Shaftesbury Care GRP Limited

Allan Court

Inspection report

Benwell Lane
Newcastle Upon Tyne
Tyne and Wear
NE15 6RU

Tel: 01912741100

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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

The inspection took place on 12 and 13 April 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Allan Court in July 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Allan Court is a care home with nursing that provides nursing and personal care for up to 60 people. The service is primarily for older people including people with dementia and there is a small unit for people with learning disabilities. At the time of our inspection there were 31 people living at the home.

The service had a registered manager. 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 found that care was provided in a safe, clean and suitably equipped environment. Risks to personal safety were assessed and managed to prevent people from being harmed. The service had established systems for protecting people from abuse and responded appropriately to any safeguarding concerns.

New staff were checked and vetted to make sure they were suitable to be employed at the home. There were enough skilled and experienced staff to ensure people received safe care and treatment. The staff team were given training and support that enabled them to effectively meet people's needs.

Prescribed medicines were stored and administered safely by trained staff. People were supported to meet their health needs and access a range of health care services. Nutritional needs were monitored and specialist advice was sought when necessary. People were offered a varied diet with choices of meals and, where needed, were assisted with eating and drinking.

The service worked within the principles of mental capacity law. Formal processes were followed to act in people's best interests when they were unable to give consent and make decisions about the care they received.

Staff had a good understanding of people's needs and preferences and were caring and respectful in their approach. They treated people as individuals and supported them to make choices about their care. People and their relatives told us they were happy with the care provided at the home. Any complaints raised were taken seriously and promptly addressed.

Personalised care plans had been developed that were reviewed and adapted as people's needs changed. Informative profiles were also in place which guided staff on what was important to each person and how they preferred to be supported. Daily activities were made available to help people meet their social needs.

The registered manager provided leadership and promoted an open and inclusive culture. People, their relatives, and staff were encouraged to express their views and feedback was acted on. Regular audits were undertaken to check and make improvements to the quality of the service.

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.

Suitable steps were taken to safeguard people from harm and abuse.

Risks were identified and reduced to keep people safe during their care delivery.

Sufficient staff were employed to provide people with safe and consistent care.

Appropriate arrangements were in place for assisting people to take their medicines safely.

Is the service effective?

Good

The service was effective.

Staff received training relevant to their roles to ensure they were able to care for people effectively.

People's rights under the Mental Capacity Act 2005 were understood and upheld.

People were supported to maintain their health and well-being and meet their dietary needs.

Is the service caring?

Good

The service was caring.

Staff were caring and had developed positive relationships with the people they cared for.

People were given support to make choices and decisions about their care.

Staff treated people with respect and promoted their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's care plans were tailored to their individual needs and preferences.

A programme of activities was provided for social stimulation.

Complaints about the service were responded to professionally and resolved.

Is the service well-led?

Good

The service was well led.

The registered manager gave direction to the staff team and took responsibility for ensuring standards were maintained.

Feedback about the service was actively sought and acted upon.

Systematic audits were completed to check and improve the quality of the service.

Allan Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 and 13 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist dementia advisor 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 we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 17 people living at the home, four relatives and a visiting professional. We observed how staff interacted with and supported people, including during mealtimes and 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. We spoke with the registered manager, the deputy manager and with 12 nursing, care and ancillary staff. We looked at eight people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People described feeling safe living at the home. Their comments included, "The staff treat me well and it's nice here, I am happy and am not worried about anything", and, "They treat me very well." One person we talked with was staying at the home short term following a fall at home. They told us they had been very well looked after and their relative said they were very happy with the care received. Other relatives commented, "My [family member] is very safe here, much safer than they were at home", and, "They always phone me if [name] has had a fall or there are any concerns."

The local authority's safeguarding policy, a poster on how to report abuse and the home's whistleblowing (exposing poor practice) policy were displayed for reference. The registered manager acknowledged the guide to the service needed updating to explain safeguarding and give people information about their rights to be protected from abuse.

