Care Quality Commission

Indigo Care Services Limited

Millfield Nursing and Residential 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?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection was unannounced and took place on the 17 May 2017. This was the first inspection of Millfield Nursing and Residential Care Home since our registration of the provider under the Health and Social Care Act in April 2016. Millfield Nursing and Residential Care Home provides accommodation, nursing and personal care for up to 45 older adults, which may include some people living with dementia. At the time of our visit, there were 35 people living at the service, including 19 people receiving nursing care and some people living with dementia.

There was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives felt people were provided with safe care. People's care and medicines along with the environment and equipment used for their care were safely managed.

Staff understood risks to people's safety from their health conditions and environment and the care actions required help reduce those risks, which they usually followed. Care and safety incidents were closely monitored. Management actions and remedial measures helped to ensure people's safety or prevent any reoccurrence of any safety incidents when required.

The provider's arrangements for staff recruitment and deployment helped to ensure people's safety at the service. Emergency contingency planning helped to ensure people's safety in the event of forseen emergency.

People, relatives and staff were confident and knew how to speak out if they had any concerns about people's safety at the service. Staff were confident, knew how to recognise abuse and report and any concerns about people's safety if they needed to.

People and relatives were happy with the care provided by staff who were qualified, trained and supported to provide care that met people's assessed needs. Staff understood and followed the Mental Capacity Act 2005 (MCA) to obtain people's consent or appropriate authorisation for their care.

People enjoyed their meals at the service and they were supported to maintain and improve their health and nutrition. Staff consulted with relevant external health professionals and followed their instructions for people's care when required.

People received care from staff who were kind, caring and compassionate. Staff treated people with respect and promoted their dignity, rights, independence and involvement in their care.

People were provided with the information they needed about their care and the provider's service they could expect to receive. Staff understood and followed what was important to people for their care and supported them to maintain their contacts with family and friends.

People's care was often individualised but not always timely or inclusive. Environmental and equipment adjustments were not always made to fully enable people's individual independence or orientation. A range of relevant adaptations and equipment were provided to help people move or eat and drink independently.

Staff understood and followed what was important to people for their care, daily living routines and lifestyle preferences. Staff knew how to communicate with people and supported them to engage and participate in home life and the wider community.

People and relatives knew how to make a complaint about the service if they needed to. People's views about the service were regularly sought, well received and used to make care and service improvements when required.

The service was generally well managed and led. Staff understood their role and responsibilities for people's care. Management arrangements for communication and record keeping helped to ensure this. Regular management checks and consultation with people, relatives and staff help to ensure the quality and safety of people's care and continuous service improvement.

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.

Known risks to people's safety associated with their health needs, environment and care equipment were closely monitored and safely managed. Staff knew and followed people's care requirements reduce any risks to people's safety. Emergency planning and staffing arrangements helped to protect people from the risk of harm or abuse.

Is the service effective?

Good

The service was effective.

Staff were qualified, trained and supported to perform their role and responsibilities for people's care. People's consent or appropriate authorisation was obtained for their care to ensure this was valid and lawful. Staff supported people to maintain and improve their health and nutrition in consultation with relevant external health professionals when required.

Is the service caring?

Good

The service was caring.

People were treated with respect by staff who were kind and caring. Staff promoted people's their rights, dignity and choice in their care. People and their relatives were appropriately informed and involved in the care provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was often individualised, but not always timely or inclusive. Environmental and equipment adjustments were not always made to fully ensure people's independence or inclusion.

Staff knew people well; supported them to engage in home and community life and upheld people's known preferred daily living routines and lifestyle choices. People, relatives and staff views, concerns or complaints were regularly sought and used to make care and service improvements when required.

Is the service well-led?

Good

The service was well-led.

The service was well generally well managed and led. Overall people living, working and visiting the services were confident of this. Staff understood; were supported and informed to perform their roles and responsibilities for people's care. Governance arrangements helped to ensure ongoing accountability for the quality, safety and continuous improvement of people's care.

Care Quality Commission

Millfield Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection on 17 May 2017 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.

