Rutland House Care Home Limited

Rutland House Care Home

Inspection report

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16 November 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 14 and 16 November 2017 and the first day was unannounced.

At our comprehensive inspection on 11 October 2016, we found the provider was not meeting legal requirements in relation to safe care and treatment and good governance. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, safe and well led, to at least good. We undertook a focused inspection on 8 March 2017 to check the provider had followed their action plan and to confirm that they now met legal requirements. We found the provider had taken all the necessary action to make the necessary improvements and improved the overall rating to good.

Rutland 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.

Rutland House care home accommodates 20 people in one adapted building. Accommodation is provided on two floors with stair lift access. The service specialises in the care and support of older people who may be living with dementia. At the time of our inspection there were 17 people living at the home.

At this inspection we found the service remained Good. The registered provider demonstrated they continued to meet the regulations and fundamental standards.

People continued to feel safe and well cared for at Rutland House. Staff knew how to recognise and report any concerns they had about people's care and welfare and how to protect them from abuse. Risks to people's health and safety were managed and staff took action to minimise these and keep people safe.

Appropriate recruitment checks were completed to make sure staff were suitable to work at the home. The staff were given ongoing training that enabled them to meet people's different needs and keep up to date with best practice. Staff were supported appropriately through regular supervision and reviews of their performance.

People's needs were fully assessed and kept under review. Care records were person centred and clearly described people's needs and risks and how these were to be managed. Care plans provided important information about people, their background histories and preferences. Staff had a good knowledge of people's care needs and personalities. People's wishes, choices and beliefs were reflected in their care plans. People were supported to make decisions and staff encouraged their independence as far as possible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff showed

understanding, patience and treated people with compassion.

There were enough staff on duty day and night to make sure people's needs were met in a safe and timely way. People experienced care and support which was respectful, dignified and took into account their right to privacy and confidentiality.

People lived in a safe, clean environment that was designed and equipped to meet their needs. The provider planned to refurbish and decorate areas of the home and provide a more stimulating environment for people living with dementia.

Activities were arranged according to people's needs and interests and were meaningful for people living with dementia. Activities were organised by care staff and entertainers visited from outside the home. Staff understood the importance of social interaction and ensured they offered people support and companionship when needed.

People were supported to maintain relationships with family and friends who were important to them. Relatives and friends were welcome to visit when they wished and invited to join in with social events at the home.

People received the assistance they needed with eating and drinking and to maintain good health and wellbeing. Staff took prompt action when people became unwell and consulted other healthcare professionals for necessary advice and support. People received their medicines as prescribed and medicines were stored and managed safely.

People received dignified care at the end of their lives and their wishes were known and understood by staff. Staff were trained and worked alongside healthcare professionals to support people with their needs and experiences.

There was effective leadership and people, relatives and staff told us the home was well run. People and their relatives found the service continued to be welcoming, open and inclusive. They were given regular opportunities to share their views about the quality of care. Any concerns or complaints were acted on and the provider used feedback to improve the service.

Staff were positive about their experience of working at Rutland House. They knew their roles and responsibilities and felt supported by management and each other.

Management and staff completed regular audits to monitor and check the quality and safety of the service. Where improvements were needed or lessons learnt, action was taken. The provider worked in partnership with other agencies to support the development of joined-up care.

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 remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Rutland House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 14 and 16 November 2017 and the first day was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make. We took this information into account when we inspected. We also reviewed other information we held about the service such as notifications, complaints and safeguarding information. A notification is information about important events which the service is required to send us by law.

We spoke with 11 people using the service and five of their relatives or representatives. We observed the care and support being provided to people. Along with general observation, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the director, eight members of staff including a cleaner and the chef. We also spoke with two visiting health and social care professionals. We reviewed care records for four people using the service. We checked personnel records for three staff members recruited in the past six months and information about staffing levels, training and supervision. We looked around the premises and at records for the management of the service including quality assurance systems, audits and health and safety records. We also reviewed how medicines were managed and the records relating to this.

Following our inspection, the director sent us information we had requested about staff training and recruitment, infection control and quality assurance findings. We also spoke with a person's relative and a community nurse who had involvement at the service. They agreed for us to use their feedback comments in

our report.

