St Philips Care Limited

Roxholm Hall Care Centre

Inspection report

Roxholm
Sleaford
Lincolnshire
NG34 8ND
Tel: 01526 832128
Website: www.stphilipscare.com

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Ratings

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

Overall summary

The inspection took place on 24 August 2015 and was unannounced.

The home provides residential care for up to 39 people who require care due to old age, living with dementia or mental health needs. It is located in the countryside four miles north of Sleaford in Lincolnshire. On the day of our inspection there were 34 people living at the home.

We carried out an unannounced comprehensive inspection of this service on 19 November 2014. Breaches of legal requirements were found. After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirements in relation to safeguarding service users from harm, ensuring people received care which met their needs, providing appropriate numbers of staff with the correct skills and support to meet people's needs, managing medicines safely, meeting people's nutritional needs and ensuring that they gathered people's views on the service and had effective systems to assess the quality of service provision.

There was a registered manager for the service, however, they no longer worked for the provider and a new

Summary of findings

manager was in post. The new manager had submitted an application to register with the Care Quality Commission and we asked the provider to request the registered manager cancel their registration. 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.

At our inspection on 24 August 2015 the provider had taken all the actions necessary to meet the legal requirements in the areas where they had breached regulations. However, time was needed to see if the systems would continue to support good quality care over time. In addition, further improvements were needed to provide person centred care which met people's individual needs.

We saw the provider had appropriate assessments to identify where people were at risk while receiving care. Care was planned and equipment used to reduce the level of risk and keep people safe. In addition, accident and incidents had been reviewed and changes made to people's care to prevent similar occurrences in the future. Medicines were stored and administered to people safely. However, records did not contain information needed to provide person centred support to people and medication records did not contain information about the creams people needed applying.

Staff received ongoing training which supported them to have the skills needed to care for people safely. However, staff did not always provide care according to the training they had received. Training in how to keep people safe from harm had been effective and staff knew how to raise concerns to external agencies. The manager had worked collaboratively with the local safeguarding authority to ensure people were safe from harm.

The manager had calculated the number of care workers needed to meet people's needs and had used this information to develop rotas which included more staff at busy periods of the day. However, at times the home was not fully staffed due to sickness and this impacted on the care people received.

People were supported to have access to hot and cold drinks and appropriate equipment was provided to support them to remain independent with drinking. Staff and the cook were knowledgeable about people's nutritional needs and ensured appropriate food was available. People had a choice of meals but could also request food not on the menu.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect

themselves. The registered manager was aware of their responsibilities under the Mental Capacity Act 2005. However, information on DoLS was not always recorded in people's care files.

There was a warm and caring relationship between staff and people who lived at the home and people were supported to be involved in planning their care. Staff respected people's privacy. However, at times people had not been supported with their dignity.

Care plans had been regularly reviewed and contained information needed to provide safe care. However, they did not always support staff to provide person centred care. There was some activities provided in the home which some people chose to join in. However, some people told us the activities did not suit their needs or support them to maintain their hobbies. The provider had recognised the need to improve activities and was working with an outside agency to improve they type of activities offered.

The manager was available and approachable and people living at the home, visitors and staff were happy to raise concerns and were confident that they would be resolved. The provider had responded to complaints in an open and transparent manner which showed they were aware of their legal responsibility to be honest with people using the service.

People living at the home, visitors, healthcare professionals and staff had been consulted about their views of the home and the manager had taken account of their views to improve the quality of care provided. There was a series of audits in place to monitor the risks to the

Summary of findings

service and quality of service provided. The manager had taken action such as informing staff of issues and providing extra training when the audits had identified concerns.

Summary of findings

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

The service was not consistently safe.

The provider had taken appropriate action to ensure they met the legal requirements to ensure the service was safe.

People were protected against harm as staff knew how to raise concerns and the manager worked with the local safeguarding authority to protect people.

Risks to people were identified and care was planned to keep people safe. Medicines were safely stored and administered. However, there was no recording of when topical medicine such as creams and ointment had been applied.

The manager had identified the number of care staff needed to keep people safe. However, sickness impacted on staffing levels and the care people received.

Is the service effective?

Requires improvement

The service was not consistently effective.

The provider had taken appropriate action to ensure they met the legal requirements to ensure the service was effective.

People received appropriate food and drink to support their well-being.

Staff received ongoing training and support from the manager. However, this was not always effectively monitored in practice..

People had been appropriately assessed under the mental capacity act. However, information related to Deprivation of Liberty Safeguards was not recorded in the care plans.