Our visit was unannounced and the inspection team consisted of an 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 service.

Before this inspection, 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 the service does well and improvements they plan to make. We also spoke with local community professionals and care commissioners and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

During our inspection we spoke with eight people who lived at the home and nine relatives. We spoke with seven care staff, including one senior care and a nurse. We also spoke with a cook and the registered manager. We looked at four people's care records and other records relating to how the home was managed. For example, medicines records, meeting minutes and checks of quality and safety.

Good

Is the service safe?

Our findings

People, relatives and staff felt that overall there were sufficient staff to provide people's care safely. Most people and relatives commented that staff were very good, worked hard and knew how to support people safely; but some felt staff were often 'stretched' and had 'too much to do.' They explained this meant staff did not always have much time to spend with people other than to carry out their direct care tasks, which some staff we spoke with confirmed. One person said, "Staff don't always have much time to talk to you; just to do what they need to do." Another person said, "When I use the call bell staff come as quickly as they can; sometimes I might have to wait a bit, but I don't mind; I know how busy they are." A relative told us, "Yes, I think it's safe on the whole; there are just about enough staff to complete the care task." Most people and relatives we spoke said they had experienced occasional staff delays, which they confirmed were not extensive and did not compromise people's safety.

Overall people told us they felt safe at the service and people's relatives felt people were safe there. One person said, "I do feel safe; staff try to accommodate us; when I need them I ring the buzzer and they often come quickly - sometimes they run down the corridor." A relative told us, "There is constant care they are looked after 24 hours a day; [person] is very happy and settled.

We saw that staff were visible and supported people safely when they needed care or assistance. For example, when people needed help to move, eat and drink or take their medicines. However, staff in charge on each care unit worked continuously across the day without a break. Both confirmed this had sometimes occurred following the deputy manager's recent redeployment, to cover a staff vacancy at night, pending staff recruitment. We observed the nurse was under continuous pressure to direct people's care, supervise staff, engage with visiting health professionals and give out people's medicines.

We discussed our findings with the registered manager who told us about their action to address this. The deputy manager's return to day shifts was assured following appointment to the night care staff vacancy. A staffing tool, was also introduced to help inform staff deployment. This took account of the numbers and needs of people receiving care at the service. Additional care staff provision was planned from, which rotas showed. This showed action was taken to ensure the deployment of sufficient staff to provide people's care.

New staff did not provide care to people until full employment checks had been carried out and verified. This included obtaining new staffs previous employment and character references. It also included checks of their qualifications, experience and with the appropriate national vetting and barring scheme. This helped to ensure that people were of suitable character, able and safe to work with vulnerable adults to provide their care

People were appropriately informed and confident to speak out if they had concerns about their own safety or the safety of others. Staff understood their roles and responsibilities for people's care and safety needs. This included how to recognise and respond to the suspected or witnessed abuse of any person receiving care at the service. Before our inspection the registered manager told us about three safety incidents concerned with people's care [where no harm resulted] when they occurred at the service. Management

records and feedback from the local authority safeguarding investigation of one of incidents; showed the provider's actions to prevent any reoccurrence and ensure people's safety. This helped to protect people from the risk of harm or abuse.

People's medicines were safely managed. People said they received their medicines when they needed them. We observed staff gave people their medicines safely and in a way that met with recognised practice. Records kept of medicines received into the home and given to people showed that they received their medicines in a safe and consistent way.

Staff responsible for people's medicines told us they had received medicines training. This included an assessment of their individual competency, which related records showed. The provider's medicines policy was reflective of recognised national guidance for the safe management and administration of people's medicines and subject to periodic review to further ensure this. For example, in relation to the safe ordering, storage, receipt and administration of people's medicines. In the event of a recent medicines error the provider told us about; records showed that required management procedures were followed to investigate and act to reduce the risk of any reoccurrence.

Staff understood known risks to people's safety from their health conditions or environment, which were assessed before people received care and regularly reviewed. People were provided with the care equipment they needed for their safety. For example, special seat cushions and bed mattresses to help to prevent skin sores or mobility equipment to help people to move safely. This helped to ensure people's safety.

