Mr & Mrs P Sohanpaul

The Red House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 October 2018. It was an unannounced visit to the service.

The Red House Nursing Home is a care home with nursing. It is registered to provide support to older people living with dementia, mental health and or physical disability. It can accommodate 32 people. At the time of our inspection 24 people lived at the home. The care home is in a rural village in north Buckinghamshire. Accommodation was over three floors. People had access to a small dining room and had a choice of two communal seating areas.

At our last inspection we rated the service good. However, we made a recommendation about ensuring people received effective care and records relating to care were accurately recorded. At this inspection we found some improvements had been made. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

People gave us positive feedback about their experience of the home. Comments included, "The staff here are lovely and [Name of person] is always very well looked after" and "They are very caring here and their approach is good" and "The good staff are fun as well as doing a good job."

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. We found some improvement were required to ensure decisions made for people who lacked capacity were made in line with the code of practise of the Mental Capacity Act 2005. We have made a recommendation about this in the report.

Risks to people had been assessed and many actions required to minimise risks were made. However, the provider did not always make recommended changes in a timely way. We have made a recommendation about responding to action plans following the completion of risk assessments.

Improvements could be made to the senior managerial oversight of the service. No service improvement action plan was in place. We have made a recommendation about this in the report.

People were supported by staff who had been recruitment safely. Staff were supported to keep their skills and knowledge up to date.

People could be confident they would receive their medicines when required. Medicines were stored safely.

People were supported by staff who knew how to recognise signs of abuse and knew what to do in the event of a concern being raised.

People's dignity was respected and people were encouraged to be independent.

Further information is in the detailed findings below.

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 improved to Good.	**Good**
Is the service responsive? The service improved to Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Red House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 4 and 5 October 2018 and was unannounced.

On day one of the inspection the team consisted of two inspectors 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. They had experience of supporting people living with dementia. On day two of the inspection one inspector visited the home.

Prior to the inspection we requested and received back a completed Provider Information Return (PIR). We used information the provider sent us in the PIR. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Throughout the inspection we offered the registered manager and staff opportunities to share with us, what they did well. We reviewed notifications and any other information we had received. A notification is information about important events which the service is required to send us by law.

When at the care home, we looked at eight people's care records and four staff recruitment and training records. We observed medicine administration, checked records and storage of medicines. We observed two lunchtime meals. We spoke with 16 people in general, however received comprehensive feedback from three. We spoke with five relatives, the home proprietors the registered manager, two registered nurses and a further four staff. Following the visit to the home we sought further feedback from staff and relatives. We also contacted health and social care professionals who had experience of working with the home.

Some of the people who live at The Red House Nursing Home had difficulty in communicating their views. 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.

Good

Is the service safe?

Our findings

People and their relatives told us care and support at The Red House Nursing Home, continued to be good. Comments from people and their relatives included. "I can and sometimes do, lock my door at night and that makes me feel safe", "Oh yes, I always think of him being perfectly safe here" and "It was a long road to get [Name of person] here but they [The Red House] took him on and we are extremely grateful, he is definitely fully safe and cared for here." Further comments included, "Here is the best place for her, she is safe, they look after her and that all helps me too," "I feel relieved that he's safe and cared for" and "Yes, we all feel that she is safe here."

We found mixed practice around the management of risks, both in relation to people's medical condition and the home environment. Risks posed to people because of their medical condition or level of support required were assessed. However, when we looked at risk assessments completed for skin damage (Waterlow) and malnutrition (MUST) we found some had not been completed correctly. We checked the level of risk recorded and the correct risk level. The correct score did not alter the level of risk identified by the incorrectly scored assessment. We checked if appropriate action was taken when a high level of risk was identified. We found the staff were knowledgeable about the level of risk and appropriate referrals had been made to external healthcare professionals. For instance, a tissue viability nurse or speech and language therapist. We discussed the discrepancies with the registered manager and a registered nurse. Both agreed that the assessments had been incorrectly scored. The registered manager advised a full review of the Waterlow and MUST assessments would be arranged.

Care risk assessments were in place but were not always accurate. For example, the records for one person showed they had a risk assessment for the use of bed rails. However, their mobility risk assessment, which included a section for safety in bed, did not include a reference to the use of bed rails.