Is the service caring?

Requires improvement

The service was not consistently caring.

The provider had taken appropriate action to ensure they met the legal requirements to ensure the service was caring.

People were involved in planning their care.

Staff had a warm and caring relationship with people living at the home, but at times staff failed to support people's dignity

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The provider had taken appropriate action to ensure they met the legal requirements to ensure the service was responsive.

Summary of findings

People's needs were assessed and care delivered to keep people safe. However, care plans did not support staff to provide care in the way people preferred.

People had access to activities; however, the activities provided did not meet their needs. People were not always supported to maintain their hobbies and interests.

People knew how to raise concerns and were confident any issues raised would be resolved.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The provider had taken appropriate action to ensure they met the legal requirements to ensure the service was well-led. However, time was needed to see if they systems would continue to support good quality care.

The manager was approachable and was trusted to resolve any issues people raised.

There were systems in place to gather the views of people involved with the service and action was taken to improve areas which people thought needed attention.

The provider had systems in place to monitor risks to the home and to assess the quality of service provided. Action was taken when risks and concerns were identified.

Roxholm Hall Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 24 August 2015 and was unannounced. The inspection was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service. This included the concerns we identified at our inspection on 19 November 2014, any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commissioned care for some people living at the service.

During the inspection we spoke with 11 people who lived at the service, four visitors to the service and spent time observing care. We spoke with, a senior carer, three care workers, a housekeeper, the chef, the area manager and the manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at four care plans and other records which recorded the care people received. We also looked at management records including how the quality of the service provided was monitored.

Requires improvement

Is the service safe?

Our findings

When we inspected on 19 November 2014 we found that care plans identified risks; however, the care delivered did not always ensure risks to people were minimised. This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. We reviewed the care plans of two people with behaviour which may challenge. We saw there was an explanation of the behaviour the person presented with and for one person there was a record of occasions when the person displayed distressed behaviour. However, there were no instructions for staff on the action to be taken to manage the person in these circumstances and calm or divert them.

Risk assessments had been completed for falls, pressure ulcers and nutrition. These had been reviewed monthly. Where people used bed rails most had risk assessments in place to ensure that they were safe and people had been consulted and consented to having bed rails. However, risk assessments relating to bed rails were not in place for one person who had recently moved into the home.

People had appropriate pressure reliving equipment and they were using the equipment prescribed for them to prevent the development of pressure ulcers. Repositioning charts were accurately completed. Staff were knowledgeable about the risks associated with people's care and were able to tell us about equipment and systems in place to try and reduce the risks to people.

We saw accident and incident forms had been completed when people had a fall or suffered injury. The manager had reviewed the accidents and incidents to see if there was any pattern to them, for example, if they were occurring at similar times of the day. If any patterns were identified the manager made changes to care to keep people safe.

The staff had considered environmental risks to people and had taken appropriate action to keep people safe. For example, each care record contained a personal emergency evacuation plan which provided details of the support the person would require in the event of an emergency evacuation of the building.

When we inspected on 19 November 2014 we found that staff did not know how to raise safeguarding concerns with external agencies. This was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 safeguarding service users from abuse.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. People told us they felt safe at the home. One person told us that they chose to have a gate across their doorway as a person with dementia had been going into their room. They said the gate had stopped this and they felt safe.

Staff told us they had completed safeguarding training as part of their mandatory training and were able to identify signs of abuse. They told us they would report concerns to the manager and they were aware there was an escalation process. They said they were confident the manager would act on any concerns raised.

The manager had worked jointly with the local safeguarding authority to investigate when concerns had been raised. The manager assessed the concerns and made changes to the way care was delivered to keep people safe and to stop incidents reoccurring. For example, there had been a medicine error when a person moved into the home after being discharged from hospital as the home had not received a discharge letter with a list of their current medicines. Systems were now in place to ensure staff contacted the hospital for a discharge letter.

When we inspected on 19 November 2014 we found that people did not feel safe in the home as there was a shortage of staff. This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 staffing.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. The manager had used a staffing tool approved by the local authority to calculate how many care hours were needed to meet people's needs. Records showed they were providing the required number of care hours to meet identified need. The manager had also rearranged staffing rotas to provide more staff at busier times of the day. For example, an extra member of staff was available when people were getting up and going to bed. Staff told us having the extra member of staff at the busy times worked well.