Good

Is the service safe?

Our findings

People continued to receive care and support from staff in a way that maintained their safety. All the people we spoke with said they felt safe in the home. One person told us, "At night, I feel safe also, as there's always someone near." Relatives shared similar views and felt their family members were kept safe. Their comments included, "She has been absolutely safe in the time she has been here", "I've never seen any mistreatment of residents" and "It was a relief her coming here as she was not safe at home."

Staff we spoke with understood their responsibilities to protect people from abuse or poor care. They knew what signs to look for and what action to take if they had concerns about a person's welfare or safety. Staff completed training to support their understanding and keep up to date with best practice. Information was displayed for people, visitors and staff to report any concerns. Policies and procedures were in place to guide staff on how to protect people from abuse. Information in the PIR supported what we found and what staff told us.

People had freedom to move around and staff were available if they needed support or assistance to walk. Our observations supported this. Staff were always present in the communal areas and used appropriate techniques to help people mobilise. One person told us "I like the freedom to go to my room or not" and another person said, "I can go out, but with someone." A relative commented, "The staff do get help when moving her." Staff showed good knowledge about the risks people faced such as how to prevent falls and making sure people had regular drinks to reduce the risk of urinary infections. People who were at risk of falls had equipment such as sensor mats to alert staff they needed help with mobilising. Call bells were in working order and were within reach of people's beds. People said staff responded promptly when they needed to use their calls bells.

There was information about people's assessed risks including those associated with falls, nutrition and skin care. Risk assessments were updated regularly or as people's level of dependency changed. Some people needed support when going out in the community and to manage their finances. We noted there was no information about the risks associated with these activities and discussed this with the director. Shortly after our inspection the director confirmed that personal risk plans had been put in place.

Accidents and incidents were managed in a way which protected people from the likelihood of them happening again. The director maintained an analysis of falls or accidents to determine patterns or trends and take preventative action. Records showed that staff learnt from events and action was taken to improve safety. For example, people were referred to other healthcare professionals when they were prone to falls.

People were protected from the spread of infection and the environment was kept clean and tidy. Dedicated staff were employed to clean the communal areas, bedrooms and bathrooms. People confirmed that the domestic staff attended to their rooms daily. Staff followed effective infection control procedures when supporting people with their personal care needs. Hand hygiene guidance and liquid soap were provided throughout the home and staff wore gloves and aprons when necessary. Arrangements were in place for the safe storage and disposal of clinical waste.

Food hygiene practice was safe and staff understood their responsibilities. We found the kitchen area and equipment was clean and well maintained. Food items were stored appropriately, had been labelled after opening and staff maintained records of food and fridge/freezer temperatures.

The premises was checked and maintained to help ensure the safety of people, staff and visitors. Health and safety checks were routinely carried out in the building. Appointed contractors completed regular maintenance and servicing of fire, gas and electrical safety. Equipment was tested that it was safe for people to use. This included checks on wheelchair safety, the stair lift, pressure relieving equipment, hoists and adapted baths. Windows had appropriate restrictors and radiators were covered to reduce the risk of people coming to harm.

There were sufficient numbers of staff on duty and staff worked flexibly to meet people's support needs. People's comments about staffing levels included, "There are enough staff, they are always on hand","I've not needed to call for help but there is always someone there" and "On the whole, I feel there are enough staff working here." Relatives told us there were always staff around when they visited and people received support when they needed it. Our observations supported this and staff were available to provide people with timely care and support.

When we inspected, recruitment was underway for two additional care staff. There were systems in place to monitor and respond to staff vacancies, sickness and absence. Any shortfalls in staffing levels were covered by existing staff and regular agency staff. This ensured people experienced consistency and were cared for by staff who knew them.

Appropriate recruitment checks were undertaken to confirm staff were of good character and had the right skills and experience to support people. This included a criminal records check and two employment references. In some staff files, we found that details of previous employment history were incomplete and any gaps had not been explored. We raised this with the director who took prompt action and arranged to meet with the identified staff to clarify and document the gaps. Following our visit, the director confirmed that they had obtained the required information and all staff files had been checked for completeness.

