Larchwood Care Homes (North) Limited

St Mary's

Inspection report

St Marys Court
Speedwell Crescent
Lincolnshire
DN15 8UP

Tel: 01724865461

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

St Marys is situated in Scunthorpe, a town in North Lincolnshire. It is registered with the Care Quality Commission to provide care and accommodation for a maximum of 47 people, some of whom may be living with dementia.

This inspection was undertaken on 10 August 2016, and was unannounced. This meant the registered provider and staff did not know we would be visiting. At the time of this inspection there were 29 people using the service (10 of those on a respite basis). The service was last inspected on 27 May 2014 and found to be compliant with all of the regulations that we assessed at that time.

There was a registered manager at the service at the time of our inspection. 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 their relatives we spoke with told us they felt safe in the service and the staff made sure they were kept safe. We saw there were systems and processes in place to protect people from the risk of harm. Safeguarding alerts were appropriately sent to the local authority safeguarding team and fully investigated.

Risk assessments were in place to reduce and mitigate the known risks to people who used the service and medicines were managed safely and administered by trained staff.

Effective recruitment and selection procedures were in place and we saw that appropriate checks had been undertaken before staff began work. The checks included obtaining references from previous employers to show staff employed were safe to work with people using the service.

Staff received supervision and support and had completed a range of training that enabled them to meet people's needs effectively.

We found staff supported people to make their own decisions. When people lacked capacity for this, staff acted within the principles of the Mental Capacity Act 2005 and ensured important decisions were made within best interest meetings with relevant people present. The registered manager understood their responsibilities in relation to the Deprivation of Liberty Safeguards.

We found there was sufficient staff on duty to support people with their assessed needs and to sit and chat with them. The interactions between people and staff were cheerful and supportive. Staff were kind and respectful; we saw that they were aware of how to respect people's privacy and dignity. People had access to a wide range of activities provided at the service.

We saw that people were offered plenty to eat and drink which helped to ensure that their nutritional needs were met. We saw that individual's preference was catered for and people were supported to manage their weight and nutritional needs.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. People who lived at the service received additional care and treatment from health professionals based in the community.

A complaints policy was in place, we saw when complaints were received they were responded to in line with this.

A quality assurance system was in place that consisted of audits, checks and feedback from people who used the service. When shortfalls were identified action was taken to improve the service as required. The registered manager was a constant presence within the service and understood the requirement to report notifiable incidents to the Care Quality Commission.

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.

Staff were knowledgeable in recognising signs of potential abuse and told us they would report any concerns regarding the safety of people to senior staff.

There were sufficient skilled and experienced staff on duty to meet people's needs. Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work.

Appropriate systems were in place for the management and administration of medicines. Appropriate checks of the building and maintenance systems were undertaken, which ensured people's health and safety was protected.

Is the service effective?

Good

The service was effective.

People's consent was gained before care and support was provided.

People were supported to make their own choices and decisions. When people lacked capacity, the registered provider acted within the principles of mental capacity legislation.

Staff had the knowledge and skills to support people who used the service. They were able to update their skills through training.

People were provided with a choice of nutritious food. People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were treated with respect. The staff were knowledgeable about people's support needs.

People's preferences regarding care and support were recorded in their care plans.

Staff spoke to people in a friendly, inclusive and familiar way.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were produced, which identified how to meet each person's needs. These plans were tailored to meet each person's individual requirements and reviewed on a regular basis.

We saw people were encouraged and supported to take part in activities.

There was a complaints policy and procedure in place which provided guidance to people who wanted to complain or raise a concern.

Is the service well-led?

Good

The service was well led.

There was a quality monitoring system which consisted of audits to check systems and meetings and questionnaires to obtain people's views.

Staff told us they felt supported by the registered manager and described them as approachable.

The registered manager understood their responsibilities to report notifiable incidents as required.

St Mary's

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 registered 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 10 August 2016 and was unannounced. The inspection was completed by one adult social care inspector.