However, they said that while they were able to provide all the physical care people needed, they said they did not have time to complete the nice bits of care such as

Requires improvement

Is the service safe?

spending time talking to people. Staff told us that when they were fully staffed they could meet people's needs but at present they were short of staff and often did not meet the required levels on the rota. On the day of our inspection they were down a member of staff in the afternoon due to sickness. One member of staff told us the impact was on the timeliness of care.

People told us did not always feel supported by staff or have an opportunity to talk about their needs. One relative told us, "Sometimes there's just not enough of them." A person living at the home said staffing levels impacted on the time they were supported to have their medicine through a device. They said, "It often goes wrong. Last night I didn't come off it until 11.30pm which is way too late for me to go to bed. It's happened lots of times."

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the service.

When we inspected on 19 November 2014 we found that medicines were not administered in a timely fashion and poor levels of recording meant it was not always clear if medicines had been taken. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 management of medicines.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. We found that medicines were stored in accordance with legal requirements. Staff had received training in medicines administration and had competency assessments completed by a senior member of staff. We observed a medicine round and saw that the member of staff administering the tablets did so in a methodical manner which reduced the risk of them making a mistake. There were records in place to ensure the rotation of the site of pain relieving patches and records for people whose health required monitoring as a result of the medicines they were taking. There were protocols in place for some medicines which had been prescribed to be given only when required but this was not in place for everyone.

However, we saw that the medicine administration records (MAR) did not indicate how people preferred to be supported to take their medicine and they did not support staff to be aware of people's allergies. While staff could tell us about which creams people used and where they needed to be applied, the application of creams were not consistently recorded on the MAR or on cream charts in people's bedrooms.

Requires improvement

Is the service effective?

Our findings

When we inspected on 19 November 2014 we found that staff did not always have time or resources to complete appropriate training. The computer on which they accessed their training was locked in the office outside of office hours meaning staff had to complete training at home in their own time. This was a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 supporting workers

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. We found that staff were now supported to access a computer during all shifts to complete training in working hours. Records showed staff training levels were meeting the providers expectations.

When staff first started at the home they had an induction where they studied mandatory subjects such as moving and handling and infection control to ensure they had the knowledge to provide safe care to people. In addition, they also spent time shadowing a more experienced member of staff who could support them to put their training into practice. The area manager explained how they are reviewing the induction training to include the new care certificate. This is a new training scheme supported by the government to give staff the skills needed to care for people. The provider had worked with an educational provider to tie the care certificate into a recognised qualification which was transferable between services.

Staff also received ongoing training and records allowed the manager to monitor which staff had completed training and what training staff still needed to complete. Staff were also supported to provide safe care through annual appraisals and routine supervisions. Supervisions are meetings with the manager where staff can discuss any concerns they have and if they feel they need more training.

While records showed that staff had received training we saw two examples where staff did not always provide care in line with safe moving practices. This was unsafe for both the person receiving care and the staff. We raised this with the manager who said they would investigate the concern.

When we inspected on 19 November 2014 we found that people were not supported to have access to drinks and staff were not aware of when to raise a concern if people were at risk of dehydration. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 meeting nutritional needs.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. We received positive feedback from people living at the home about the food. One person told us, “I’m a bit particular, but it’s very good.” While a visiting relative said, “[My relatives] food is fabulous. Homemade chips and lovely choices. She eats all she’s given.”

While people were offered a choice from the menu on a daily basis they were also supported to ask for anything they wanted. One visiting relative told us, “They did her scrambled egg specially one day when she’d had a upset tummy.” In addition, we saw the cook was willing to make people anything they wanted to eat. For example, one person asked if there was custard for pudding, while it was not on the menu the cook happily made custard for this person.

The cook was able to speak knowledgeably about people’s food likes and dislikes, their nutritional needs and what support people needed. In addition, the sheets used to record people’s lunch choices listed any special requirements they had so staff could support people to make an appropriate choice.

During the day we saw that people had access to cold drinks and were offered hot drinks at meals and when the tea trolley came round. People were supported have drinks in specially adapted cups and beakers to help them to be independent with drinking.

Where people were at risk of not being able to eat or drink enough to keep them healthy monitoring charts were in place and appropriately completed. This supported staff to raise concerns if people’s intake fell below an acceptable level. Where concerns were noted people were referred to the GP and dietician to help them maintain a healthy weight. If people were struggling to swallow safely we saw they had been referred to the speech and language specialist for advice on how to keep them safe when eating.