The environment and equipment used for people's care was clean, safe and generally well maintained. People, relatives and staff told us this was consistently so and we received many positive comments about this. One person said, "Nice smell, always clean." Another said "yes – they often give my room a right good going over." We observed that staff used the correct type of personal protective equipment when required. For example, gloves and aprons when handling body waste products or dirty bed linen.

Management records showed regular monitoring of environmental and equipment safety. For example, in relation to cleaning procedures or for the regular servicing and maintenance of equipment. Planned environmental redecoration and refurbishment had commenced to further ensure a comfortable, pleasant environment for people.

Emergency plans were in place for staff to follow, which they understood. For example, in the event of a person's sudden collapse or the procedure to follow in the event of a utilities failure. Clear information was also provided and displayed for people about key safety procedures such as in the event of a fire alarm. This helped to ensure people's safety in the event of a foreseeable emergency.

Good

Is the service effective?

Our findings

People and relatives were happy with care provided by staff at the service. We received many positive comments about this. One person said, "They seem to know everything there is to know; I have no complaints at all; the staff do so much." Another said, "They know more about me than me! They get the doctor if needed." A relative told us, "They ask about the medical history and health needs; they know everything they need to know and don't hesitate to let us know if there any changes."

People were supported to maintain and improve their health and nutrition. People's care plans showed how their health conditions affected them and their related care needs, which we saw staff understood and followed. People's care was regularly reviewed in consultation with relevant external health professionals when required.

People were supported to access external health professionals when they needed to. For example, following any changes in their health condition or in relation to routine health checks such as diabetic, mental health or eye and foot care checks. People's care plans showed any instructions from external health professionals, which staff understood and followed.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood and mostly followed the Mental Capacity Act 2005 (MCA) to obtain people's consent or appropriate authorisation for their care. People said staff explained what they were going to do and asked for their consent before they provided people's care. People's care plans often showed how people's consent was obtained for their care; or how people's care was authorised or provided in their best interests if they were unable to consent. However, related care plan records for people living on the nursing unit at the service; were not always accurately maintained to show this, which a visiting health professional also told us. Discussions with the manager and senior staff showed that action was in progress to address this.

Some people had legally appointed others to act on their behalf to make decisions about their care, in relation to their finances or health and welfare. Staff responsible in the nursing unit did not always know this information, which was held by the registered manager. People's care plans and recorded staff handover information about people's care, also did not provide this information to help inform staff; which could result in people receiving inappropriate care that may not be in their best interests. We discussed our findings with the registered manager who agreed to take the action required to mitigate any risk to people from this. Otherwise, where people lacked capacity to make certain decisions the provider followed the

principles of the MCA to check that best interest decisions were made lawfully.

Staff told us that some people needed their care to be provided in a way that was necessary to keep them safe. The MCA DoLS require registered care providers to submit formal applications to a local a 'Supervisory Body' for authority to provide care in this way. Records showed the provider had made the required authorisation applications. This meant people's rights were upheld, and any restrictions in people's care were lawful.

Staff received the training and supervision they needed to provide people's care. People and relatives said staff understood their care needs and supported them well, which we observed. One person said, "Staff know what to do and when." A relative said: "The care is very good; staff seem to know what's what."

Staff told us they received the training and supervision they needed to provide people's care, which related records showed. One care staff said, "Training is well organised; there is a rolling programme of updates; staff are expected to attend all required training." A new staff member told us about the training and support they received on their employment induction and said, "It was really good – I didn't provide people's care until I had completed the training; they gave me time and checked I was confident and knowledgeable."

Care staff followed a nationally recognised induction process and they were supported to achieve relevant national vocational qualifications. Nurses received relevant clinical training to support or extend their role to help them keep up to date with nursing practice and maintain their valid nursing registration with the Nursing and Midwifery Council (NMC). The NMC is the registering body and professional regulator for all registered nurses, who are required to demonstrate their fitness to practice through on-going professional development.