Staff had access to the provider's policies on safeguarding and whistleblowing. They received safeguarding training during induction and thereafter were trained on an annual basis. Most staff had completed this training and courses had been arranged for the remainder to update their knowledge. The staff we spoke with were able to describe the action they would take if they had any concerns about people's safety.

Safeguarding allegations had been appropriately reported to the relevant authorities. A log was kept with details of allegations and outcomes, including co-operation with investigations which had been carried out. We confirmed the provider had introduced a 'duty of candour' policy and that this was understood. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

We looked at the arrangements for the safekeeping of personal finances. The service had established where people were supported with their finances by relatives and representatives with legal status, such as power of attorney. Cash was held securely and transactions were suitably recorded, backed by receipts and witness signed. Checks of balances and cash had lapsed with the last check carried out in January 2016. We were told monthly checks were being resumed.

An appropriate recruitment process was followed to check the suitability of new staff. Pre-employment checks included proof of identification and completion of application forms with work history and details of training. References, including one from the last employer were obtained, though we noted some minor discrepancies with the dates of references in two of the files we viewed. Checks were carried out with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. We discussed the introduction of a system for checking the portability of DBS checks with the registered manager. Monthly checks were undertaken to ensure qualified nurses were maintaining their professional registration.

There was a full team of nurses, care and ancillary staff to support the running of the home. Staffing levels were calculated each month using a staffing model based on the numbers of people living at the home and

their care needs. The current levels were two nurses and eight care staff, including seniors, during the day and one nurse and five care staff at night. The registered manager worked in a supernumerary capacity and a proportion of the deputy manager's hours were also in addition to the usual staffing levels. An on call system was operated outside of office hours that enabled staff to get support and advice at any time and, when necessary, to escalate emergencies.

Cover for absence was mainly provided from within the staff team and the home had one bank nurse. External agency nurses were used on occasions for covering sick leave and holidays. We spoke with two agency nurses who told us they were receiving good support from the staff. They confirmed their agency supplied the same nurses to help build continuity with the home.

During our visits we observed there were enough staff on duty to safely meet people's needs. We saw people with mobility difficulties were assisted safely and staff suitably assisted people who might be at risk when they were eating and drinking.

Individual risk assessments had been completed and care records gave staff information about the ways to reduce identified risks in people's care delivery. This included strategies for risks associated with medicines, moving and handling, falls, nutrition, and skin integrity. Specific risks such as medical conditions and frailty in physical and mental health were properly addressed to protect people's personal safety and welfare. Each person had an individual plan in the event of needing to be evacuated from the home in emergency circumstances.

The home was clean and comfortable and we observed that housekeeping staff worked to cleaning schedules. Measures were taken to provide a safe environment including doors secured with keypads and alarms and restrictors on windows. Clinical rooms and medicine trolleys were kept locked, 'sharps' bins were provided to prevent needle stick injury, and refused medicines were disposed of in bins with tamper-proof lids. There were no obvious tripping hazards and handrails were provided throughout the building to help people move around safely. Appropriate equipment to support people's care and safety was made available including mobility aids, bed rails and pressure-relieving mattresses.

A range of safety checks were routinely carried out in the home. These included the inspection of all rooms, areas and equipment, and checks and tests relating to fire safety, water temperatures and infection control. Accidents and incidents were suitably reported and analysed to identify any trends and corrective action needed. For instance, where a person had experienced a number of falls they had been referred to a specialist falls team for further assessment. The registered manager told us the regional manager held weekly conferences calls with managers during which any safety matters were reviewed and lessons learned were highlighted.

Arrangements had been made to make sure people received their medicines safely. Medicines were ordered monthly and we were told the supplying pharmacy provided a good service, including prompt delivery. All staff involved in administering medicines had received training and thorough competency assessments were carried out. People had care plans for their medicines routines and, where applicable, protocols for medicines prescribed to be given 'as required'. Care plans included the individual's requirements, for example in relation to pain management and treatment of seizures. No medicines were authorised to be given covertly (disguised in food or drink). A peripatetic nurse told us advice was taken from GPs if medicines needed to be prescribed in other forms, such as liquids, to help a person who had difficulties in swallowing tablets. We noted one person's medicines had been reduced and discontinued in line with current professional guidance.