At our inspection on 24 August 2015 we saw that people were supported to maintain good health by visiting health

Requires improvement

Is the service effective?

care professionals. Records showed that people had been seen by the GP and community nurses when concerns about their health arose. People were also supported to access care from visiting opticians and chiropodists.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) are laws which protect people's human rights when they are no longer able to make decisions for themselves. We saw there was a MCA policy and a DoLS policy in place for staff to refer to. Staff had received training in the Mental Capacity Act 2005 and told us how they offered people choices in their everyday lives.

Records showed people had received capacity assessments when it was not clear if they could make decisions for themselves. Records showed that where people were at risk of being deprived of their liberty, they had been referred to the local authority for assessment. However, we saw this information was not clearly recorded in one person's care plan as DoLS documentation was stored centrally so staff may have been unaware of the application and the actions needed to keep the person safe.

Requires improvement

Is the service caring?

Our findings

When we inspected on 19 November 2014 we found that staff did not always support people to maintain their dignity and people told us that at times staff spoke sharply to them. Staff did not always provide comfort and reassurance when needed. People were not supported to spend time in private when relatives visited. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 respecting and involving service users.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. All the people we spoke with told us they were treated with dignity and respect and complemented the staff. One person told us, "I can't fault the girls." Another person said, "The night staff, they're champion." We saw there was a warm and caring relationship between staff and people living at the home. For example, one person was really happy to see a member of staff on duty and greeted them with a kiss. However, we saw three people who had been left without access to their call bell and would have been unable to call for assistance.

The staff were polite and addressed people by their preferred name and treated them in a respectful way. Staff greeted people in the corridors when they passed them and checked on their well-being. A housekeeper told us how people liked to have a chat and showed a real understanding and empathy for people using the service. They said, "It is nice to have a little chat with them." "You speak to them and they know you are there, even if they don't remember later."

People and their relatives told us they had been involved in planning the care they received and supported to see the care plan. One relative told us, "Her care plan came with her from hospital and we didn't get to see that. But I've seen the one here now." Another family member told us, "As her daughter, I've been involved in her care planning and we're happy." A senior carer said that they had recently started to write care plans and where people could input in to the care plan they would talk to them. For people who were not able to express a preference about their care the senior carer would use observations and talk to other carers to identify people's preferences. Staff were aware that one person had an advocate to help them make decisions. An advocate is an independent person who will support people who are unable to communicate their choices by speaking for them.

People told us staff respected their privacy and would always knock on their bedroom door before entering and we observed this during the inspection. We saw one person was able to entertain their visitor in private in their bedroom. Staff said they would always offer people choices wherever possible such as clothes they wanted to wear and when they wanted to get up and go to bed.

We saw that staff supported people's dignity by speaking to people discreetly while offering care, giving care in private and ensuring people were offered choices about their care and lives. However, we identified some dignity issues. For example, we saw one person who was unable to ensure their own dignity was wearing trousers which were too small for them and would not do up properly. This person spent most of the time walking about communal areas of the home and people living at the home and visitors could see that they were improperly dressed.

We also saw at times care was not presented in a way which provided the best experience possible for people. For example, people were offered a choice of squash at lunch times. However, the squash was made up in and offered to people out of an old squash bottle.

Requires improvement

Is the service responsive?

Our findings

When we inspected on 19 November 2014 we found that care did not always meet people's needs and people were not supported to take part in meaningful activities. This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation.

People were now supported to make choices about their care so that it met their needs. For example, what times they wanted to get up and go to bed. A relative told us, "They used to get [my relative] up early as she's at the start of the corridor, but then she said she wanted to be later, so they changed it for me." We saw some good examples of staff supporting people, For example, one person living with dementia left their place every few minutes to sit somewhere else and one member of staff continued to take their meal to them and quietly supported the person. In addition, staff were able to tell us about people's needs including recent changes in care. For example, one person had an infection and was on antibiotics.

We found that there was a pre-admission assessment in each person's care record and care plans which provided information on the care and support each person required. The care plans had been regularly reviewed and updated to take account of changes in people's needs. Staff told us that they had time to read the care plans. One member of staff said, "If you know them a bit you can give a higher quality of care."

However, information in the care plans did not always support staff to provide care in a person centred way and people told us that care was not always delivered the way they preferred. For example, a relative told us, "[My relative] needs her legs cleaned and creamed every day – and the help varies. [My relative] wants it done in the morning before she gets dressed but may have to wait until bedtime. It depends who's on duty and knows her." We also saw one example of staff being task focused and failing to make a person more comfortable when they requested to be moved as the staff were too busy.