Medicines were managed in line with national guidance and people received their medicines safely. One person told us, "I am given my medication and they watch me take it" and another person said, "My medication is always there when I need to take it." Medicines we checked for people corresponded with their medicine administration records (MARs). There were no gaps in the signatures for administration and staff completed daily audits of people's prescribed medicines to minimise the risk of error. Staff had information about how people preferred to take their medicines as well as any known allergies or side effects. They completed training and their competency to administer medicines was checked every year to make sure practice was safe. The GP and pharmacist completed a review every six months to make sure people were receiving the right medicines.

Medicines, including controlled drugs, were securely stored and at the correct temperature. There was a system for checking all prescribed medicines and records for their receipt and disposal. Policies about medicines including covert administration were in place and understood by staff. (Covert is the term used when medicine is administered in a disguised way that is in the person's best interest and when they don't have the capacity to consent).

Good

Is the service effective?

Our findings

People continued to experience effective care and support. Full assessments were undertaken by the registered manager or director before people moved to Rutland House. This enabled them to determine what support and care people wanted and required. Relatives we spoke with said they were involved in the assessment process and any reviews thereafter. Records supported what they told us. People and their relatives felt confident in the care provided by staff and that staff knew their care needs well. Their comments included, "Staff seem well trained", "The staff do seem good at their jobs" and "I definitely think staff do know her needs."

Staff completed regular training to keep up to date with best practice and extend their skills and knowledge in meeting people's needs. Staff told us about recent training that had helped them in their work and furthered their knowledge. Examples related to dementia care, behaviour management and stoma care. New staff completed the Care Certificate, a nationally recognised framework for good practice in the induction of staff. Induction included a period of time working with more experienced staff until they were confident they had the skills to work independently. Comments from staff included, "We get on the job training and are required to do e-learning" and "The manager oversees the training, for example, fire training and falls."

Staff demonstrated knowledge of how to care for people in the right way. Examples included how to correctly assist people who experienced reduced mobility, who were at risk of developing sore skin or who needed help to eat and drink well. Staff were supported to improve the quality of care they provided to people through direct observation of their practice. This included staff capability when using moving and handling techniques or administering medicines. Staff files contained evidence of induction, supervision and yearly reviews of their work performance. Supervision meetings included discussions about people's care and support as well as individual learning or development needs.

People were supported to eat and drink well and offered a choice of varied meals. Comments from people include, "The food is very good", "We do get plenty to drink", "I've been very happy with the food here" and "There's good variety and it's always warm." We observed the mealtime was relaxed and unhurried and people were offered food and drink choices. Meals were well presented and staff explained what the food was when serving people. Staff supported people appropriately where they needed help, taking time to chat and encourage people to finish their meals.

The chef was familiar with people's dietary needs and their personal preferences. They explained people were offered a choice and they prepared alternative meals if people didn't like the menu options. Care plans recorded when people had specific needs and how staff should support them at meal times. For example, there was information to prepare food to the right texture where people were at risk of choking. Staff were aware of the importance of good nutrition and how to manage risks around eating and drinking. Monitoring charts were used where people experienced appetite or weight changes and staff involved other professionals if there were concerns.

Arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included use of the Vanguard 'red bag' initiative set up by the local authority. The red bag contained important information about a person's healthcare needs should they need to go into hospital in an emergency. This helped ambulance and hospital staff determine the person's needs and provide effective treatment promptly.

People told us they received effective support with their health care needs and saw a range of community professionals. These included GPs, chiropody service and the community nursing team. One person told us, "The doctor is called when I'm not well." Care records provided staff with accurate information about people's healthcare needs and included guidance and advice made by other professionals.

People received care and support in an environment that was suitably designed and maintained. Aids and adaptations had been provided to help maintain people's safety, independence and comfort. This included hoists, adapted baths and beds, walking frames and wheelchairs. Picture signage enabled people to move around the building confidently. For example pictures of toilets on bathroom doors to help people recognise where they were. Bedrooms were comfortably furnished and personalised to reflect people's individuality as well as meet their needs. Parts of the premises were due to be updated and redecorated. The provider had an ongoing refurbishment plan in place to support this. The director told us they were also planning to improve the environment for people living with dementia.

