Care Quality Commission

Malhotra Care Homes Limited

Cestria House Residential Home

Inspection report

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Ratings

Overall rating for this service	
Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Summary of findings

Overall summary

This was an unannounced inspection carried out on 17 and 19 February 2016.

We last inspected Cestria House on 12 September 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Cestria House provides accommodation and personal care for up to 24 older people. Care is provided to older people, some of whom are living with dementia or dementia related conditions. Nursing care is not provided.

A registered manager was in place. '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 said they were safe and staff were kind and approachable. There were sufficient staff to support people. We had concerns that robust arrangements were not in place to reduce the risk of fire as a person smoked in their bedroom.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Systems were in place for people to receive their medicines in a safe way. However, we have made a recommendation about the management of medicines.

The environment was mostly well-maintained but some areas required attention.

People had access to health care professionals to make sure they received appropriate care and treatment. However, we had concerns peoples' privacy and dignity was not respected as we observed some people's treatment took place in the lounge.

Cestria House was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were not always made appropriately on behalf of some people, when they were unable to give consent to their care and treatment.

Appropriate training was provided and staff were supervised and supported.

Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected by Cestria House staff.

There were a variety of activities, outings and entertainment available for people.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided, however they had not identified the issues during their audits that we noted during the inspection.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running 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?

Requires Improvement

Not all aspects of the service were safe.

Suitable arrangements were not in place to protect people in the home when people smoked.

People told us they felt safe and staffing levels were sufficient to ensure people were looked after in a safe and timely way. Staff were appropriately recruited.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe manner. However, we have made a recommendation about the management of medicines.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff were supported to carry out their role and they received the training they needed.

People's treatment needs were met by health care professionals who attended the home. However, we had concerns some peoples' privacy and dignity were not respected when treatment was carried out.

Best interest decisions were not always made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet to meet their nutritional needs.

The building was not well-maintained in all areas.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. People received support in the way they needed because staff had detailed guidance about how to deliver their care.

People enjoyed a variety of activities and entertainment and there were opportunities to go out supported by staff.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided. However, the registered manager had not identified the issues relating to risk, maintenance of the environment and maintaining peoples' privacy and dignity.

Care Quality Commission

Cestria House Residential 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.'

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We received no information of concern from these agencies.

This inspection took place on 17 and 19 February 2016 and was an unannounced inspection. It was carried out by an adult social care inspector.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We undertook general observations in communal areas and during a mealtime.

As part of the inspection we spoke with six people who were supported by Cestria House staff, the registered manager, three support workers, a cook and two relatives. We observed care and support in communal areas and checked the kitchen, bathroom and bedrooms after obtaining people's permission. We reviewed a range of records about people's care and checked to see how the home was managed. We looked at care records for four people, two peoples' medicine records, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits the registered manager and operational manager completed.

Requires Improvement

Is the service safe?

Our findings

People told us they were safe and could speak to staff if they were worried. Their comments included, "Yes, I feel safe living here," "The staff are always around, I'm quite safe," "I definitely feel safe," "I have a bell to call staff if I need to when I'm in my bedroom," "There are plenty of people around to help when you need it," and, "I think there are enough staff to keep us safe." A relative commented, "I'm quite sure (Name) is safe here."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, moving and assisting and falls. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. We had concerns a robust risk assessment and arrangements were not in place for a person who smoked in their bedroom on the third floor of the building. This was a risk to people in the home in case of fire. This was addressed at the time of inspection by the registered manager. A robust risk assessment was put in place and the person was discouraged from smoking in their bedroom. The registered manager told us this would be monitored. An alternative smoking area was provided on the ground floor. Discussion took place with the registered manager to ensure the human rights of people who used the service who smoked were balanced with the rights of people who did not smoke. A designated smoking area with adequate ventilation was to be made available for people who used the service who smoked whilst the designated smoking area was indoors, to ensure people who did not smoke were not subjected to the effects of passive smoking.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. Staff members' comments included, "I'd report any concerns to the registered manager," and, "I'd tell the person in charge straight away."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place and three safeguarding concerns had been raised with the local authority. They had been investigated and resolved. One of the alerts had been with regard to a person, who required support, leaving the building without being observed. We discussed the action taken as a result of the incident as it was thought they had left via two secure exits that had been left open leading onto a lane at the back of the building. We observed one exit, which we were informed may have been left open, was where staff smoked outside the fire door. We discussed with the registered manager the need to adhere to the smoke free legislation that had been passed in July 2007, Smoke-free (Premises and Enforcement) Regulations 2006. This stated staff and the public were not to smoke in the vicinity of the premises, in this case the home. The legislation was passed to make work places smoke free environments and to protect individuals in the work place.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. We did not see that the staff member remained with the person to ensure they had swallowed their medicines. We observed one person sat holding their medicine for over an hour until the registered manager encouraged the person to take their medicine. This meant staff did not always remain with the person to ensure they took their medicine. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Staff members who administered medicines told us they would be given outside of the normal medicines round time if the medicine was required. We saw written guidance was in place for the use of some "when required" medicines. The guidance included when and how these medicines should be administered to ensure a consistent approach to the use of such medicines, such as for pain relief.