There had also been some improvement in the activities offered to people. There was an activity coordinator employed and a four week activity rota in place. Records showed that some entertainment had taken place. For example, we saw that a singer had visited once a month and people were supported to take part in exercise on a monthly basis to support their health. Some people told us they chose to take part in some of the activities on offer. One person told us, ""I'll go upstairs and join in sometimes." However, most people agreed that the activities provided did not meet their needs. One person said, "I'd like to see some more adult things done, not just silly games." Another person told us, "There was a singing dancing thing. I'd like to be able to sew as I used to do a lot of sewing years ago. Keep my fingers working."

In addition, the activity coordinator was on leave on the day of our visit. While staff came into the lounge regularly to check on people and offer them drinks, there were no activities and staff were task centred; there was little social chatting or engagement of the people sitting there. Individual staff supported some people to maintain their hobbies and interests, one member of staff told us how they brought an RAF magazine for a gentleman who had been in the RAF. However, not everyone experienced this level of support. For example, a person who loved to read but had poor eyesight was not supported to access books with large text.

People were not always sure on the formal process to raise a complaint but all the people were happy to raised concerns with staff and the manager. One person said, "If I had a concern, I'd ask the carers." Another person told us. "My daughter would see to it with the manager." Staff were clear that they would take any concerns raised with them by people living at the home or their relatives to the manager.

People told us that they were happy with how the manger had responded to concerns and complaints raised. One person told us, "I wrote to [the manager] and she called me in. We went through it and got it all sorted." Prior to our inspection a person had contacted us regarding a complaint, We looked at this complaint and could see the provider had responded to the complainant and had been open and honest with the person and their family. This showed the provider was aware of their legal duty of candour. This is a law which requires providers to act in an open and transparent way in relation to the care and treatment they provide to people.

Requires improvement

Is the service well-led?

Our findings

When we inspected on 19 November 2014 we found that there was a lack of communication between the staff and management in the home and staff told us they did not always feel supported by the provider and manager. The provider's systems to monitor the quality of service people received were not always effective. This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision.

The service is required to have a registered manager and there was a manager registered with us for this service. However, they were no longer working at the service and a new manager had been employed. The new manager confirmed their intention to register with the CQC.

At our inspection on 24 August 2015 found the provider was no longer in breach of the regulation. We saw that the provider, manager and staff had improved the standard of care people received. The provider had a set of audits which were routinely completed to identify if there were any ongoing concerns in the home. For example, audits of the information recorded in care plans and medication audits. Where issues were identified action was taken to improve the quality of care people received. For example, the manager had arranged for more care plan training to help staff recognise the information which needed to be recorded to support person centred safe care. Staff told us they received feedback from audits that are completed so that they know which areas need improving.

However, time was needed to see if the improvements were sustained and if the audits continued to identity concerns. In addition there were still some areas where improvements were needed. Staff deployment did not always support staff to provide person centred care and activities did not always meet people's needs. Furthermore, staff did not always follow the training they had received to deliver safe care.

The manager had worked hard to change the culture of the home. People living at the home and their relatives told us the manager was often seen about the home, was approachable and they were confident that any concerns they raised would be dealt with. One relative told us, "I don't feel a need for a formal meeting – I just see [the manager] ad hoc." A person living at the home told us, "I see [the manager] about sometimes, or I'll go to the office if I need to."

Staff also told us that they felt confident to approach the manager and that they would listen and take action around concerns raised. One member of staff said, "I am happy to raise concerns .In the past I have spoken to them and it's always confidential. [The manager] will take action and has always followed concerns through and will tell me the outcome." Another member of staff told us, "The best manager I have had. She is really approachable, if you raise a concern she will put systems in place to resolve problems. Staff told us they were supported with staff meetings on a six monthly basis.

There was a whistleblowing policy in place and staff knew this protected their rights if they raised concerns within the service to the provider or registered manager. One member of staff told us, "I would not feel concerned about raising issues as I feel the company would listen." Another member of staff told us they had raised concerns and the manager had dealt with them.

There were systems in place to gather the views of people living at the service. The manager had plans to restart residents' meetings at the home and the first meeting was planned for 17 September 2015. They had also sent out questionnaires to residents' relatives, staff and healthcare professionals to gather their views of the service provided. We saw the results from the healthcare professionals' survey had been analysed and an action plan had been produced for areas where improvements were needed.

In addition, the provider was accessing good practice guidance. For example, the regional manager confirmed that they are reviewing how activities are provided across the providers services. To do this they were meeting with the National Activities Providers Association who are a charity which promote high quality activity provision for older people.