Before the inspection, the registered 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 looked at the notifications we received from the service and reviewed all the intelligence we held to help inform us about the level of risk for this service. We contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the service. They told us they had no concerns about the service at the time of this inspection.

During our inspection we spoke with two people who used the service and three visiting relatives. We also spoke with the registered manager, regional manager, the deputy manager and three members of staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us and allows us to spend time observing what is happening in the service and helps us to record how people spend their time and if they have positive experiences. We observed staff interacting with people who used the service and the level of support provided to people throughout the day, including meal times.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as four medication administration records (MARs), visits from health and social care professionals, activities and accidents and incidents. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important

decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, training records, the staff rota, and minutes of meetings with staff, quality assurance audits, complaints management and maintenance of equipment records.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service, their comments included, "Oh yes I feel safe up to now" and, "Yes I feel safe here." A relative told us, "Someone is always here and [Name of relative] has a mat that alerts staff" and another told us, "There are plenty of people about."

The provider information return (PIR) we received told us, 'We have policies and procedures in place as part of quality monitoring to protect people from harm and abuse.' We saw there were policies and procedures in place on safeguarding adults from abuse. The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse and this was demonstrated in the training records we saw.

Staff were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the registered manager or any senior member of staff. One member of staff told us, "I have done safeguarding training yearly and I would report any concerns I had," another said, "Last year I did safeguarding training on electronic learning and if I thought anyone was at risk I would report it to my manager" and a third staff member told us, "Staff are trained in safeguarding. I have never seen anything concerning, if I did I would report it to my manager, CQC or the local council."

We asked staff how they kept people safe and their comments included, "We are trained in using hoists, we do safeguarding training and there are policies and procedures to follow. There are key pads on the building and window restrictors" and, "We are trained in using the right equipment and slings. Peoples own slings are kept in their own bedrooms and people have their call bell in their rooms." Throughout the inspection we noted call bells were answered quickly which provided assurance people received the care and support they required in a timely way.

On the day of the inspection we observed staff transferring people using the mobility hoist, and saw that this task was carried out safely. We also saw that people had been provided with pressure care equipment when they were assessed as being at risk of developing pressure sores.

A concern was raised with us during the inspection in relation to one person's sleep routine, time spent in bed and pressure care. We looked at the persons care plan in detail and saw a skin assessment had been completed which indicated significant pressure damage to the person's heel. We saw staff at the service had contacted the district nurse (DN) with their concerns and the DN had subsequently visited to support the person. We saw a pressure care plan had been implemented which included appropriate equipment in place such as, airflow mattress, pro pad cushion and foam boots (which we saw the person was wearing during the inspection). Two hourly pressure relief was also in place and completed appropriately and the DN was visiting the person every other day. We discussed the person's night time routine with the registered manager during the inspection and this recorded '[Name] likes to go to bed early evening and is to be repositioned every two hours.' However, there was no indication of how the person had consented to going to bed early evening and if this was beneficial to the persons pressure care.

The regional manager updated us the day after the inspection and provided evidence of an updated pressure care plan which included clear instructions for the persons daily bed rest and sleep routine, a mental capacity act assessment, best interest decision and DN recommendations in relation to the person's pressure relief regime. We also saw this had been recorded in the staff's handover records to make them aware of the changes.

We reviewed four people's care files and saw that risks to people's safety were identified and risk assessments put in place to guide staff on how best to support that person to prevent avoidable harm. We saw risk assessments in relation to falls, use of bedrails, medication, and nutrition and skin integrity. Risk assessments contained appropriate information and were updated regularly to reflect people's changing needs. For example we saw one person's nutrition risk assessment had been updated on 24 July 2016 for the person to be weighed weekly due to weight loss. It was recorded that the person could potentially have a urinary tract infection and we saw the persons GP had been consulted.