Medicine administration records (MARs) were colour coded to assist staff in identifying the times each person needed their medicines to be given. Three people did not have photographs on their MARs for identification purposes and this was rectified during our visit. The MARs were clearly signed by staff to confirm when medicines had been administered. The issue of using one consistent method for recording topical medicines was raised with the registered manager to follow up. We also noted the policy of recording controlled drugs stock checks in the register meant it was sometimes difficult to determine a clear audit trail of the medicines administered. Monthly audits were conducted to check for any deficits and assure people their medicines were being managed safely.

Good

Is the service effective?

Our findings

People told us they were happy with the service they received. Their comments included, "I like it. I've no problems with anyone and I don't think it can improve"; "We are very well looked after"; and, "I am happy here. Nobody upsets me and I do what I want." A relative told us their family member had settled into the home very well and was eating well. They said, "I can't fault the staff here, they are very encouraging and helpful."

New staff received an induction to the provider's company and the home, and were supernumerary to the staffing levels for their first week. They went on to complete the Care Certificate, which was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. An induction information file had been developed that external agency staff were expected to go through before being allowed to provide care to people living at the home.

A programme of training was in place for the staff team with a mix of face to face and e-learning courses. This included mandatory training in safe working practices, most of which were refreshed annually, and topics specific to the needs of people living at the home. A laptop computer was made available for staff to use to access e-learning courses whilst at work. The registered manager and staff spoke highly of the training given by the main training provider who also assessed the competency of nurses in clinical aspects of care. These included catheterisation, the use of syringe drivers (a means of administering medicines in a continuous and controlled way), palliative care and other areas on request. Advanced training had also been arranged for staff who were being assigned lead roles in the home, according to their skills and interests. 15 of the care staff had achieved nationally recognised care qualifications, five were currently studying and three new care staff were being enrolled to study for these qualifications. The training matrix was being updated to fully reflect all of the courses completed and booked for the staff team.

The staff we talked with told us they felt supported in their roles and that suitable training was facilitated. For example, the chef told us they received relevant training including health and safety. Other staff comments included, "I've attended a lot of training and have just completed end of life training"; "My appraisal and supervision are done by [registered manager] and are up to date"; "My training needs are being met. I recently completed wound management, others are pending"; "I most recently completed courses on subcutaneous fluids (injecting fluids to prevent or treat dehydration) and PEG feeding (where food and supplements are provided through a tube in the abdominal wall into the stomach)"; and, "I've had manual handling, challenging behaviour and learning disability training. I'm now doing a mental capacity course with an outside college."

The provider's policy for supporting staff included provision of six supervisions a year and an annual appraisal. Records confirmed most staff had received at least five supervisions the previous year and an appraisal. Although supervisions took place regularly they were at times generic or used to reinforce the provider's policies and procedures. The registered manager agreed that supervisions needed to provide more opportunity for staff to discuss their performance and any training or support they required. They told us the appraisal process had been improved to make it more personalised. Staff had been asked to set

individual objectives and these were planned to be reviewed during supervisions throughout the year.

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 found that the service worked within the principles of the MCA. Staff had a good understanding of the need to gain people's consent to their care and treatment. A document was used to record whether people had agreed and consented to their planned care, for medicines and vaccinations to be given, and to be photographed for purposes relating to their care. This was updated with people when their care was reviewed. Where necessary, decision specific mental capacity assessments had been carried out in consultation with people's representatives. Decisions made in people's best interests were clearly recorded and regularly evaluated to check they remained valid. Care plans were in place around people's abilities and capacity to communicate their preferences and make choices about their care, including for people who were subject to DoLS authorisations. The records demonstrated a focus on involving people in decisions about their care and upholding people's rights through following formal processes under the MCA.