Risk assessments were written for a variety of elements of providing care and support to a person. For instance, risk assessments were written for the use of bedrails and assistance people needed with moving position as examples. Where risks were identified, we found staff were aware and followed the guidance provided.

Risks associated with the home environment had been assessed. The provider had a fire risk assessment dated 19 February 2018 and a Legionella risk assessment dated February 2018. Both assessments had identified remedial action was required to improve and minimise risks to people. We asked the provider and registered manager if the work had been carried out. They were unable to confirm with us if all the actions had been completed. This was because there was little monitoring of the actions. There had been a change of maintenance personnel. We spoke with the provider who gave us reassurance a system would be implemented to monitor actions required. On the second day of the inspection the provider showed us how they intended to monitor action plans.

We recommend the provider seeks support from a reputable source about how to effectively monitor required actions arising from risk assessments.

Each person had a personal emergency evacuation plan. These provided details on what support people required in an emergency. Equipment used by people was routinely maintained. Gas and electrical items were serviced to ensure they were safe for people to use.

Incidents and accidents were recorded. Staff were aware of the need to report incidents. The registered manager supported staff to learn from accidents and incidents to prevent a reoccurrence of a similar event. A monthly falls audit was carried out to monitor any trends in people falling.

Systems were in place for lessons learnt to be cascaded to staff. Information was shared with staff in daily handover meetings and more formal staff meetings. The registered manager received medical device alerts and safety device alerts. These are national alerts sent to providers to identify faults and defects in equipment.

People were protected from the risk of abuse. The service had a safeguarding procedure in place. Staff received training on safeguarding people. The local safeguarding telephone number was displayed in the nurse's office and staff were aware of it. Staff had knowledge on recognising abuse and how to respond to safeguarding concerns. One member of staff told us "I will report it to my line manager and if no action was taken. I will report it to the home management and if still no action was taken. I will report to safeguarding, police or CQC." People we spoke with stated they knew who to speak with if they had any concerns. Where concerns were raised about people's safety or potential abuse, the service was aware of the need to report concerns to the local authority.

People were supported by staff who had been recruited safely. The provider was aware of the requirements and procedures for recruiting staff with the appropriate experience and character to work with people. Pre-employment checks were completed for staff. These included employment history, references and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. Where qualified staff were appointed appropriate checks were in place to ensure they could practise as a nurse.

We received mixed feedback about staffing levels and deployment. Positive comments from people included "I think the number of staff here is just about right although it seems that there might be fewer carers around at weekends," "I have a bell and I do use it" and "I feel safe here, fifteen minutes is probably the longest I have had to wait, if you press the bell in an emergency they will come running." Negative comments included "There is more staff here now than there were a couple of months ago," "I do push the bell, but it does depend on which staff are on as to how long they take to attend" and "The staff are overworked and at times it only needs two people to attend to someone and everything comes stretched." However, we observed call bells were in easy reach of people. On both days, we observed call bells to be answered, we looked at rotas and observed staff interaction. The registered manager used a dependency tool to calculate how many staff were required per shift. On each morning staff were allocated people to support. The registered manager told us the service was fully staffed. The registered manager was available to support staff at busy times. We observed the registered manager walking around the home and talking to people. The registered manager monitored staffing levels and could increase staffing numbers if the level of dependency increased.

People were protected from the spread of infections. The environment was maintained to a high level of cleanliness. Staff had access to personal protective equipment. For instance, gloves and aprons. Staff who supported people with food preparation had completed appropriate training. The provider had guidance for staff on how to manage infection control, the guidance followed nationally-recognised good practice. Staff had received training in the prevention and control of infections and had good knowledge on how to minimise the risk of the spread of infection. The home had been visited by the local environmental health

team in July 2018 and was awarded the highest rating for food hygiene. We found two areas which required the attention of the person in charge of maintenance. These were in bathroom areas where sinks required sealing to prevent the risk of infection. Once this was bought to the registered manager's attention it was rectified immediately.