We saw that any accidents or incidents involving people who lived at the service were recorded. These included information in relation to the type of accident, the person involved, the nature of any injuries and any follow up action taken. Accident and incident reports were collated and analysed monthly to identify any patterns or trends and people were observed post-accident or fall for 24 hours after the incident had occurred. This system ensured that steps were taken in response to incidents to reduce the risk of reoccurrences.

Checks of the building and equipment were carried out to minimise health and safety risks to people using the service and staff. We saw documentation and certificates which showed that relevant checks had been carried out on the electrical installation, gas services, portable electrical equipment and hoists. We saw that a fire risk assessment was in place and regular checks of the fire alarm system, fire extinguishers and emergency lighting were carried out to ensure that these were in safe working order. Records showed that fire drills were held to ensure that staff knew how to respond in the event of an emergency and we saw at the time of this inspection 89% of the 34 staff were trained in fire safety. A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who may require support to leave the premises in the event of a fire. This showed that the registered provider had taken appropriate steps to protect people who used the service against risks associated with the home environment.

The registered provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as flooding or a fire forced the closure of the service. This showed us that contingencies were in place to keep people safe in the event of an emergency.

We saw evidence to confirm staff were recruited following the registered providers recruitment policy. We checked the recruitment records for four members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with people using services. These checks meant that only people who were considered safe to work with people using the service had been employed at St Marys.

People were supported by suitable numbers of staff. There were five care staff (one of whom was a deputy manager) in the morning and five care staff (one of whom was a senior staff) in the afternoon/evening and three night care staff during the night. In addition, there were separate catering, domestic, laundry, activity and administration staff which meant care staff could focus their attention on caring tasks The service had a registered manager and a deputy manager on duty during the week and the regional manager told us they

visited the service regularly. Staff told us there were sufficient staff on duty and they did not feel rushed when supporting people.

A medication policy was in place at the time of our inspection that outlined how to order, store and administer medicines safely. We found medicines were managed well and obtained and stored appropriately in trolleys and cupboards in the dedicated medication room. Those medicines which required more secure storage were held in a controlled drugs cupboard and those which required cool storage were held in a fridge. The temperature of the room and fridge were taken each day to ensure it met with manufacturer's recommendations.

We observed staff administered medicines to people in a safe way. Staff wore a red tabard to alert people they were concentrating on administering medicines and were not to be disturbed. When administering medicines to people, they spoke to them, provided a drink and then signed the medication administration records (MARs) when they observed it had been taken. Staff recorded when medicines were omitted for any reason.

MARs were utilised by the service and included photographs of people which helped minimise potential administration errors from taking place. The MARs we checked were completed accurately without omission and adequate stocks of medicines were securely maintained to allow continuity of treatment.

We found the service was clean and tidy. Staff had completed training in the prevention and control of infection. There was personal protective equipment available when required such as gloves and aprons. Communal sinks had paper towels and liquid soap, and there were hand wash signs to guide people on good hand hygiene techniques. We noted that two bathrooms and one toilet had minor issues with the flooring and it had begun to lift behind the toilets and a large gap was in the flooring of one of the bathrooms where a bath chair had been installed. This meant that any spillages would be able to leak under the floor. All of these issues would prevent the area from been effectively cleaned, increasing the risk of infection. We discussed this with the regional and registered manager and we received an update the day after the inspection that it was anticipated the floors would be replaced imminently.

Good

Is the service effective?

Our findings

People and their relatives told us staff supported them effectively. Comments included, "They [staff] look after you well" and, "If you need anybody there is always someone to help you."

We confirmed from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the requirements of their posts. Staff we spoke with told us they received training that was relevant to their role. We confirmed from our review of records that staff had completed training which included safeguarding vulnerable adults, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), dementia, dignity and respect, equality and diversity, fire safety, food safety, moving and handling, medication and infection prevention and control. We found that the staff had completed an induction when they were recruited. This had included reviewing the service's policies and procedures and shadowing more experienced staff. In addition to this we saw the induction included monitoring and evaluation sessions and a review at month three and six of the staff members probationary period.