The use of restraint or excessive control, including sedation, were not advocated when caring for people with cognitive impairments. Care records showed that medicines prescribed for symptoms of distress or anxiety were used appropriately and to good effect in conjunction with behavioural interventions. The home also accessed a specialist challenging behaviour team when needed for support with individuals. We observed people's freedom was not unduly restricted. Staff explained that people who did not have DoLS authorisations could be given the access codes for entry and exit from the home.

Nutritional needs were assessed and advice was sought from dietitians, speech and language therapists and dentists when concerns were noted. Nutrition care plans addressed people's needs including special diets, provision of dietary supplements and support with eating and drinking. Details of individual's dietary needs and food and drinks preferences were made available to the catering staff. The chef reported that staff were good at keeping them informed about any updates to people's requirements. They catered for special diets and showed us they followed guidance, for example, foods to be avoided when people needed a soft texture diet.

The menus offered a balanced diet with choices of food at each meal. Snacks and drinks were provided between meals. We observed that the food served at lunchtime looked appetising. There were good portion sizes and extra helpings were offered. The people we talked with gave positive feedback about the quality of the food and told us there was always plenty for them to eat. One person said, "The food is lovely and I help with the washing up." A relative told us, "The food is good and [family member] has a great appetite. They used to forget they had eaten but they're more settled now."

We saw that medical history information had been gathered and people's health needs and risks were assessed. People were supported to access GPs and a range of other health care services. Records were kept of all contact with other professionals and any changes in treatment. Care plans were also revised, where applicable, to include any changes in people's health and advice given by health care professionals. Future decisions of instructions not to be resuscitated were documented, identifying the actions staff needed to take in emergency situations.

We talked with a visiting health care professional who was part of a project supporting care homes in the Newcastle area. They worked with the staff giving advice, and training if necessary, aimed at preventing people from being admitted to hospital inappropriately. The professional told us that the nurses were "competent and forward-thinking" and made appropriate referrals for health care support. They said the home had successfully cared for people with complex needs during a time when 'step down' placements were being provided to alleviate winter pressures on a local hospital.

Good

Is the service caring?

Our findings

There was a calm and relaxed atmosphere in the home and we observed that staff were attentive to people's needs. Staff engaged with people and used humour and tactile communication appropriately. People appeared comfortable and trusting of the staff and responded positively and smiled when they were interacting with individual staff members. People told us, "It's nice here, I like living here and I have a lovely room"; "I've lived here 18 months and enjoyed every minute of it"; and, "There is a happy atmosphere, the residents are friendly and I have made some friends."

A visiting professional told us, "I love coming in here. It has such a nice atmosphere and the staff know the best approaches to take with people." A relative commented, "I am very satisfied. The good thing is we can visit at any time and [family member] seems to be happy here. The staff are very understanding."

A guide to the service was provided to people that informed them about what could expect from living at the home. A range of information was also displayed for people and their relatives and visitors to refer to. This included that staff worked to the NHS 'six C's' of creating a culture of care, compassion, competence, communication, courage and commitment. There were the home's newsletter; details of social activities; dates of 'resident and relative' meetings; a suggestions box; and information about complaints, advocacy services and other external support agencies. Actions taken in response to the findings of surveys which relatives had completed were also displayed.

The registered manager and two nurses we talked with described the ethos of the home as 'putting people first'. This was confirmed by our observations. We saw that staff were caring and respectful in their approach and gave people time and space to do things at their own pace. For instance, as people walked around the home the staff would follow at a distance to be on hand should they require assistance. Mealtimes were not rushed and staff helped with cutting up of food, enabling people to eat independently. Some people took a long time to eat their meals and they were not hurried and were served the next course when they were ready. Staff attended to people's needs in a timely and unobtrusive way and no-one was ignored. We saw a staff member showed great kindness in consoling a person who was distressed and assisting them to enjoy their meal.

The registered manager told us that people and their families were consulted about care and treatment and involved in making decisions. They said people could be referred to advocacy services if they did not have family who could represent their views.

There was recognition of the importance of having information about each person's individuality. Personal profiles had been developed which gave the historical context of the person's life, their significant others and milestones, as well as hobbies and favourite places, foods, music and television programmes. Where necessary, this information had been obtained from the relatives to ensure staff were made aware of people's preferences.