Medicines were managed well within the home. We observed the registered nurse administered medicines to six people. Medicine administration charts we looked at were accurate and completed in line with best practice guidelines. The nurse explained the medicines to each person and was kind and gentle in supporting them to comply with the prescribed medicines. One person who was woken, refused to take what was offered and the nurse respected this decision, completing the records to reflect this.

Clear systems were in place to ensure that medicine stock was managed and stored safely. For example, we saw items no longer required by a person, were returned to the pharmacy in a timely way. External quality visits were completed by a pharmacist and any recommendations were actioned. The most recent visit was completed in June 2018 and the recommended action of purchasing appropriate homely remedies had been taken.

The registered manager informed us there had been no medication errors identified at the home since the last inspection. Only registered nurses supported people with medicine administration. They had received training and had their competency assessed.

Staff were familiar with the process required to administer covert medicines to a people. Covert medicine administration is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. We looked at the records for a resident who received covert medication and found that this decision had been taken in their best interests by a nurse, the person's GP and their family.

Good

Is the service effective?

Our findings

People and their relatives told us they continued to receive effective care. Comments from people included "I like my room very much", "The good staff are fun as well as doing a good job" and "The staff are good on the whole, they have one or two good staff."

We found mixed evidence about how staff complied with the Mental Capacity Act 2005 (MCA), Code of Practice. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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. We viewed applications made by the service. We noted the registered manager had a system in place to keep track of applications made.

We found that staff were aware of the importance of seeking the consent from people to receive care and support within the home. This included consent for day to day matters such as entering their rooms, to undertake daily support and taking photographs. Staff explained the importance of working together to meet the person's care needs through a written plan of care and sought written consent to this. However, we noted this had been completed when a person first moved into the home but had not been rechecked.

When people had been assessed with limited capacity to make an informed decision and decisions needed to be taken in their best interests, assessments of needs were completed. For example, we saw records of decisions relating to personal care and the use of bed rails had been completed. However, when best interest decisions involved a family member there was no evidence that they had given their written consent.

Assessments for best interest decisions were not consistently recorded. For example, a person who had deteriorated in recent months, did not have an assessment to support the use of bed rails. Another person with a safety gate on their room door, did not have a record the decision had been assessed and action taken in their best interests. We discussed this with the registered manager. They informed us some records required updating due to people's change in need.

We recommend the service seeks training for staff to ensure they are working in line with the Code of Practice of the MCA.

Prior to people moving into the home a pre-admission assessment was carried out. Senior care workers, registered nurses and the registered manager carried out the assessment. On day two of the inspection we noted a social worker from the local authority had contacted the registered manager about a potential new admission. Later that day the social worker's assessment had been sent to the registered manager. The assessment was used as a screening tool. This was to ensure the home could accommodate the person's needs.

The assessment covered people's physical, social and metal health needs. For instance, it referred to people's communication, medical history, mobility and sight as examples. Prior to people moving into the home, they were encouraged to visit, to ensure it met their requirements. On the second day of the inspection we observed a registered nurse arranging a viewing with a family member.

People were cared for by staff who had been supported with an induction following their appointment. Staff told us "At my induction I can recall orientation to the building, staff, service users. Discussion of my job description and was supervised by senior staff for three days" and "During my induction which last for 3 days, I was oriented to the building, introduced to staff, residents, daily routine and job description was discussed." Staff told us they felt supported in their role.

Staff were supported to carry out training in topics the provider deemed mandatory. Staff new to the role as a care worker were encouraged to study the Care Certificate. The Care Certificate is a set of nationally-recognised standards all care staff need to meet. The standards include communication, privacy and dignity, equality and diversity and working in a person-centred way as examples. Ongoing support was provided to staff. There was a clear management structure in place. Staff told us and we saw records which confirmed, they had received regular one to one meetings with a line manager and an annual review of their performance. The service worked with the local authority's quality in care team to ensure staff had training to suit their job role. For instance, nursing staff attended nurse study days.

