Care UK Community Partnerships Ltd

The Terrace

Inspection report

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Date of inspection visit:
02 February 2016

Date of publication:
11 May 2016

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

This inspection took place on 2 February 2016 and was unannounced. The service was last inspected in June 2014, when the service was found to be compliant with the standards assessed at that time.

The Terrace is registered to provide personal care and accommodation for up to 44 people, including people living with dementia, old age, physical disability and mental health difficulties. The service is not registered to provide nursing care. At the time of our inspection 35 people lived at the service. The home is situated in the market town of Richmond and is set in its own grounds, with parking facilities.

The registered provider is Care UK Community Partnerships Ltd. The service had a registered manager, who had been registered with us since October 2012. 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 using the service, their relatives and other professionals told us The Terrace was a safe place. Staff knew how to report any concerns about people's welfare and had confidence in the registered manager taking appropriate action. Safeguarding concerns had been reported appropriately when needed.

Checks were completed on new staff to ensure they were suitable and there were enough staff on duty to care for people safely.

People had individual risk assessments in place to help ensure staff were aware of the relevant risks and how these should be managed. Medicines were safely stored and staff administered medicines in a safe way.

The service's premises and equipment were well maintained and in safe working order.

Staff were supported to have the skills and knowledge they needed through relevant training. Staff felt supported and received supervision and appraisal.

The service was following the principles of the Mental Capacity Act 2005. At the time of the inspection eight people were subject to a Deprivation of Liberty Safeguards authorisation, with a further 12 authorisations awaiting assessment by the authorising body.

People told us that the food was good and snacks and drinks were available between meals if people wanted them. People's dietary needs were assessed and monitored.

We received positive feedback from two health care professionals, who told us the service worked well with them and provided a good standard of care to people.

People told us that staff treated them well, and with dignity and respect. People and relatives expressed satisfaction with people's care and how they were treated.

Care staff knew people well and were able to answer our queries about people's individual needs. People had their needs assessed and had care plans in place, which were regularly reviewed. Some care plans were basic and would benefit from the inclusion of more person centred information, but the registered manager was already aware of this and in the process of making improvements.

People had access to activities and were being given the opportunity to be involved in developing and improving how activities were provided. Visitors were made welcome and could visit when they wanted.

A complaints procedure was in place and information about this was available in the reception area and people's rooms. Complaints had been recorded and responded to appropriately.

Audits and checks were completed and a service improvement plan was in place, to help the service continually improve.

People who used the service, relatives and other professionals told us the registered manager was well thought of, approachable and that the home provided a good service. The atmosphere was described as good and people said they would recommend the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People who used the service and their families told us they felt safe.

Staff were recruited safely and there were enough staff on duty to care for people safely.

Staff knew how to safeguard people and administered medicines safely.

People lived in a safe and well maintained environment.

Is the service effective?

Good

The service was effective.

Staff were provided with training and supervision relevant to their roles and felt supported by the registered manager.

The service followed the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's dietary needs were assessed and regular meals, snacks and drinks were provided. Special dietary needs were catered for when needed.

The service sought advice and support from health and social care professionals when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and maintained people's dignity. We saw people receiving kind and individual support from staff.

People were able to maintain relationships, with visitors made welcome.

People were supported to make decisions and choices about their day to day lives, such as daily routines, where they spent their time and what they ate and drank.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and planned. Staff knew about people's needs and provided responsive care.

The manager had identified that the information in care plans could be more detailed and person centred and was working towards this.

A complaints procedure was in place and complaints had been responded to effectively.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. They were known and well thought of by people using the service, relatives and staff.

Effective systems to monitor, assess and improve the quality of the service were in place. These included opportunities for people using the service, relatives and staff to provide feedback.

People told us the home was a pleasant place, with a good atmosphere.