The Mental Capacity Act (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.

Staff understood the need to obtain consent and people's right to refuse. We saw and heard staff explain what they were going to do before support was provided. People's feedback also confirmed this. One person told us, "Staff do talk to me when dealing with me" and a relative commented, "I've seen staff ask residents' permission before attending to them."

People's capacity had been assessed and applications made to the local authority under DoLS where needed. For people who were subject to DoLS, appropriate records were maintained and kept under review. Where people were unable to make decisions about aspects of their care, staff were guided by the principles of the MCA to make decisions in the person's best interests. Records showed involvement from people's family, staff and external professionals. Relatives confirmed they were involved in decision making where people were unable to contribute. Policies and guidance were available to staff about the MCA and DoLS and all staff had received appropriate training to support their understanding.

Good

Is the service caring?

Our findings

People were supported by patient, compassionate and caring staff. Comments we received from people and relatives were all positive about the care provided. These included, "I like all the girls (staff), it's a happy place to be", "All the staff are lovely, so attentive" , "They (staff) do look after us well" and "Staff are lovely, they are very kind to Mum." People described staff as "kind and likeable", "very nice" and "so caring." One relative told us, "Nothing's too much trouble. Staff are friendly and always helpful." Another relative said they would recommend the home and commented, "The care is fantastic."

Our observations supported what people told us. Staff were friendly and treated people with kindness and respect. People and staff spent time sitting together, chatting and sharing jokes. We saw positive conversations and interactions that promoted people's wellbeing. Staff used gentle touch and clear language when communicating with people living with dementia. People were encouraged to engage in discussions or activities that interested them. People looked relaxed in the company of staff and smiled when staff approached them.

Staff showed patience in their approach. When people were supported to walk or transfer from their chair, they were supported to move at a pace that was comfortable for them. At lunch we heard one member of staff reassure a person by saying, "Take your time, there's no rush." Staff were attentive and gave emotional support when people needed it. Staff held people's hands to let them know they were listening and provide reassurance or comfort to individuals.

People were supported to express their views and make choices and decisions about their care as far as they were able. Care records included detail about people's likes, dislikes, personal history, preferred routines and what was important to them. Relatives told us they were asked for information about their family members' backgrounds and life history. A member of staff told us this was useful for building up a relationship with people which was based on their interests. They explained how they supported a person to join in with dancing as the person used to be a dance teacher.

Other discussions with staff showed they knew people's preferences and routines well. Staff shared examples of this. They spoke about one person's favourite colour clothing they liked to wear, people's previous careers and hobbies, what people enjoyed eating and times they liked to wake and go to bed. During our inspection, staff supported people to make decisions such as asking people where they would like to sit, what their food and drink choices were and whether they wanted to join in with activities.

People felt that staff respected their independence and rights to privacy and dignity. One person told us, "I do feel at freedom in here, independent" and another person said, "I have been encouraged to be independent." A relative told us how staff had kept their family member mobile for as long as possible before the person's health had deteriorated. During lunch and activities, we observed staff offering reassurance and guidance rather than doing things for people. Care records described the level of support people needed and what they could manage on their own.

People were appropriately dressed and had been supported with their choices regarding clothes, hairstyle and accessories that were important to them. Staff addressed people by their preferred names and assisted individuals with their personal care needs in a dignified way. We saw staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms. People's private information was kept confidential and records kept secure when not in use. Feedback from relatives also supported this. Comments included, "They are very respectful, like not talking in front of others" and "If I am in Mum's room, they always knock before coming in." People's rooms were personalised with their belongings, memorabilia and photos or possessions that were meaningful to them.

Good

Is the service responsive?

Our findings

People continued to experience a personalised service and remained confident that staff understood and met their needs. One person told us, "Yes, I do feel I'm getting the care I need." A relative told us, "The thought of putting your Mum in a care home is daunting but they have made it a lot easier." They told us how their family member's wellbeing had improved significantly since moving in. They felt this was because their relative was eating better and medicines they were prescribed had been reduced. A visiting professional told us, "(The director) and staff understand dementia and know the residents very well."