People were supported with their nutritional and hydration needs. We observed people could choose where they preferred to eat their meal. Comments from people included "I enjoyed that, it was very nice" and "I usually get what I want." Relatives we spoke with, were complementary about the food, "The food here is brilliant and the kitchen staff are so good too" and "It is certainly good quality food here." Staff provided people with support and assistance. People were offered a choice of meal and we observed staff showing pictures of meals to help them decide. One person requested a meal which was not on the menu. The kitchen accommodated their choice. However, we noted that not all residents were adequately supported to eat their meal in a timely way. For example, we noted one person who did not seem able to focus on feeding themselves and began to mop their food on their plate with a napkin. There was no member of staff to supervise or encourage this person to eat their meal. Staff deployment at lunchtime could be better managed. We provided feedback to the registered manager about this.

People were supported to maintain their health and had access to external healthcare professionals. We spoke with a visiting health professional from a local GP practice. They told us that staff knew people's needs very well, they called the practice for support and advice when it was appropriate to do so and were very caring.

Care records we reviewed showed that staff referred to external health professional for specialist advice and support. For example, one person had been referred to the Speech and Language Therapy Team and the Tissue Viability Nurse.

Staff worked together and with external organisations to ensure people received effective care. Daily handover meetings between staff shifts took place. On day two of the inspection we observed a meeting in action. Staff were given an update on how people had been in the previous 24 hours. Staff were allocated people to support. One member of staff told us "The staff work well together. Sometimes there is difference of opinions. But we always act in the best interests of our services users and adhere to company policies." We observed there was good communication amongst staff.

The service had received support from a dementia specialist from the local authority, in relation to

improving the environment. Additional items had been purchased to offer people living with dementia an opportunity to engage in activities. For instance, two fiddle boards had been erected on the wall. The boards had items on them which gave different senses and could be turned or pushed. In addition, two interactive toy animals had been bought. Doors to toilets had been painted a different colour. People had personalised their rooms with items which had meaning to them. Staff had suggested in a meeting with the proprietor that people would benefit from a sensory area. At the time of our inspection, this was being considered. The service was looking at other ways the environment could be improved to engage people living with dementia.

Good

Is the service caring?

Our findings

People and their relatives told us staff continued to be kind, caring and considerate. Comments included "It is not my real home here but they do try their best for me," "The staff are pretty good," "I'm reasonably happy here" and "The staff here are lovely and [Name of person] is always very well looked after. They are very caring here and their approach is good."

We observed many kind and professional interactions between people and staff. Staff acknowledged people at every opportunity. We observed one person who was sitting in the quite lounge. Every time a staff member passed, they waved to them and said hello, the person's face lit up and it was clear they appreciated the contact. We observed staff were mindful of people's changing mood. We observed staff were skilled in managing situations which had the potential to challenge. Staff told us they had received training on situations which may challenge. One member of staff told us how good communication can sometime help defuse a situation. Another member of staff told us "I feel we have good support with dealing with challenging behaviour, as we received training in this area, also the manager supports us."

We received positive feedback from people and their relatives. Comments included. "As soon as you walk into the home, if feels that it is a home and not like a hotel like the larger homes are."

A relative had written to the home to thank them for their support. They said "We would have no doubts to recommend the home to anyone who asks. We will miss the home as it became part of our family." Another relative had written to the home. They said, "It was lovely to find that all my fears about care homes were, in the case of the Red House, unfounded and that we were both going to be welcomed into your little family and expertly care for, and listened to and supported."

People's privacy and dignity was respected. We observed staff knocked on doors prior to entering a room. Staff were knowledgeable about people's personal preferences with regards to personal care. Staff told us "I ensure dignity of my residents by always knocking on their doors, seek consent to perform care, close windows, doors, curtains. Allow them to participate in task if they are able to do so, give them choices and preferences." A relative told us "Staff are fantastic and nothing is too much trouble for them. They speak to him with respect and always use his first name." Another member of staff told us "Dignity is very important to each person, it is maintained in a number of different ways, from shutting the door and curtains during personal care. Asking if they have a choice of clothes they'd like to wear, if there is an activity they'd like to do. A person-centred approach is key."

People were encouraged to be as independent as they could be. We observed staff always sought consent from a person prior to supporting them. Staff also asked the person, what they needed support with. A member of staff told us "I always explain the task I am about to do and give them a choice in every task I carry out. I take a person centred approach. To find out what is their likes and dislikes." People were encouraged to express their views about the care.

