out for day trips. People had been to the local safari park, shopping trips, garden centres, the beach and local pubs for lunches. Where people preferred their own company, staff were seen to spend time with them engaged in meaningful discussions or activity. For example, one staff member was with a person looking through books and photos, recalling happy memories, and showing a genuine enthusiasm in the person and their story.

A separate quiet room had been developed on the dementia unit for people to have one to one relaxation time. This was used to provide people with hand massage, relaxation and quiet one to one time. People told us there was always something going on which they were free to join if they wished. One person said, "I love to go to the bingo and raffles. I always win. I go to the garden centres, and on any trips really. I like to go out. We have been in the garden when it wasn't too hot, we have had barbecues, and we had tea and cake. We can just go out at any time, I like to walk about and be in the fresh air." A second person said, "I can go to the entertainment if I wish, but I like to read, and I have friends that come and take me out, there's no restriction here, and friends are very welcomed by the staff."

People were encouraged through regular meetings to discuss activities and matters relating to the home. One person said, "In the meeting most people talk about the food or laundry, we get feedback on what's going on, so it's good. More importantly it lets us see people we don't always get to see and talk to as they may not want to do the activities, so it's a real social event as well." Residents meetings were designed to be a social event where people could get together, share their views and socialise. People told us they felt these meetings were valuable. One person said, "I go to the meetings as well, some people might say they don't like something on the menu, others have suggested different things to cook. The chef is good and very obliging, there is a massive difference now, they are like a friend to everyone."

People receiving end of life care and their families were treated with compassion and kindness by staff who were committed to ensuring they received the best care possible. The service worked with relevant health care professionals who supported people's clinical needs when approaching the end of their life. Staff were aware of people`s wishes nearing the end of their life. They were aware of what was important to people, where people wanted to spend their final days, the people they wanted present and arrangements for afterwards. There were clear records if people had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decision in place or if they wished to be resuscitated. When required, end of life medicines were held in case people needed them to support a dignified death to manage pain or help people rest comfortably.

People told us they felt confident in raising a concern or complaint with staff or the management team. Complaints were recorded, investigated and responded to appropriately. When complaints were received, these were analysed by the provider to ensure these were robustly reviewed, and if necessary informed future practise. One person said, "I can go to the carers, the manager or in the meetings to raise anything, it's very open and they welcome any criticism. I have made my complaints and things get done."

Requires Improvement

Is the service well-led?

Our findings

People's care records were not accurately maintained, or completed as required. Risk assessments and the accompanying care plan were comprehensive and documented well people's needs when written. However, in all examples we saw the progress and evaluation sheets did not review robustly people's changing needs.

For example, one person was assessed as medium risk of falls. They had two accidents in one month, both which had been reported as an incident, but did not trigger a review of the risk assessment. The progress notes recorded, "Mobilising independently, and [Person] is still the same, no change." This was not an accurate reflection of the person`s care for this period. Although staff were able to tell us about this person's mobility, and how they supported this, records did not instruct staff how to support based on the most recent evaluation.

A second example was where a person had displayed challenging and agitated behaviour towards others. Staff had recorded and reported the incident to both the registered manager and local safeguarding authority, but the review of the care did not address the change in needs. When the person`s dementia plan was reviewed three days after, staff recorded, "[Person]has been quite settled for the past month, [Person`s] behaviour is not monitored at present." This was found to not be the case, with staff telling us they regularly monitored this person, and were well aware of their agitation.

This showed clearly that the review process did not take account of known factors that should have triggered an assessment and revision of the care plan and is an area that requires improvement.

Care records were cumbersome, in many cases duplicating information. Staff had completed a global care plan, which was a quick reference guide to supporting people, for example with mobility, skin care or personal care. These were found to be up to date and accurate. Staff told us that due to the size of the care plans, they did not read them. Key information therefore held in the more comprehensive care plan was not always reviewed. We spoke with the registered manager and provider about this. They accepted that the care records were not sufficiently updated, and also agreed that staff spent time unnecessarily completing records as opposed to spending time with people. They told us after this inspection that they were implementing a new electronic care plan which would help to ensure people's care needs were recorded accurately. They also told us they felt assured it would give staff more time to spend with people.

People, staff and relatives were positive about the registered manager, telling us they were visible, approachable and supportive. One person said, "[Registered manager] is perfect in every way, that's what I have got to say, you can ask for anything, I can go to them at any time." A long-standing staff member said, "The [Registered manager] has been a real positive. Since they arrived there has been changes in staff, these are positive, some of the staff are progressing their career, and the standards have raised. Some staff that worked here before the problems have now come back. [Registered manager] is easy to talk to and doesn't keep secrets from us, they tell us what is going on, ask how we are going to get things done, and helps us do it."

Staff told us that they had regular meetings, and these were important to them to raise their concerns or hear about matters relating to the running of the home. One staff member said, "Since [Registered manager] has been here, meetings are good. We share our thoughts about the home, about [Provider] as they listen to us and take us seriously. I think [Registered manager] remembers what it is to be a carer so that makes them listen to us."

People's feedback about the quality of care they received had been sought, in addition to the views of staff and health professionals. At the time of the inspection this information was being analysed, and the results would be shared with staff, people, relatives and visitors to the service. Where feedback suggested that improvements were required, the registered manager told us they would form part of the overall improvement plan for the service.

The provider had systems in place to monitor the quality of care provided to people. The registered manager and senior staff carried out a range of weekly and monthly audits of the quality of care provided. These included areas such as infection control, health and safety, care records and food. Where improvements needed were identified these were recorded in a service development plan and then regularly reviewed with the regional manager. In addition to the visits by the providers quality team, the registered manager submitted key performance information to the provider for monitoring the quality of care, such as staffing and incidents and accidents. Where incidents had occurred, these had been reported to the registered manager, and then assessed to identify themes, trends or patterns. These were in areas such as falls, injuries, weight loss, risk of developing pressure wounds and staffing.

Notifications that are required to be made to CQC of particular events had been made in a timely manner. Where necessary the registered manager had also referred incidents and accidents to the local authority safeguarding and had positively supported any investigation in a timely manner.