Staff told us that they had received supervision sessions, which overall they found were informative and helpful. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Records were in place to confirm that supervision had taken place. One staff member told us, "I have a supervision that is planned monthly" and another told us, "I have supervision once every month. I never have any problems so don't always find them beneficial." A third staff member told us, "I have regular chats with the manager and I do find it beneficial."

When we started the inspection we found that people who were up had been given cups of tea and jugs of juice were available in people's rooms and communal areas. We saw staff frequently offered people drinks. One staff member told us, "There are fizzy drinks available for people and some people like to have wine and beer." We observed staff providing a glass of wine for one person after their evening meal.

We observed the care and support given to people over the evening meal and observed that people received appropriate assistance to eat. People were treated with kindness, respect and were given opportunity to eat at their own pace. The tables in the dining room were set out well and consideration was given as to where people preferred to sit. During the meal the atmosphere was calm and sociable. People were offered choices in the meal and staff knew people's personal likes and dislikes. The quality of the food looked good. All the people we observed enjoyed eating the food and we saw very little was left on people's plates.

We saw there were menus available on each table in the dining room and a pictorial menu board on the wall. We noted these did not align together for the lunchtime meal which may have caused confusion for people living with dementia. We discussed this with a staff member and the regional manager which led to some conflict as to instructions that had been given to the kitchen staff. The pictures were taken down from the menu board to reduce potential confusion and we discussed the issues with the registered manager who updated us the day after the inspection to tell us they had met with the kitchen staff to discuss the issues and provide support.

From our review of the care files we saw that nutritional screening had been completed for people who used the service, which was used to identify if they were malnourished, at risk of malnutrition or obesity. We found that where people had lost weight dieticians were contacted and 96% of the current staff team had completed nutrition training. One member of the kitchen staff told us, "We have a communication book in the kitchen that tells us who is on a fortified diet. We have people on pureed diets and information on any allergies people have."

We saw records to confirm that people had health checks. We saw that people were regularly seen by their clinicians and when concerns were raised staff made contact with relevant healthcare professionals. For instance where people had lost weight, the staff had contacted the GP and dieticians who assisted staff to support people to maintain a healthy diet. A visiting relative told us, "[Name] had a bout of bronchitis and the registered manager told the doctor they needed to come out." This helped to ensure people continually received the most effective care to meet their needs.

We found the environment was suitable for people's physical needs and attention had been paid to supporting people with dementia. For example, there was pictorial signage as prompts to locate bedrooms, toilets, shower rooms and communal rooms, block coloured bedroom doors and dark blue toilet seats.

People's capacity to provide consent to the care and treatment they required was recorded in their care files. Best interest meetings had been held when assessments had been completed and it was apparent people lacked the capacity to make an informed decision themselves. Best interest meetings were attended by relevant healthcare professionals and other people who have an interest in the person's care, like their relatives.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. In discussions, staff were clear about how they gained consent from people prior to carrying out tasks. One staff member told us, "We always ask people if we can help them before we do anything." We observed staff sought consent prior to completing tasks. For example, we saw staff ask people discreetly if they wished to go to the toilet, if they wanted to join in activities and whether they wanted to go to the dining room for their lunch and evening meal.

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). The registered manager was aware of the criteria for DoLS and had made eight applications to the local authority; they were awaiting authorisation for these.

Good

Is the service caring?

Our findings

We carried out a Short Observational Framework for Inspection (SOFI) in the lounge; this is a way of observing care to help us understand the experience of people who could not talk with us. The SOFI observation highlighted a number of positive interactions between members of care staff and the people living in the service. We saw when one person made it known they wanted to join in the activity the staff involved them immediately and another person said they were cold and a staff member covered them with their blanket. We saw that staff knew when to use touch, eye contact and gestures to enable them to effectively communicate with people.

During the inspection we saw that that friends and family were able to visit whenever they wanted to and could stay as long as they liked. One relative said "[Name] has got sons and daughters that visit and we are always made welcome." Other comments included, "Oh god they are caring. We like the atmosphere and it's like walking into her home."