Where required people were referred to advocacy services. Advocacy gives a person independent support to

express their views and represent their interests. A member of staff met regularly with people to ensure their views were shared. One member of staff told us "I am a key worker to a certain service user who has mental capacity and has complex physical needs. On a monthly basis when I update her care plan, I go and have a conversation with her about her care, if she is happy, if we could do more for her, if she feels we are meeting her needs and if not why?"

People were encouraged to maintain important relationship with family and friends. We observed family members were warmly welcomed by staff.

Good

Is the service responsive?

Our findings

At the inspection carried out on 16 and 17 February 2016, we found care records did not accurately reflect the needs of people and staff were unaware of when wound dressing required changing. We recommended the service sought advice and guidance from a reputable source, about effective care planning and reviewing. At the time we rated the key question of responsive as requires improvement. At this inspection we checked if improvements had been made. We reviewed care records for people who were being support with wound care. We found records were accurate and up to date. Staff were knowledgeable about the wounds. Referrals had been made to specialist external healthcare professionals for support. The rating for this domain has improved to good.

People told us they received a personalised service. One person told us "Quite often I don't have food from the regular menus and the staff are good and I get a good alternative choice." Care plans reflected people's preferences and choices. All new residents were encouraged with family help to complete a 'This is me' document. Staff used information gathered to help them to get to know the person. Staff told us "We normally look at our service user's life stories and picture memory boxes to identify what hobbies and interests our service users have. We also asked the next of kin." Each person had a registered nurse and a care worker identified as Keyworkers. The keyworkers were responsible for co-ordinating the person care and updating care plans. It was clear keyworkers were knowledgeable about the person they were assigned to.

People were encouraged to participate in meaningful activities. The home had recently recruited an activity co-ordinator. Relatives told us they were confident opportunities would increase for people to keep occupied. Activities on offer, included, Bingo, trips to garden centres and indoor games. External entertainers visited the home to play music and sing. We observed people singing along to music being played. The music invoked found memories for people and they became animated and talkative at the time. Staff told us they tried to support people be active. One member of staff told us "To help people to participate in activities I will discuss with individual, relatives or friend, what are their hobbies and interests by collecting a life story and work according to individual wishes. For example, carpenter as past job, I will provide a tool box with artificial tools, we currently have a resident who loved to play golf, we play indoor golf and I am booked to take him out to a golf course near by next week.

The home had arranged for pop up farm to visit people. A number of animals visited the home, which included a goat, and miniature pony. People told us they enjoyed stroking the animals.

People were encouraged to celebrate important events, like birthdays and anniversaries. One person told us how they had been to a local public house to celebrate a special birthday, it was clear from the smile on their face they thoroughly enjoyed the event. A member of staff who supported them told us "One of the service users requested specially for me to attend her 80th birthday party at a pub in Aylesbury. I was officially off duty. She requested just the day before, red shoes to go with her outfit and we took her to town in Buckingham for her to choose the shoes she liked. I took the service user to her special event. Just to see the smile on her face was priceless. She never stops talking about her special day." Staff supported people

outside of their working hours, to ensure they were supported by staff who they were comfortable with. One member of staff had supported a person to a hospital appointment. They told us "I decided I would accompany them, even if it was on a day off. I felt this was in the best interest of both parties and would help keep a difficult time calm." A person told us how one member of staff had gone out of their way to support them. They told us "There was a cockup with the ambulance bringing me back from my last hospital appointment- but someone from here volunteered and drove to Oxford to fetch me. I know they had to work overtime too." Another person told us "A carer has put in new hooks on the outside wall for me for my new bird feeder, she is very good like that. There are a lot of birds that we get here."

Staff were aware of equality and diversity and the need to challenge discrimination. Each member of staff had completed equality and diversity training. People were supported to observe and practice their religious beliefs. The registered manager told us about one person who they had supported in the recent past. The person was unable to leave the home to attend their place of worship, due to their complex medical condition. Staff ensured an area was made in the person's bedroom where they could make their prayers. The area had been decorated with important artefacts related to their religion. Another person was visited by a member of their chosen religious order and took weekly communion.