People received a balanced diet and regular drinks of their choice. Food menus showed variety, choice, healthy eating and helped to inform people's meal choice. Cold food snacks were also readily available for people to help themselves. People told us they enjoyed their meals and said there was plenty of choice, including drinks, which were routinely offered. One person said, "I eat what I want the food is brilliant; there is lots of choice - as much as you want." Another person told us, "If you don't like what is on the menu you can have an alternative; there's always a good choice of drinks."

At lunchtime people were served their meals either in their own rooms or in the dining rooms as they chose. Meals were individually plated and served directly by the cook. People said they enjoyed their meal, which was described as 'hot and tasty.' Lunchtime was a relaxed and sociable occasion. We saw staff offered people choices of meals and drinks and provided them with the assistance and support they needed. Staff knew people's dietary needs, preferences and followed relevant instructions from external health professionals concerned with people's nutrition where required. For example, the type and consistency of food to be provided for people with swallowing difficulties because of their health condition. This helped to ensure people received sufficient amounts of food and drink.

Good

Is the service caring?

Our findings

People received care from staff who were kind, caring and promoted people's dignity, rights and involvement in their care. People and relatives spoke highly of staff who they felt were caring, respectful and knew them well. We received many positive comments from them. One person said, "Staff respect me; they help me do what I like; to get out and about." Another told us, "They [staff] always knock on my door and call my name; it's like a good friendship and family – they are always respectful." Another said, "Staff are always polite; they are great, remarkable; you always have a choice about what you can do and they respect that choice; I cannot fault them." Two people's relatives told us, "I know the staff well enough; they treat my relative with respect;" and "[person] is right happy here and cared for really well."

People or their representatives were involved in agreeing and reviewing people's care. People and relatives confirmed staff regularly discussed people's care and daily living arrangements with them. Each person had a named nurse or key care worker who had specific responsibilities for the co-ordination of their care. For example, supporting people to maintain their contact with family and friends or to contact relevant health and social care professionals concerns with their care. Regular meetings were held with people and relatives to help inform and involve them in home life and daily living arrangements. Records of recent meetings showed this included topics such as environmental security and redecoration, food menus and arrangements for social activities, events and entertainments at the service. This helped to ensure people's rights and involvement in their care.

People's care plans showed their known choices and preferences for their care and daily living routines. They also showed arrangements for peoples' contact with family, friends and others who were important them. People were supported to spend private time with their family members if they wished. Relatives told us they were able to visit at any time to suit the person they were coming to see at the service and there were no restrictions on visiting hours. This showed people's right to private and family life were respected and upheld.

We observed throughout our inspection that staff were kind, caring and mindful of people's rights, wishes and choices. For example, staff acted promptly and took time to ensure one person's dignity when the person did not recognise this was compromised because of their health condition. Staff supported another person to move independently by making sure their walking frame was close by. Staff also made sure that doors were closed when they provided personal care to people. Staff supported people to make choices about their care, such as what to eat and drink, where to spend their time, or whether they needed their pain relief medicines. Staff also made sure that things were to hand for people such as their drinks or call bells and that they were comfortable in their position or pain free. The registered manager told us they planned to train and introduce staff dignity champions to further ensure people's dignity in care at the service.

We observed staff were gentle, compassionate and discreet in their support of one person's bereaved relatives following their recent expected death at the service. Staff ensured time and privacy for them and offered drinks refreshment in a quieter part of the home away from the busy communal area. Staff told us they were trained and received support from the local hospice and MacMillan nurses to help inform their

practice for people's end of life care. Work was in progress for the service to complete and achieve a recognised local authority quality award concerned with end en people's end of life care at the service. This showed people were treated with respect by end of life care. This showed people received care from staff who were caring, compassionate and ensured people's rights in their care.

A range of key service information was provided to help inform people and their relatives about the provider's arrangements for people's care. This included how people should expect to be treated by staff and the provider's arrangements for people's occupation and leisure, meals and laundry at the service. It also included how to access independent advocacy services if people needed someone to speak up on their behalf. The registered manager advised key service information could be made available in alternative formats, including other languages if required; to aid people's understanding. For example, large print or easy read pictorial formats. We saw some key service information was displayed in prominent places where people could see it easily. Such as pictorial information to support people's meal choice or information to inform people about social activities they could join. Photographs of most staff, along with their names were also displayed to help people know them. This helped to ensure people's understanding and inclusion in home life.