Routines in the home were flexible and people told us they were able to make everyday choices such as

when to get up and go to bed and where and how they spent their time. One person told us, "I've just got up" later in the day. Two people we talked with said they preferred to stay in their bedrooms and only come out for meals. People could take meals in their rooms if they wished. We saw that staff worked with people, such as supporting them to make drinks and helping them to choose meals from the day's menu. People with learning disabilities were encouraged to clear the table and wash their own dishes after meals. In another example, we saw the activities co-ordinator intervened when they recognised a person was restless and becoming upset. They asked the person if they would mind helping with the mid-morning drinks and they went to the kitchen together to collect the drinks trolley. The person's relative arrived to visit their family member and was happy to see they were engaged in helping out.

Where people needed support this was given patiently. We observed a care assistant walking alongside a person who used a mobility aid as they left the dining room. The care assistant reassured the person by gently placing their hand on their back as they walked, chatted as they moved along the corridor, and discreetly asked if they needed to visit the toilet. We saw many occasions when staff offered sensitive one-to-one support. These included helping to calm a person who had become tearful, and responding to another person who was distressed with distracting and reassuring interventions.

Staff were mindful of protecting people's dignity and this was evident in the way that care was planned. For instance, where a person had Deprivation of Liberty Safeguards in place, they had a specific care plan for guiding staff on how to deliver dignified care and promote their personal choices and self-esteem.

It was evident from our observations and conversations with the care and nursing staff that they knew the people they cared for well. They spoke respectfully about people and were able to give clear accounts of individual's needs, preferences and lifestyles. The registered manager told us they had identified staff who would become, after additional training, the dignity and dementia 'champions' with roles of promoting best practice in the home.

Good

Is the service responsive?

Our findings

The people and relatives we talked with had no concerns about the care provided. One person said, "I'm enjoying my retirement here after working for over 40 years." A relative commented, "I am very content. The staff are caring and respond to [family member's] needs. I'm very pleased with the place and the care; no concerns."

During our visits we observed that staff supervised people in communal areas and in their bedrooms, and kept checks on individuals who might wander and come to harm. We saw staff responded quickly to people's needs, for instance when a person had fallen and the emergency call system was activated. The staff showed concern for the person's well-being; they were checked over by a nurse for any signs of injury and were closely monitored for the rest of the day.

Assessments were carried out before people moved into the home to ensure their needs could be adequately met. People's needs were then reassessed on a regular basis and there was evidence that care plans were adapted in response to changes. For example, care plans had been updated as a person became frailer and required additional support with their personal care. There was a clear system of assessing needs, developing care plans and establishing whether people were able to agree to their care. Care plans addressed identified needs and were sufficiently detailed and informative, guiding staff on providing personalised care and treatment. A good level of information had also been compiled about people's backgrounds and routines which gave staff further direction on how best to support individuals in the ways they preferred.

Reports of on-going care were recorded and handovers took place between shifts to make staff aware of any changes in people's well-being. Care plans were routinely evaluated to ensure people's care remained effective. People's relatives were invited to attend and contribute their opinions to care review meetings. The deputy manager told us they were putting in place 'family communication' records to make sure all contact with relatives was properly captured.

Staff told us they took a pride in their work. Their comments included, "The residents are well cared for as the staff know them very well and respond appropriately"; "I have been here through many changes and think this is a good home. The staff are very committed"; "The place is homely, everyone gets on and most of the residents have been here a while so we know them well. The staffing levels have been improved recently so we can do more one to one, as mostly people do not want much activity due to ill health and old age"; and, "I love it here, looking after the patients. I do get attached to individuals but not too emotionally and make sure I give my time equally to each person."

The home employed an activities co-ordinator who organised a programme of social activities and events. They explained that information about people's interests was incorporated into the programme and new activities were organised in response to needs and requests. For example, armchair exercises to encourage increased mobility and reintroducing activities specifically for gentlemen following an increase in the number of males living at the home. We saw people making sweet treats with the activities co-ordinator and

were told every fortnight the chef did cookery demonstrations or baking sessions. Staff who worked with people with learning disabilities showed us items that people had made during arts and crafts sessions.