The Terrace

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 2 February 2016 and was unannounced. The inspection team consisted of one inspector and a specialist professional advisor (SPA). The SPA for this inspection had experience of managing care services and working with people living with dementia and mental health difficulties. This experience included assessments relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Before the inspection we reviewed all of the information we held about the service. We looked at notifications we had received from the service. Notifications are information about changes, events or incidents that the provider is legally obliged to send us within the required timescale. We asked the local authority (LA) commissioning team for feedback about the service. We also contacted Healthwatch. Healthwatch represents the views of local people in how their health and social care services are provided.

The registered provider had completed and submitted a provider information return (PIR) in June 2015. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with nine people who used the service, seven relatives and a friend/visitor. We also spoke with two healthcare professionals who regularly visited The Terrace and worked with the people who lived there. We spent time observing how people spent their time and the interactions between people and care staff. We looked around communal areas within the service, and we saw a small selection of people's bedrooms, with their consent.

We spoke to the registered manager, deputy manager, a senior care worker, four care staff, the hairdresser and the cook. During the inspection we reviewed a range of records. This included four people's care records, including care planning documentation and medication records. We also looked at staff recruitment and training records, records relating to the management of the home and a variety of policies

and procedures.

Good

Is the service safe?

Our findings

All of the people who used the service, relatives, health professionals and staff we spoke with were unanimously of the opinion that The Terrace provided a safe and caring place for people to live.

We looked at the arrangements that were in place for managing allegations or suspicions of abuse and managing concerns. Staff told us that they had been trained on how to identify and respond to abuse. The training records we saw confirmed this. Staff we spoke with were able to describe the different types of abuse, how they would report any concerns and said they felt comfortable and confident raising any concerns with the registered manager. We looked at the way recent safeguarding concerns had been raised and handled by staff. We found that the incidents had been reported appropriately, with actions taken to help keep people safe. This included the review of people's care needs and involvement of other professionals.

We found that staff were recruited safely and people were protected from unsuitable staff being employed at the home. We checked the recruitment records for three recently employed staff members. The records showed that a thorough recruitment process had been followed. This included interviewing prospective staff, obtaining written references and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, helping employers make safer recruiting decisions. Proof of identification had also been obtained.

People who lived at the home and their relatives told us that staff were usually available when needed and responded to calls for assistance. This was confirmed by our observations. For example, we saw staff supervising communal areas during our visit to ensure that people were safe and cared for. One person told us that sometimes staff did not respond to their call bell as quickly as they would like and others said that staff sometimes seemed busy, but that this was not something that had caused them any particular difficulties. Staff felt that, although they could be busy at times, the home was staffed safely and appropriately. The only problems arose if there was sudden, unexpected sickness, but that bank staff [staff who were employed by The Terrace, but did not work at the service on a regular basis] were available and used to cover this wherever possible.

We spoke with the registered manager about staffing levels and looked at staff rotas. The registered manager was able to describe how safe staffing levels were determined using a dependency assessment tool and staffing guidance. The home did not have any care staff vacancies at the time of our visit and bank staff were employed to provide flexibility and additional support when needed. At the time of our visit 35 people were receiving care. During the day two senior care staff and four care staff provided care. At night two senior care workers and two care workers provided care. Ancillary support from domestic, maintenance and administrative staff was provided in addition to these care staff numbers. The registered manager was supernumerary and supported by a deputy, who also had supernumerary management hours allocated each week. This meant that management staff had allocated time to concentrate on management tasks.

We looked at the arrangements that were in place to ensure the safe management, storage and administration of medicines. We spoke with the two senior care staff on duty, who were responsible for administering medicines. Both confirmed that staff who administered medicines had received training, including a recent 'refresher' to keep their knowledge up to date.

The senior care staff were both able to answer queries about people's individual medication needs and describe safe practices for handling medicines that required special arrangements, such as Warfarin. We also observed some very good interactions between the staff member administering medicines and people who used the service. For example, staff pleasantly asking if the person wanted to take their medicines and giving explanations. Staff gave one person space to take their medicines independently without staff standing over them, while watching from a discreet distance to ensure that the medicine was taken. When asked about this the staff member told us that this person did not like staff staying and watching them take their medicines, so they respected this while still ensuring the medicines were taken safely.