Requires Improvement

Is the service responsive?

Our findings

People and relatives were mostly positive about the timeliness of people's care. They told us staff were helpful and mostly prompt to provide people's care when they needed it. One person said, "I like to stay in my room a lot; Staff come as quickly as they can when I need them; I press my bell it doesn't take too long for them to come." Another said, "They [staff] come when I need them but often don't have time to spend; just enough to get the task done."

We observed staff were visible, mostly observant and often provided people with care in timely manner when required. When this occurred, it was done in a way that usually promoted people's comfort, independence and inclusion. For example, staff supported one person in a timely, sensitive manner when they became visibly distressed. Staff explained this occurred sometimes when the person was not able to understand what was happening around them or what they needed to do because of their health condition. We saw the person subsequently responded positively to staff's approach and became visibly more relaxed and positively engaged.

However, at lunchtime staff did not always respond or support people in timely manner when required. For example, we saw one person living with dementia who was not able to communicate verbally and who wanted to use a napkin. Staff did not respond to assist them, which resulted in the person using the table cloth to wipe their face. We saw another person, who was also not able to communicate verbally because of their health condition, left sitting alone at a dining table with no place setting. Staff did not respond to assist the person when they tried to move to a table to sit with others, where a space was set. This resulted in the person showing visible signs of frustration, which staff did not acknowledge. The person subsequently gave up their attempt to move and later ate their meal with staff support.

Some people felt they would like provision to help themselves to drinks when they wanted to. One person said, "They [staff] bring round drinks at set times; so if I need I drink in between I have to get one from the bathroom." One person's relative said, "[Person] likes to drink more and would like drinks to be more readily available." We observed that food menus were provided in printed and picture format, which helped to inform people's meal choice. Cold food snacks were openly provided for people to help themselves throughout the day but drinks were not made available in this way.

Environmental design and adaptations were not sufficiently considered or made to support the individual needs of some people living with dementia or sensory needs. Environmental adjustments were not always made to optimise people's inclusion, understanding, independence or environmental orientation. For example, by use of relevant signage, sensory hearing equipment or other suitable orientation aids.

We saw that one person living with dementia struggled to find their way around and recognise their own room. The person's room showed their name in writing on the door. Staff confirmed the person was not able to recognise this because of their dementia. Staff also advised the person regularly went into other people's rooms by mistake, which often caused distress to both parties. The provider had not fully considered or undertaken an assessment of the impact on the person from their environment in relation to their health

condition; or for others living at the service with sensory needs who may benefit from this. For example, in relation to the provision of a hearing loop system that may be helpful to people who wore hearing aids.

We observed a range of relevant adaptations, aids and equipment were provided to support people to physically move or eat and drink independently. For example, lighting, corridor hand rails, adapted crockery and drinking cups. One person living with an eye impairment, which affected their vision; had their own special light and talking clock to assist them.

People often received individualised care from staff who understood what was important to them. People told us staff understood and supported their preferred daily living routines and choices, which we saw were recorded in people's care plans. This included people's bathing and showering preferences, rising and retiring times and supporting people to choose their clothing and how to spend their day. One person said, "Staff are very good – they listen and follow what I want." Another said, "They know I like to get out and about they make sure I do – it suits me."

Staff told us they gathered information from people or their relatives and others who knew them well to help inform people's care and daily living routines. This information was recorded in people's care plan records and included information about people's social and family histories, known daily living preferences and their related likes and dislikes. Staff felt it was important to understand people and get to get to know them to help inform their care and daily living arrangements. One staff member said, "It is always better if you know how to care for people; makes for better care if you know people, what suits and what's important to them."

Staff told us about one person who was known to have always taken pride in their appearance. Staff explained that because of the person's health condition they could easily become upset and refuse personal care because they often didn't understand what was happening around them. We saw staff were respectful, patient and gentle in their approach, which resulted in the person accepting the care they needed.