We saw that staff were courteous towards people who lived at the service, knocking on bedroom doors prior to entering and dealing with any personal care needs sensitively and discreetly in a way that respected the person's privacy and dignity. One staff member told us, "I always close doors when helping people to wash and dress" and another said, "I knock on doors and wait for the person to ask me to come in. if helping with personal care I would keep the doors closed and cover the person to maintain their privacy."

Each person was provided with a bedroom for single occupancy and there were quiet lounge areas in the service that people could use. This afforded people privacy if they required it. All the bedrooms we went into contained personal items that belonged to the person such as photographs and pictures and lamps. The staff took care in looking after peoples' possessions. One relative told us, "[Name of relative] has their own private room and their clothes are always clean."

We saw staff involved people and helped to create a positive and caring atmosphere. Staff said, "Staff talk to people in a caring manner, you can hear that people care. I would be happy to put my granddad in this home" and another told us, "Yes, staff care. If you approached any staff member they would be able to tell you something about the people that live here."

Information was available to people throughout the service. For example, there were notice boards informing them of planned activities, the menu of the day in picture formats and advocacy services. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. Each person had a notice in their bedroom which included the name of their specific key worker.

The registered manager and staff were aware of the need to maintain confidentiality and to keep personal information secure. Information regarding people who used the service was held securely in lockable cabinets in one of the offices and staff personnel files were held in the registered manager's office. Medication administration records were held with the medicine trolley in the locked treatment room and

staff were able to hold shift handovers and make telephone calls to health professionals and relatives in the privacy of an office so they were not overheard. This helped to ensure peoples information was kept confidential.

Good

Is the service responsive?

Our findings

People who used the service told us there were activities for them to participate in if they chose and they felt able to raise concerns and complaints in the belief they would be addressed. Comments included, "We do games" and, "I enjoy the bean bag game and I scored 250 points." A relative told us, "They are always doing activities and my sister has been to all the meetings and would know how to complain" and another said, "The activity worker is very good and they play bingo in an afternoon and there was a summer fair. [Name of relative] likes to get involved."

People who used the service and relatives were very positive about the service itself and the staff and no-one said they were unhappy or wished to be elsewhere. There was a good level of engagement pre and post lunch that was observed during the inspection and we saw people were engaged in games, having their nails painted and conversation was observed to be meaningful between staff and people who used the service.

We spoke with the activity co-ordinator for the service who worked during the week (Monday to Thursday) to provide people with social events and activities to take part in. They told us they provided both group and individual activities for people dependant on their preference and ability. The activity programme we saw indicated that games, bingo, weekly outings, shopping, hairdressing and entertainers were all part of the regular events taking place in the service. We saw the service had a dedicated activity room that contained seating and tables, books, games and arts and craft equipment for people to use if they chose to. The activity worker told us, "We have a set plan of what we do each week but people pick certain games and we can play them every day. One person likes to sit and read and another likes to knit. The local library changes the books regularly and other people have newspapers brought in."

Relatives told us staff were responsive to their family member's needs and they had been involved in assessments and planning their care. They told us, "We were asked everything when [Name] first moved in" and, "I was involved with the care plan."

Before people were offered a place within the service a pre-admission assessment was completed. The assessment was used to capture people's needs, abilities and levels of independence as well as information about their life history. The registered manager told us information was obtained from people and their families when possible; as well as the local authority commissioning team to ensure they could meet people's individual needs before a place in the service was offered.

We looked at four people's care plans; each plan contained guidance for staff to ensure people received the support they required consistently and in line with their preferences. People's care plans had been written in a person centred way and re-enforced the need to involve people in decisions about their care and to promote their independence. For example, one person's care plan recorded how they liked their hair and nails to be done and what type of deodorant they liked to use. The care plans we saw covered all aspects of people's care and support needs including personal hygiene, physical well-being, diet, weight, sight, hearing, falls, medicines and personal safety and risk.