Medicines were stored safely, including arrangements for the storage of drugs that are liable for misuse [sometimes called controlled drugs]. We looked at a sample of people's Medicine Administration Rercords (MARs) and the controlled drugs register. Each person's MAR included a photograph, relevant personal information and information was available to help staff administer medicines prescribed on an 'as required' basis. When we checked the stock of some medicines available against administration records, the stock and records tallied correctly. A recent audit by the home's pharmacy provider had not raised any significant concerns. People received their medicines safely and as prescribed.

The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering each individual person's care. For example, risk assessment and risk management plans were in place to help identify individual risk factors, such as safe manual handling, falls, nutrition, and maintaining skin integrity. These had been reviewed regularly to identify any changes or new risks.

Records were available to show that premises and equipment were regularly checked and maintained in safe working order. Our observations showed that the service was clean and well maintained. The communal areas were furnished comfortably and pleasantly decorated. There was also evidence of work being completed to improve the environment for people living there. For example, the patio area was being re-laid and a new hand rail was being installed, to ensure the area was safe for people to use during the coming spring and summer.

A maintenance person was employed and described the systems in place to ensure that routine and urgent maintenance tasks were identified and completed in a timely way. A schedule of daily, weekly, monthly, quarterly and annual safety checks was in place, with records confirming these had taken place. An external contractor had completed a fire risk assessment in August 2015 and an action plan was in place. This showed the registered manager had been working on completing the recommended actions. The fire alarm and other fire equipment had been checked and serviced appropriately. A 'traffic light' system was in place to identify the support individuals would need to safely evacuate the building in an emergency.

Accidents and incidents were recorded. These were reviewed and analysed by the registered manager each month, to ensure that appropriate actions had been taken and to identify any trends or further actions that were needed. The registered manager was aware of notification requirements [events that the service is legally required to tell us about] and we had received appropriate notifications from the service.

Good

Is the service effective?

Our findings

People told us that the Terrace provided them with the care and support they needed. People also felt that staff were competent and pleasant. For example, one person who used the service told us, "The staff are very good, I've no complaints." A visitor described how the person they visited always appeared to be clean and well cared for. One relative told us, "Staff are well trained, they look after [name of person] very well."

All of the staff we spoke with told us about the home's e-learning system, which staff could access from home if required. A computerised training system provided up to date training information that the registered manager could monitor, to ensure that staff were up to date with required training. Training records showed that staff had completed training on dementia care, fire safety, food safety, health and safety, manual handling, infection control, the Mental Capacity Act and safeguarding adults, including refresher training. We saw evidence on one of the staff files we looked at showing that the registered manager had given staff a formal written prompt to complete training that was due. This showed that training was being monitored to ensure staff had the skills they needed.

The registered manager was aware of the new Care Certificate training for staff and able to explain and show us how this was being implemented as part of induction training. The Care Certificate is a recognised qualification which aims to provide new workers with the introductory skills, knowledge and behaviours they need to provide compassionate, safe and high quality care. Overall we found that staff had the skills and knowledge required to support people who used the service.

The staff we spoke with had received regular supervision as well as annual appraisals of their performance. Staff told us that they felt supported by the registered manager and could seek support when needed. The supervision records we looked at showed that staff received a detailed and formal supervision session when these did take place.

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). 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.

The service had in place a policy outlining the principles of the MCA and how people should be supported with decision making. Training on the MCA was provided to staff, although when we spoke to staff regarding the MCA and DoLS their knowledge and confidence varied. The registered manager had undertaken training on the MCA and was able to describe the main principles of the act and how they involved people as much as possible in making decisions about their care. They were also aware of the DoLS and how to apply for

authorisations when someone was being deprived of their liberty. At the time of our visit eight people were being deprived of their liberty. The manager had applied for DoLS authorisations for 12 others, who were still awaiting assessment by the authorising body. We saw the records relating to these authorisations and applications.