Some of the people we talked with told us they followed their own hobbies and interests. Other people gave variable views about the level of activities provided. One person, who spent their days in their bedroom, had little in the way of stimulation and told us they did not go out much. They said they liked to watch the birds and might like to have a radio to listen to. We relayed this to senior staff to follow up. Another person told us they did not always receive their allocated one to one time with staff to go out in the community. They said, "I don't like getting ready to go out and then it's cancelled." The registered manager told us they had had to deploy staff on another floor and the unit manager would make arrangements for the person to go out later in the week. A relative told us, "They could do with more activities but I think most places could."

The complaints procedure was provided to people and displayed in the home. We reviewed complaints logged over the past year and found they had been responded to appropriately, investigated and resolved. Complaints were also analysed to check for any emerging patterns which might identify the need to improve any areas of the service.

Good

Is the service well-led?

Our findings

The home had a manager who had been registered with the Care Quality Commission (CQC) in October 2015. They demonstrated a good understanding of their management responsibilities and registration requirements, including notifying CQC of changes, events or incidents which affected the service. The registered manager described their priorities as providing leadership to staff, promoting person centred care and continuously checking the quality of the service.

The registered manager was supported in their role by senior management, a deputy manager, a learning disability unit manager and staff with clinical expertise. Other staff had delegated responsibilities or had taken on lead roles with accountability for different aspects of the service. Regular meetings were held with staff to cascade information and discuss practice and employment issues. The registered manager told us they aimed to work inclusively with staff and followed up any comments or concerns either directly or in supervisions and meetings. For instance, they had met with night staff to review and, where possible, make adjustments to shift patterns to accommodate their needs.

The staff we talked with told us, "There have been many managers, [registered manager] has made a difference"; "The manager is brilliant, she has been so supportive to me"; and, "This is my first care job and I love it. It is all about helping people and I enjoy making them happy. I have no concerns; it's a pleasant place to work." One staff member commented, "Not much has changed since the new company took over, but they did change our contracts and reduce our hours." There was generally good morale amongst staff, though some were concerned about whether the care of people with learning disabilities would continue to be provided. The registered manager confirmed the vision for the future of the service was being decided following a recent change in the provider's registration.

The provider operated a pension scheme and employee benefits, such as paying for nurses' registrations during their first year as an additional employment incentive. Positive feedback was recognised and we noted that praise given by a visiting professional about two staff members had been relayed during a staff meeting. Both staff were awarded gift vouchers and one had subsequently been named as the 'employee of the month'.

Systems were in place to obtain and act on feedback from people and their relatives. For example, the findings of mealtime satisfaction surveys had been used in helping to devise new menus. Comments from the latest relative survey had led to including activities in the home's newsletter and a decoration plan to improve parts of the environment. Surveys were also carried out with staff and external professionals who worked in partnership with the home to seek their views about the service.

The registered manager told us they had evaluated and were committed to improving the standards at the home. They gave examples of having introduced an induction for agency staff; establishing more specialised training provision for the staff team; and being proactive in developing best practice around end of life care.

A range of internal audits were carried out to monitor the service and the care people received. These included checking the environment was safe, hygienic and being properly maintained. Other areas audited included care documentation, medicines arrangements and catering. Any issues highlighted during the audits had either been rectified immediately or were taken forward in action plans to be completed within stated timescales.

Reports of key performance indicators for each of the three units in the home were completed monthly and were accessible to the regional manager. The registered manager also submitted weekly reports to the regional manager that kept them appraised of the running of the home. The provider's senior management had regular oversight of the service. The regional manager visited the home every month and reported on standards, including checking people's care experiences and progress with action plans. Bi-monthly visits, based on the CQC standards of quality and safety, were undertaken and the home had recently been given a rating of 92% compliance. These measures ensured that the quality of the service was regularly assessed and improved.