People were supported to engage in home life and to participate in activities and events they enjoyed, both in and outside the home. One person said, "There's plenty to do; I really enjoy the quizzes." Another said, "I like to get out and about; they help me sort transport." A relative told us, "The activities co-ordinator is brilliant; they do a lot; the singing is really good for [person]." Another said, "Staff take my relative out for regular walks; they would be lost without their walks out."

Arrangements for people's social, recreational and occupational activities were co-ordinated by two dedicated staff members; supported by staff and sometimes people's relatives. Photographs were displayed around the home, which showed people's engagement in a range of social and recreational activities. A weekly programme of activities such as singing, baking, music, table top games, crafts and quizzes were offered, which people could choose to join. One to one activities were also provided for some people in their own rooms, such as reading and hand manicures. Sometimes activities were sourced through external providers, such as mobile animal zoo, which enabled people to see, touch or hold small animals. During our inspection we observed a group of people were supported to undertake crafts and listen to music in a dedicated activities room.

People said they were regularly supported to engage in seasonal events, celebrations and trips out. Fund raising events were regularly held, such as seasonal fayres, which helped to support activities and entertainments provision. Recent trips out included to Chatsworth House estate, local garden and shopping centres. People had access to a shared minibus also used by a sister home and staff regularly supported some people who chose, to use community transport to access the local community.

People and their relatives knew how to make a complaint if they needed to. All felt that staff usually responded to their comments and suggestions without the need to make a formal complaint. People and relatives views about the service were regularly sought. This included through regular one to one or group meetings and through periodic care surveys held with people and their relatives. A computer system was provided in the reception area for people and their relatives to post their comments and views about the service. Minutes of meetings, care survey results and planned service improvements were routinely shared with people and relatives. For example, in relation to security, social activities and entertainment, food menus and confidentiality. This meant people's views, suggestions and complaints about the service were routinely sought and used to make improvements when required.

Good

Is the service well-led?

Our findings

People, relatives and staff felt the home was well managed and found the registered manager to be visible and approachable. One person said, "The manager is lovely." A relative said, "The manager will call us if there are any issues; they all work hard; [person] is well cared for. Another person's relative said, "On the whole management are approachable; it's well organised."

Staff were generally positive about the management of the home and felt management and senior staff were visible and supportive. Staff we spoke with understood their role and responsibilities for people's care and overall felt they had the information and support they needed to provide this. This was supported by relevant communication and reporting procedures for staff to follow for people's care. For example, in the event of an accident such as a person's fall or any change in a person's health condition. One person's relative told us about a delay in obtaining prompt medical advice for the person when needed. Records showed this incident was reviewed by the registered manager who took relevant action to prevent any reoccurrence.

Staff told us management or senior staff held regular meetings with them, such as individual, care handover or group meetings. Staff said this helped to inform them about any service developments and improvements and the reason for this; which staff meeting minutes reflected. This showed that staff were appropriately informed and supported to deliver people's care

Staff understood how to raise concerns about people's care if they needed to. The provider's procedures also included a whistle blowing procedure. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their responsibilities and rights to raise concerns about people's care if they needed to.

Staff understood and followed the provider's aims and values for people's care to promote people's involvement, rights, equality and safety. Related staff training and regular checks of care practice helped to promote this. People, relatives and staff were involved in developing and improving the service though regular consultation with them. This included through meetings and questionnaire type surveys.

The registered manager told us they carried out regular checks of the quality and safety of people's care. This included checks of people's health, nutritional status and related care; checks of medicines and staffing arrangements and checks of the environmental safety and equipment used for people's care. Accidents, incidents and complaints were monitored and analysed to help to identify any trends or patterns. This helped to inform people's care and any improvements needed. Examples of recent improvements either made or assured from this included environmental safety, health emergency procedures and staffing measures.

Records relating to people's care were mostly accurately maintained and they were securely stored. Record keeping improvements were assured where required in relation to some people's care plans. The provider maintained regular oversight of the management of the service and sent us written notifications about

important events that happened there when required. For example, to tell us about a person's expected death or an outbreak of infection.