The service encouraged feedback from people and their relatives. A suggestion box was located in the front foyer area. Information on how to make a comment about the care provided was displayed on notice board. Complements and complaint were kept. The provider had a policy which referred to how they handle complaints. The registered manager kept records on the complaints made and action taken as a result. One person told us "I would complain if I ever had to." Twice a year the provider sent satisfaction surveys. We looked at the results from the last survey and feedback was very positive.

At the time of our inspection, the service was not supporting anyone with end of life needs. However, staff had received training and had provided support in the past. The home worked with external healthcare professionals to ensure people who had been at end of life received appropriate pain free care. Decisions about end of life care for people who lacked capacity, had been made with family and in consultation with GP. Where people were happy to provide it. They shared their end of life wishes with the home. People's relatives were encouraged to have a discussion with the family member about their wishes, to ensure their chosen preference was respected.

The service was aware of the need to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information was available in large print, as an example.

Good

Is the service well-led?

Our findings

People were supported by a service that continued to be well-led. There was an established registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We received many positive comments about the registered manager. These included "[Name of registered manager] is 'hands on' and well respected here," "[Name of registered manager] the manager is good," "[Name of registered manager] is very nice and she won't have any nonsense from her staff, in a nice way," "The home is clean on the whole, [Name of registered manager] always makes sure of that" and "The boss is very good."

People, relatives and staff told us the registered manager was approachable, professional and calm. Comments included "The manager [Name of registered manager], is lovely, very calm and professional. She makes me feel very confident that my dad is being well looked after" "I think my manager is approachable and flexible and she acts immediately on any concerns raised. She is hardworking and caring" and "I think my manager is caring, dedicated, flexible and approachable." Another member of staff said "I work with a manager who is always supportive professionally and personally. She is always hands down. The directors are also very supportive."

The registered manager was aware of the need to report important events to us and was aware of the requirements under the duty of candour regulation. We expect providers and registered managers to be open and transparent, there are a number of required actions when the duty of candour threshold has been met. We checked and the registered manager had compiled with the regulation.

There was a clear management structure and staff were aware of the vision to provide a high-quality service. Staff felt valued and listened to. Staff told us they were encouraged to share their views on the service and make suggestions for improvements. One member of staff told us "I feel I am able every day to make suggestions whether it be through daily meeting or weekly or staff meetings. I can suggest things at any time and feel that my level of experience is respected and that my opinion is regularly sought and listened to." The registered manager and provider facilitated staff meeting where important information was cascaded. Following a review by the local authority the registered manager discussed a policy at each meeting. Staff said they felt it had been a positive introduction to team meetings.

The registered manager and provider had some quality assurance processes in place. These included audits and surveys. Audits were carried out for medicines, care plans and mattresses as examples. The home had also introduced a resident of the day. However, we found the audit had not integrated the detail in risk assessments and had not identified the issues we found. We discussed the managerial oversight with the registered manager and provider. There was no single action plan which held full details of required action as a result of a risk assessment or audit. Information was available; however, it was difficult to track action taken. We provided this feedback on day one of the inspection. On day two of the inspection we were shown how the registered manager and provider had planned to improve monitoring of the service.

We recommend the provider ensures there is senior managerial oversight to ensure records are accurate and up to date.

The service had forged links with the local community. Students from the local private school visited the home on a regular basis. One member of staff was a dementia champion and had planned to cascade training to new staff. The home was due to host a dementia information session over coffee. People from the home were supported to attend coffee mornings at the local church.

The service worked in partnership with external organisations. For instance, they facilitated annual contract monitoring by the local authority and worked with the local psychiatric services. The registered provider attended local provider forums to ensure they kept up to date with changes in regulation.

The service used team meetings and handover meetings to share lessons learnt. The registered manager identified where information technology systems to help support people. For instance, one person had a sensor on the floor to alert staff when they moved from the bed. However, staff had noticed the person kept moving the sensor to under the bed. The registered manager arranged for another sensor to be fitted under the mattress to ensure staff were highlight when the person moved from the bed. The person required staff to be aware as they were at high risk from falls.