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us and their training records showed they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used. For example, with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests." We were told one person received covert medication. A record was not available to show how the decision had been made as there was no evidence to show that a 'best interest' meeting had taken place. A letter was available from the General Practitioner but it did not show who had been involved in the decision making. There was no documentation to show why covert medicine was required or to show if all other ways had been exhausted before the decision was reached. The registered manager told us this would be addressed immediately.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We considered staffing levels were sufficient but should be kept under review as people who were currently more independent became more dependent. The registered manager told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. At the time of our inspection there were 19 people who lived in the home. The home was staffed by three support workers from 8:00am until 9:00pm and two support workers from 9:00pm until 8:00am. These numbers did not include the registered manager who was also on duty during the day and was available 'on call' overnight to provide any support and guidance when required.

We spoke with the registered manager and other members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Criminal Records Bureau, now the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full

employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist bath.

We recommended the registered manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Requires Improvement

Is the service effective?

Our findings

We looked around the building and the environment was mostly well-maintained and decorated for the comfort of people who lived in the home. We saw bedrooms were well-decorated and personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff respected people's belongings. The building was also bright and well-lit for people as they walked around. However, some carpets such as at the main entrance, the middle and top floor hallways were marked and showing signs of wear and tear. The carpet on the fire exit stair well was stained and marked at ground floor level and we observed litter in this area on the ground floor and on the stairs as we progressed to the top floor of the building. One of the bedroom ceilings on the top floor showed was marked and the paint was flaking off, there were signs of water damage and this water damage was also apparent on the fire exit stair well between the ground floor and first floor. We saw to the top floor, part of the floorboards and floor covering on the fire exit stair well was missing. We showed the registered manager who told us it would all be addressed immediately. On the second day of inspection we saw the necessary action was being taken and the identified areas were being measured for new carpets and the other identified works were being addressed.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, a community nurse, a dietician, a psychiatrist, the behavioural team and General Practitioners (GPs). Records were kept of visits and any changes and advice was reflected in people's care plans. We considered that peoples' privacy and dignity were not always maintained when they received medical treatment. Before lunch, we observed a visiting health care professional provide treatment to some people who did not have the capacity to consent, they had their injection of insulin for diabetes administered in a public area. They carried out this treatment in the lounge where other people were around to observe, rather than in a private area, such as the person's own bedroom or a treatment room as the injection was required. We were told the injection for one person was administered to the person's thigh or stomach which required items of their clothing to be raised when they were also sitting next to a person of the opposite gender. We discussed this lack of dignity with the registered manager who said it would be addressed with the district nurse.

Relatives were kept informed by the staff about their family member's health and the care they received. One relative commented, "I am kept informed about (Name)'s care." A comment from a relative from a provider's survey carried out in December stated, "On arrival at the home an update about (Name) is usually given."

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from the registered manager every two months. Staff comments included, "The registered manager does my supervision," and, "I have about six supervisions a year." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. Staff members' comments included, "I have an appraisal annually," and, "We have a midyear appraisal before the end of year meeting."

Some staff told us they had worked at the service for several years. Staff members comments included, "I love working here it's so homely," and, "I've worked here for years." Staff members were able to describe their role and responsibilities. Some staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. The registered manager told us new starters were to study for the Care Certificate as part of their induction to equip them with some of the required skills to work with people.

Staff told us and training records showed they were kept up-to-date with safe working practices. Staff members' comments included, "We do lots of training," "There's always training and we have opportunities for more," and, " The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Staff training courses included dementia care, end of life care, nutrition and hydration, mental capacity, dignity, care planning and deprivation of liberty safeguards.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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 are called the Deprivation of Liberty Safeguards (DoLS). Cestria House records showed five people were legally authorised and two applications were being considered by the local authority. Records showed assessments had been carried out where it was considered people did not have mental capacity to make decisions with regard to their care and welfare. Staff confirmed they had received training about mental capacity and DoLS.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. For example, with regard to going out unaccompanied and handling their own medicines. Staff said if a person did refuse support for example with regard to their personal care or taking their medicine they would offer alternatives or leave the person and try again later.

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a communication book that provided information about people, as well as the daily care entries in people's individual records. A staff member commented, "I think communication is good."

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. The cook told us they received information from the registered manager when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce.

We saw food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received good food. However, they did say they did not have a choice at the lunch

time meal. On the day of inspection we saw people were served turkey but there was not a second choice of meal if people did not want the option that was available for vegetarians. People's comments included, "There's plenty to eat," and, "There isn't a choice of food." We discussed this with the registered manager who said it would be addressed immediately. We were told people were offered a choice at the evening meal and we saw the book that recorded people's choice of evening meal. The registered manager said the same system would be used for the lunch time meal so people were offered a choice for their main course. Hot and cold drinks were available throughout the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day. The food charts used to record the amount of food a person was taking each day did not accurately document the amount of food a person consumed as it did not refer to portion sizes and the daily fluid intake for a person was not checked to ensure they had received sufficient hydration. The registered manager said that this would be addressed.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were all positive about the care provided by staff. Comments included, "The staff are lovely," "Staff are very kind," "It's a very good home," "It's homely," and, "It's a lovely home, we get very good care." A relative commented, "The staff are angels, we worried about (Name) coming into care but they've settled very well." Several cards of appreciation were available from relatives commending the staff and the care provided to their relatives. Responses from professionals in a provider's survey included, "Have found all the staff from the cook, laundry and care staff to be excellent, and, "The care is excellent better than satisfactory." Comments from relatives in the provider survey included, "A warm and friendly atmosphere and genuinely caring staff," "The staff are always polite," "Very happy and settled, feels like every day is a holiday."