We saw staff consult people and seek their consent throughout the inspection. For example, we saw staff offer people choices and explanations, such as choices of meals and drinks, and that people spent their time in different places, depending on personal preferences.

We looked at how people were supported to maintain their nutritional wellbeing. People living at the home and relatives told us that the food was generally good and plentiful. People said they had enough to eat and drink. One person told us, "I get as much choice as I want; it is very good that way." Two people told us that although the food was good, they felt the menu was, "Repetitive." This was particularly felt to be the case with the teatime meal when soup and sandwiches featured very regularly. Menus showed that there was always a choice of meals provided, although one of those choices at tea time was usually soup and sandwiches.

We spoke with the cook, who was able to describe people's dietary needs and how these were met. For example, one person required a gluten free diet. Others had foods fortified with cream and butter and high calorie shakes to help build them up. The food we saw being served looked appetising and appealing. The menu was displayed on the tables and people were offered a choice of the two dishes on offer. Where people had difficulty understanding or making a choice staff showed them the food to help them make a decision. Throughout our visit we saw people being offered and provided with drinks. For example, people had drinks within reach and we saw people being offered hot and cold drinks throughout the day. One person told us, "They [staff] are here all the time and serve tea all day."

The care records we looked at included nutritional risk assessments. These assessments included regular weight monitoring and helped to identify anyone who was at risk due to poor nutrition or weight loss. The computer records system was able to display people's weight and nutritional monitoring information in a helpful visual way, which made it easy to identify weight gain or loss. We also saw evidence of the involvement of the doctor, dietician and speech and language therapy team where there was concern about a person's nutritional wellbeing.

We saw evidence that the service liaised with relevant health care professionals based on people's needs. People who used the service also told us that they had access to doctors and other health and social care professionals when needed. For example, one person told us, "The doctor comes every week and calls specially if needed, and there are plenty of district nurses coming in."

Two health care professionals visited the home during our inspection. Both confirmed that they were called when needed and regularly involved in people's care. Both told us that staff knew people well and followed their instructions to ensure people's health needs were met. Comments made by one of the healthcare professionals included, "If I end up in a home I'd like it to be this one." The other healthcare professional told us, "I find them [the staff] very helpful. Their practices are good. I have no problems, I do like it here." Visits by doctors, nurses and other relevant professionals were recorded in people's care records.

Good

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. All of the people we spoke with were complimentary about the approach of staff and how they treated people. For example, one person described the staff as, "Lovely people who will help you, every minute of the day." Other comments made by people about staff included, "They [staff] are kind, very helpful." And, "Respectful and very helpful." One person told us, "The staff speak respectfully, there is no nastiness or meanness." One visitor told us, "The staff are caring and I would not mind moving in myself."

We observed the care and support people received during our visit. We saw that staff treated people well. For example, we saw staff explaining what was happening and giving people choices throughout the day. When care tasks were carried out, such as moving and handling, we saw staff offering explanations and reassurance throughout. We also saw several examples where staff knew people's individual preferences and respected these in a caring and thoughtful way. For example, providing privacy while someone took their medicines and knowing the best way to speak with one person so they could hear them. Throughout our visit there was a friendly and homely atmosphere evident, with people appearing comfortable.

During our visit we observed that staff ensured people's dignity and privacy was respected. During our inspection we observed staff knocking on doors before entering and ensuring that care was carried out in private. Staff we spoke with were able to describe to us how they helped to maintain people's privacy and dignity, by giving people as much privacy as possible during care tasks and ensuring doors and curtains were closed.