People's individual support needs had been fully assessed prior to moving in. Assessments and care plans included person centred information about people's needs and explained the support people required for their physical, emotional and social well-being. Care plans were current and staff said they provided the information they needed to know about people's care and support needs. Relatives were asked about people's life history and this was included in the care records. People had profiles that reflected individual preferences, how they liked their support, their needs and background information including previous hobbies. These profiles gave staff information about the person and their identity.

People's diverse needs were understood and supported, discussed as part of the admission process and recorded in the care plans. Staff had completed equality and diversity training and knew how to support people's cultural, religious and personal needs. They gave examples of this such as providing preferred cultural meals and respecting people's faith or beliefs. Members of the staff team spoke other languages and were able to support people where English was their second language.

Plans were reviewed at least monthly or more frequently where a person's needs had changed. For example, following an illness, an incident or accident, a medicines review or time in hospital. Staff obtained support of healthcare professionals when needed. A referral had been made to the community mental health team following a change in one person's behaviour. Staff completed daily records about people's health and well being and shared information at each shift change. This ensured staff were made aware of any changes concerning people's care and support.

Activities were organised to promote people's well-being and reduce the risk of social isolation. People and relatives spoke positively about the activities and the choices available. Their comments included, "The entertainment is variable","I like the dogs visiting","There is enough entertainment in here to suit me" and "There's plenty to do here, but you don't have to do anything if you don't want to." One person told us they liked to play the piano. Some people said they enjoyed watching rather than joining in with activities and staff respected this.

During our inspection there was a lively atmosphere in the main lounge and staff supported people with group and individual activities. These included ball games, bingo, chair exercises, music and dancing. There were a variety of resources available for people to engage with such as puzzles, board games and reading material. We saw people smiling and laughing with staff and each other. Some people enjoyed holding and touching sensory items such as soft toys, blankets and dolls. Sensory and tactile activities can provide

comfort for people living with dementia and help alleviate anxiety.

There were other meaningful activities for people living with dementia. External visitors held weekly reminiscence sessions where people were encouraged to reflect on events or activities from their earlier years. An organisation visited the home to provide live music with songs from classic films and musicals. People were supported to acknowledge events such as remembering people who fought in the war. People also took part in day to day tasks such as washing up, laying tables and folding laundry. Staff told us this helped empower people and gave them a sense of purpose.

People were supported to maintain relationships with those close to them. Relatives told us they could visit at any time and were always made to feel welcome. They confirmed that staff always kept them up to date with issues concerning their family member. Comments included, "The manager rings me at the drop of a hat" and "They keep me well informed about Mum's condition." Relatives were invited to social events such as parties and other celebrations. During our inspection, one person celebrated their birthday with their family.

People were supported at the end of their life with sensitivity and staff had attended training to give them the skills and knowledge to care for people appropriately. Records showed that the registered manager had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at the home. A relative spoke about the care and compassion staff showed at this difficult time. They also told us, "They moved her downstairs to suit her condition" and "The end of life care here is very good." A visiting professional told us, "The home is very engaged with the training" and said the director "has high standards with the documentation on end of life care."

Some people had DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) agreements in place. These are decisions made in relation to whether people who are very ill and unwell would want to be resuscitated or would benefit from being resuscitated, if they stopped breathing. The forms we checked had been completed correctly in consultation with the person, doctors, and family, where appropriate. This ensured that people's wishes would be carried out as requested.

People told us they had not needed to make a complaint but would inform staff if they were unhappy with their care. One person said, "I've had no reason to complain, but I would speak up if needed." Another person commented, "No complaints and never have." Relatives said they would go to the management if concerned about anything. Information about how to make a complaint was displayed and accessible to people and visitors.

The registered manager kept a record of complaints and concerns and how these had been dealt with. Where issues or complaints had been raised, these had been recorded accurately along with a full report of the outcome and any action taken in response. This included a letter of apology where needed. There had been one complaint about the service in the last twelve months. Records confirmed that this was resolved.

Good

Is the service well-led?

Our findings

The same registered manager was in post since our last inspection. She was closely supported by a director with the management of the home. 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.