Staff promptly responded to any signs that people were experiencing problems or their care needs had changed and we saw in peoples care plans that the staff contacted healthcare professionals such as district nurses and GPs when people's health deteriorated. We saw that reviews of people's care, treatment and support were conducted periodically. This helped to ensure people continued to receive the care and support they required as their needs changed or developed.

We saw staff provided people with person-centred care. For example, staff knew which people required specific equipment to meet their needs. This included moving and handling aids, pressure relieving cushions and mattresses. People were encouraged to join in activities but their decisions were respected when they chose not to. We observed people walking about the service freely. Staff knew people's needs well and provided them with choices. People were able to spend time in their preferred places such as their bedroom or communal rooms.

A range of equipment was readily available within the service which ensured, as far as reasonably practicable, people were supported to maintain their independence. We saw numerous handrails, in corridors, bathrooms and toilets, raised toilet seats, bath chairs and hoists. A relative told us, "[Name] never walked at home and since they have been here they are now walking around the home with a walking frame."

The service had a complaints policy and procedure which detailed timescales for acknowledgement and investigation. It also provided information of who to escalate complaints to should the person remain unsatisfied following an internal investigation. The procedure was on display in the service and was also included in the service user guide. The service did not receive many complaints but when people raised issues we saw these were dealt with according to the registered provider's policy.

Good

Is the service well-led?

Our findings

When we asked people who used the service and their relatives if the service was well led we received comments including, "It's all right" "I think it's managed well. If you need anyone there is always someone around to help you" and, "The manager is brilliant and nothing is too much trouble."

Staff we spoke with were complimentary about the registered manager. Comments included, "The management has changed and slightly improved. [Name of registered manager] is very approachable. She does a walk around and is very good with the residents" and, "[Name of manager] started last year and is a lot more approachable."

There was a registered manager in post who was supported by a deputy manager. Relatives we spoke with knew the registered manager's name and staff were aware of, and knew the name of, the registered manager who had a hands-on approach to the running of the service.

Throughout the inspection we noted that the registered manager was visible within the service and the people using the service were clearly relaxed and content in their presence. The registered manager explained that part of their role was to be available for the people who used the service whenever they required support.

We asked for a variety of records and documents during our inspection. We found these were well maintained, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

We observed that there was a good level of organisation at all levels within the service; staff we spoke with knew what they were doing and what was expected of them. We saw that there were clear lines of communication between the registered manager, the deputy manager and the care staff. The registered manager knew what was going on within the service at an organisational level and about the specific needs of people using the service.

We saw that numerous meetings were held regularly between the different staff teams to share information and discuss changes and improvements to the service. The registered manager attended managers meetings with registered managers from other services, run by the registered provider. We saw that senior staff and care staff had their own team meetings. We reviewed the minutes in relation to these meetings and saw discussions were held around service policies and procedures, safeguarding, activities, infection control and quality assurance. This showed us that team meetings were used to share information to drive improvements.

Surveys were completed by people who used the service, their relatives or people with an interest in their care and relevant professionals. The survey results we saw were consistently positive and there was

evidence that comments or suggestions were implemented when possible. This helped to ensure people who used the service had an opportunity to develop the service and their views were heard.

The registered manager and regional manager conducted a number of audits on different aspects of the service such as health and safety, accidents, deprivation of liberty safeguards (DoLS), medicines, complaints, pressure care and nutrition. We saw evidence to confirm when shortfalls were highlighted action plans with appropriate timescales were developed to improve the service as required.

We asked the registered manager how they kept up to date with changes in legislation and guidance on best practice. They told us they accessed the CQC website and attended quarterly meetings with the local authority. They also told us the service had four staff who were nominated 'champions' in infection control, dementia, dignity and end of life care (EOL) and through these roles staff had made links with the Alzheimer's society, local authority safeguarding teams and district and Macmillan nurses.