We looked at the arrangements in place to support people in maintaining relationships. During our visit we spoke with people who used the service, their relatives and friends and observed people visiting throughout the day. People told us that there were no restrictions on visiting and that staff were welcoming and supportive of people's relationships. For example, one relative told us how the home had provided a three course meal in a private lounge on their wedding anniversary, so that they could celebrate the special occasion with their loved one. Another visitor told us, "They [the staff] are fantastic and I can come [visit] any time." Records showed that staff training had included equality and diversity, to help staff understand and support different relationships within the home.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives. We saw that people had their own routines and preferences respected and that the staff we spoke with were aware of these details. For example, we saw one person brought into the lounge in a wheelchair and the staff member asked them, "[Name of person], would you like to sit in your comfortable chair?" Some people spent time in the communal areas while others spent time in their own rooms, according to their preference. We also saw people being offered choices regarding their meals and drinks.

One person was receiving end of life care. Staff explained how medicines had been prescribed in advance, in case they were needed quickly to reduce the person's distress. Staff explained how this could reduce

unnecessary delays and ensure the person was comfortable. They told us, "We just have to call the district nurse and they'll come and give it [the medicine]." Both staff had completed end of life care training and were able to describe in detail how they looked for non-verbal indicators of pain, such as facial expressions, resistance to being moved or crying out to ensure that the person was comfortable and cared for at the end of their life. The staff also told us that a local practice nurse was working with the home, to look at how they could improve the interface between the home staff and community nursing services, to ensure people received the best possible care.

Good

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure that people received person-centred care that had been appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person. People we spoke with and their relatives expressed satisfaction at the level of care provided. For example, one person who lived at the home told us, "They look after people as individuals." A relative told us, "The staff listen to you and they will get you something if you want it."

During our visit we saw staff assisting and interacting with people in an individual way. For example, staff addressed people by name and greeted them pleasantly when they came into the room or were close by. We also saw staff being attentive and responding to people well. For example, a staff member assisting someone to get more comfortable, saying, "I'll just put your chair down for you [name of person]." The staff we spoke with knew people well and could answer any questions or queries we had about people's individual care needs.

During our visits we looked at the care plans and assessment records for four people. The home used a computerised system for care records, accessed through computer stations situated throughout the home. The care records we looked at all contained assessments, risk assessments and care plans covering key areas of care, such as nutrition, manual handling and skin integrity. The risk assessments had been reviewed and updated regularly to ensure that risks to people's wellbeing were monitored. The care plans contained information about people's care needs, so that staff knew how to care for people.

Regular evaluations of people's care plans had been completed, to review people's needs. However, the care plans we looked at lacked detail and in some case information recorded in the evaluations had not been added to people's main care plans. This meant that staff could only be sure that they had a full picture of people's care needs if they read the care plan and all of the evaluations. We also saw that there was not a lot of information in people's care plans about their involvement in decision making, capacity or consent, other than that relating to specific DoLS authorisations that were in place. We discussed this with the registered manager during our visit, sign posting them to guidance such as the Social Care Institute of Excellence's report 'The Mental Capacity Act (MCA) and care planning.' They had already highlighted the need to improve the detail contained within people's care plans in their service improvement plan, following recent audits, and were working with staff to make improvements.

We looked at the arrangements in place to help people take part in activities, maintain their interests and encourage participation in the local community. This had been an area highlighted for improvement in a recent satisfaction survey completed by the home, and was part of the service's improvement plan. One person told us "There is singing, playing bingo, and I like painting. I help out the lady who does the job [the activities coordinator]." Another person told us, "Lots of different things go on." A regular visitor told us, "There is always something going on and in summer they [people living at the home] get outside." Throughout our inspection we saw relatives and visitors coming and going, and one visitor told us how they visited very regularly and could have meals with their relative if they wished.

Some people were happy with the activities provided, while others would have liked more to do, the main complaint being that the other people living at the service didn't want to join in and that more trips out would be welcome. The home had recently employed a new member of staff to help coordinate activities and social events. During January 2016 this staff member had held a meeting with people who used the service to discuss activities and the changes people would like to see. It was planned that these meetings would become a regular event. As a result of the meeting arrangements had been made to make a mini bus available once a week, so that more trips out could be arranged during the spring and summer.