There was an open, positive culture within the service which involved people and their families, as well as staff. People, their relatives and staff felt the home was well managed. One person said, "I do feel they run the place well" and another person told us, "It's friendly here, the management is competent, they treat you as an adult." A relative commented, "I have complete confidence in the home." Another relative told us, "(The director) is very hands on and organised, she directs the troops well."

The registered manager and director took an active role in supporting people using the service and working alongside the staff team. The staff we spoke with were all very positive about working at Rutland House. One staff member commented, "I have job satisfaction and making a difference to people" and another staff member told us, "There's always someone to help, I'm very happy here." Staff spoke about good teamwork and supportive colleagues. They said the registered manager and director were approachable and they could go to them if they had any concerns. A member of staff described the director as "helpful and friendly." Visiting professionals told us there was effective leadership and communication.

The registered provider had clear values about the way care and support should be provided. These values were based on providing a person centred service that put people at the centre of their care. They included encouraging independence, enabling choice and maintaining dignity. Staff were aware of these values and management monitored that they applied them in practice through regular supervision and observation checks. The home's philosophy of care and values were displayed around the home.

Staff told us they were clear about their roles and responsibilities. They had designated duties to help support the running of the home. Handover meetings took place for staff between shifts to support continuity of care. Staff meetings were held regularly and staff said they were able to contribute their ideas. Records of these meetings showed clear discussions for keeping everyone up to date about people's care and support and developments in the home. To support staff in their roles, important information was shared and displayed. In the office, there was guidance and posters about eating well with dementia, preventing falls and urine infections and recognising sepsis. Staff told us this was useful in helping them identify and manage risks to people's health.

The service promoted and encouraged open communication between people, relatives and staff. Comments from people and relatives included, "They (management) always listen to you", "There has been a recent questionnaire" and "I feel sure I could bring something up, if I wanted." Questionnaires for 2017 were being analysed at the time of our inspection. Results from the previous survey in September 2016 reflected positive comments from people and their relatives. Responses ranged from "good" to "excellent"

with 7 of the 11 respondents agreeing they were "extremely likely" to recommend the service to others. The home had addressed the two areas where people felt the home could improve. These related to redecoration in parts of the environment and to increase activities for people.

We asked people what they thought the service did well. People's comments included, "The best thing for me is I'm not lonely", "I know I will be looked after here", "I feel cosy here" and "There is always someone here, I didn't like being on my own." Relatives told us they would recommend the home and had "peace of mind" that their family members were safe and well cared for. One relative said, "I couldn't ask for a better place for Mum to be."

The quality of the service continued to be monitored and check that people were safe and appropriate care was being provided. The director completed a monthly report on aspects of people's care such as nutrition, pressure damage, infections and reasons for hospital admissions. This enabled her to see where people's general health was improving or deteriorating and take appropriate action. For example, when a person lost weight or sustained a pressure sore, appropriate professionals were involved.

Other audits and checks included making sure care was consistently provided in the right way, medicines were managed safely and staff had the knowledge and skills they needed. People's care plans and risk assessments were reviewed and health and safety checks took place. These checks were undertaken weekly or monthly and looked at areas such as the environment and equipment, food safety, water hygiene, cleanliness and fire safety. Records were clearly maintained and showed what action was being taken in response to any shortfalls.

The service continued to work in partnership with other professionals and external organisations to achieve the best care for people. This included liaison with the local authority in order to share information and learning. One example was the joint working with the local authority to promote best practice in end of life care for people living with dementia. Professionals involved with this project told us the management and staff were very engaged with the training.

People benefitted from a well run service because management kept themselves up to date with current best practice. The director and registered manager attended regular learning events at forums run by the local authority. Information from these events was shared with staff through meetings and correspondence.

The registered provider understood their responsibilities in line with the requirements of their registration. They were aware of the need to notify CQC of certain changes, events or incidents that affect a person's care and welfare. We had been notified appropriately of any reportable events and the rating from the previous inspection was displayed in the home.

The PIR provided clear information about the service and what improvements had taken place or were planned. This showed us they had a good understanding of the service and their responsibilities in meeting the fundamental standards and regulations. Our findings from this inspection corresponded with what the provider told us in their PIR.