People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people were very relaxed. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. However, we discussed with the registered manager the comments we overheard from one staff member with a person, which although kindly meant, could be interpreted as paternalistic. The registered manager said this over-familiarity would be addressed. Staff asked the person's permission before they carried out any intervention. Staff explained what they were doing as they assisted people, for example as they assisted them in the hoist transfer and they met their needs in a sensitive and patient manner.

We observed the lunch time meal. The meal time was relaxed and unhurried. Staff interacted with people as they served them. People sat at tables set with tablecloths and condiments. Specialist equipment such as cutlery and plate guards were available to help some people. Tables were set for three or four and staff remained in the dining area to provide help and support to people. Staff provided assistance or prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way. However, we observed one person who was assisted to eat was not offered small amounts of food by staff but the fork was loaded with food and we saw it took the person some time to eat each mouthful. We discussed this with the registered manager who said it would be addressed.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. They described how they supported people who did not express their views verbally. They gave examples of asking families for information. We saw juice cartons that showed pictures of fruit were shown to people, if needed, to help them make a choice of drink. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. A care plan stated, "Staff to observe and offer Paracetamol if needed."

People told us they could move around the home as they wished. Some more independent people told us

they went out when they wanted. They could choose to spend time in their bedroom and could get up and go to bed when they wanted.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told two people had the involvement of an advocate.

We spoke with relatives and asked them whether they were able to visit their family member. One relative told us, "Yes, we visit every day." They confirmed they were able to visit their relative at any time.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. Comments included, "I go out every day," "I go to a club," "I meet friends and attend a knit and natter group," "I do some of my own shopping," and, "I go out with my family." We were told a trip out to the local dog stadium was planned for the weekend. Some people told us they had been for meals out at local restaurants and enjoyed trips out to the coast, theatre, garden centre, cinema, town centre and other places of interest. Activities and events took place in the home such as bingo, board games, baking, crafts, hairdressing, church services, visiting entertainers and planned seasonal parties.

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Up-to-date written information was available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs took place with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, wound care, mobility and falls and personal hygiene.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, with regard to nutrition. Care plans reflected the advice and guidance provided by them and other external health and social care professionals.

Staff completed a daily report for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when people were bathed or assisted with personal care. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

The care plans gave staff specific information about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They detailed what the person was able to do to take part in their care and to maintain some independence. For example, a care plan for personal hygiene stated, "Staff to help to prepare washbasin with warm water and get the toiletries," and, "Encourage (Name) to apply make-up and brush hair." Care plans were up-to-date and they were reviewed monthly and on a more regular basis, if a person's needs changed. Staff told us they were responsible for updating designated peoples' care plans.

Information was available to help staff provide care and support for when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information which had been collected from the person or from their families about their life history and likes and dislikes. This gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. Examples in care plans included, "I am very sociable, I enjoy a glass of wine," "I like small

meals with a gravy boat at the side as I dislike food covered in gravy," "Never ask me to play bingo as I hate the game," and, "I dislike drinks such as Horlicks." Information was available with regard to peoples' wishes for care when they were physically ill and recorded their spiritual wishes or funeral requirements.

Regular meetings were held with people who used the service and their relatives. The registered manager said meetings provided feedback from people about the running of the home. We were told the meetings were an opportunity for people to give feedback about the care they received. Topics discussed included, menus, activities and outings.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw no complaints had been received since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post and they were registered with CQC in 2011.

People told us the atmosphere in the home was warm and friendly and relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. Comments included, "The manager is very approachable," "You can speak to the manager at any time," "The manager is really supportive," and, "The registered manager is a lovely person."

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on care documentation, the environment, medicines management, training, accidents and incidents and nutrition. Three monthly audits were also carried out for care documentation, health and safety, catering, medicines and infection control. The registered manager told us three monthly visits were carried out by a representative from head office to speak with people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Although audits were carried out and included checks on the environment, these audits had not highlighted deficits in certain aspects of safety and deficits in the environment. Staff respected peoples' privacy and dignity however, they had permitted the practice of providing treatment to people in a public area, which did not respect peoples' privacy and dignity.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. Records showed that where a person had fallen more than twice they were referred to the falls clinic. The registered manager told us if an incident occurred it was discussed at a staff meeting to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

Staff told us regular staff meetings took place and these included health and safety meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. We saw surveys had been completed by people who used the service and relatives in February 2016. We were told the results were analysed so that action could be taken as a result of people's comments, to improve the quality of the service. Relatives' comments included, "A big thank you we have seen a vast improvement in (Name)," and, "There's a good atmosphere in the home."