A weekly programme of activities was on display and included a movie and popcorn afternoon, games, singers, movement to music, puzzles, reminiscence and beauty therapy sessions, such as hairdressing and nail care. During our visit we saw the activities coordinator assisting people to the hairdresser and doing nail care, as described in the activities programme. There were also other links with the local community, through visits by the local church, a visiting library, the delivery of newspapers and a volunteer who visited regularly to provide company to a person living at the home.

We looked at the arrangements in place to manage complaints and concerns. Everyone we spoke with, including people living at the home, relatives and staff, stated that they felt able to raise any concerns with the manager. They felt that they were listened to and responded to. Information about the complaints procedure was available in the service's reception area, where people could easily see it. Information about raising concerns and complaints was also provided each bedroom, within the service user's guide to the home.

There had been five complaints over the last year. A record of these and the actions taken to resolve them was available. We looked at the most recent complaint and saw that it had been resolved appropriately. This had included the registered manager meeting with the complainant to discuss the situation and taking actions to resolve the situation.

Good

Is the service well-led?

Our findings

We looked at the arrangements in place for the management and leadership of the service. At the time of our inspection visit, the home had a registered manager in place who had worked at the service since October 2012. A registered manager is a person who has registered with CQC to manage the service.

During the inspection we received feedback from people who used the service, relatives, visiting professionals and staff that the registered manager was well thought of and very approachable. People knew who the registered manager was and felt able to go to them to discuss issues or concerns. People felt that the manager listened to them. One person told us, "I know [name] is the manager and she comes in to speak with you." A relative told us, "It is a very nice place….I do recommend this home." One staff member we spoke with described the atmosphere within the home as "Excellent" and the management as "Supportive".

Throughout our visit the registered manager was open and provided the information and explanations we asked for. The registered manager told us they felt well supported by the registered provider and had received support and supervision from senior management. They described having daily contact with their line manager by phone and a monthly manager's meeting, where support was available from other home managers within the Care UK group of homes. A new initiative had recently started where registered managers completed audits on each other's homes, to provide additional oversight and share good practice.

Arrangements were in place to gather feedback from people who used the service and their relatives. Satisfaction surveys had been completed with people who used the service, relatives and staff during 2015. The results of these surveys were available in a report and provided to us. The registered manager told us that the survey was an annual event, with results and actions displayed in the home for people to see. Meetings had commenced to try and involve people who used the service in the development of social activities and events at the home. 'Resident and relatives' meetings had taken place during 2015, but had not taken place recently. We discussed this with the registered manager, who informed us that attendance at these meetings had been very poor, despite trying different times. Instead they tried to offer an 'open door', and encouraged people to come and see the manager whenever they needed to, rather than wait for a formal meeting.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services. A service improvement plan had been developed, and set out the key areas for development and improvement for the year. A schedule of planned audits was in place for the coming year, with a monthly topic of focus. During the year this planned focus included medicines, health and safety, nutrition, tissue viability, documentation, infection control and other relevant areas of practice.

The registered manager completed monthly management reports, which were submitted to senior management for oversight and review. These reports looked at the occurrence of pressure ulcers,

safeguarding incidents, medicine errors, deaths, infections and hospital admissions. The registered manager also showed us the records of regular checks that were completed on the premises and equipment, to ensure the service was safe and maintained in good order. Regular medication audits and checks had been completed, along with competency checks to ensure staff administered medicines safely. Where improvements had been identified there was evidence of staff taking action. For example, implementing the disciplinary process and re-training staff following an issue that had occurred with medicines.

We looked at the standard of records kept by the service. Overall the majority of records we viewed at the service were up to date, accurate and fit for purpose. Where more detail about person centred care and user involvement was needed in care records, this had already been identified as part of the service's governance systems and included in the service's improvement plan.