Shaw Healthcare (Ledbury) Limited

Ledbury Nursing Home

Inspection report

Ledbury Community Health & Care Centre
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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 and 19 June 2017 and was unannounced.

Ledbury Nursing Home provides accommodation with nursing and personal care to a maximum of 36 older people. There were 28 people living at the home when we visited.

A registered manager was in post and present during 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.

At our last inspection on 3 and 4 May 2016, we found a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. We gave the service an overall rating of requires improvement. This breach related to the provider's failure to ensure people received personalised care and treatment to meet their needs. The provider sent us an action plan setting out the improvements they intended to make.

At this inspection, we found the provider had made improvements to the service, and was now meeting the requirements of Regulation 9.

The information recorded on people's repositioning charts about the support they required and received with this important aspect of their pressure care was not always accurate or complete.

Staff had received training in, and understood, how to recognise and report abuse. The risks associated with people's individual care and support needs had been assessed, reviewed and plans put in place to manage these. The registered manager assessed and organised their staffing requirements, based upon current dependency levels. Prospective staff underwent pre-employment checks to confirm they were suitable to work with the people living at the home. Systems and procedures were in place to ensure people received their medicines safely and as prescribed.

Staff received effective induction, training and ongoing support to enable them to fulfil their duties and responsibilities. People's rights under the Mental Capacity Act 2005 were understood and promoted. People had the supported they needed to eat and drink, and their nutritional needs were assessed and managed. People were supported to access healthcare services as required.

Staff adopted a caring approach towards their work, and showed concern for people's comfort and wellbeing. People were encouraged and supported to share their views and be involved in decisions that affected them. Staff understood and promoted people's rights to privacy and dignity. People could receive visitors at the home without unnecessary restrictions.

People's care plans included information about their individual needs and preferences, and staff followed

these. The involvement of people and their relatives in care planning was encouraged. People were supported to spend time doing things they found interesting and enjoyable. People and their relatives knew how to complain about the care and support provided.

The management team promoted an open and inclusive culture within the service. People's relatives had confidence the management team would deal with any issues or concerns fairly. Staff felt well-supported by an approachable management team. The provider's quality assurance activities had resulted in improvements to the service people received.

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 understood how to recognise and report abuse. The risks to individuals had been assessed and kept under review. Care plans were in place to manage these risks and keep people safe. The management team managed the use of agency staffing to promote continuity of care. People received their medicines safely from trained staff.

Is the service effective?

Good

The service was Effective.

Staff had the training and support needed to succeed in their job roles. The registered manager and staff understood and protected people's rights under the Mental Capacity Act 2005. People were supported to make choices about what they ate and drank. Staff sought professional medical advice and treatment in response to any significant changes or deterioration in people's health.

Is the service caring?

Good

The service as Caring.

Staff knew people well and treated them with kindness. The provider took steps to encourage people's involvement in care planning and decisions affecting them. Staff understood people's rights to privacy and dignity.

Is the service responsive?

Good

The service was Responsive.

People's care plans promoted personalised care. People had support to participate in social activities they found enjoyable. People and their relatives knew how to complain about the service, and felt comfortable doing so.

Is the service well-led?

Requires Improvement

The service was Well-led.

The management team encouraged an open, ongoing dialogue with people, their relatives and visitors, and staff. Staff felt well-supported and understood what was expected of them. The provider carried out quality assurance audits and checks to identify and address areas for improvement in the service.

Ledbury Nursing 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.

This inspection took place on 14 and 19 June 2017 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account during our inspection of the service.

As part of our inspection, we looked at the information we held about the service, including the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority and Healthwatch for their views about the service.

During our inspection, we spoke with 15 people who used the service, seven relatives, a local GP, a community care nurse specialist and a speech and language therapist. We also spoke with 13 members of staff, including the operations manager, registered manager, deputy manager, catering manager, nurses, activities coordinator and care staff. We looked at five people's care records, medicine records, three staff recruitment files, incident and accident records, records of complaints, selected policies and procedures, menus, and records associated with the provider's quality assurance systems

We also spent time in the communal areas of the home to observe how staff supported and responded to people. As part of this, 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.

Good

Is the service safe?

Our findings

People told us they felt safe living at Ledbury Nursing Home. One person explained they felt secure "because they (staff) are always around." During our inspection, we saw people were at ease in their home, and comfortable in the presence of the staff supporting them. People's relatives were also confident in staff's ability to protect people's safety and wellbeing. One relative told us, "I feel they (staff) are looking after [person's name] and they are safe." Another relative felt reassured by "the attention [person's name] receives, the attitude of the staff and the custom-built facilities." Other relatives drew confidence from the openness of their communication with staff and the unrestricted visiting arrangements.

The provider had put measures in place to protect people from avoidable harm and abuse. Amongst these, staff had received training on how to recognise, respond to and report abuse. The staff we spoke with understood the potential signs of abuse, and told us they would report any concerns of this nature to a nurse or the management team immediately. The provider had developed clear procedures to ensure any abuse concerns were reported to the appropriate external authorities and investigated. We saw the registered manager had notified others and conducted investigations in line with these procedures.

The individual risks to people had been assessed, recorded and kept under review, using recognised tools such as the Waterlow Pressure Sore Risk Assessment Tool. The risk assessments conducted considered key aspects of people's safety and wellbeing, including long-term health conditions, nutritional needs and the support needed to safely mobilise. Care plans had been drawn up to manage these risks, which were reviewed by the nurses on a monthly basis. For example, where people were at risk of developing pressure sores, appropriate pressure-relieving equipment was in place. The management team also completed a monthly vulnerability tool to help them monitor the key risks to individuals.

Staff demonstrated insight into the risks to individuals, and understood the importance of working in accordance with people's care plans. Any significant changes in the risks to people were shared with staff during daily handovers and "flash meetings" organised, as needed, throughout the day. Handover is a face-to-face meeting in which staff leaving duty pass on important information to assist those arriving on shift. We saw people and their relatives had been involved in decisions about risks, such as introduction of falls prevention equipment.

If people were involved in an accident or incident, staff recorded these events and reported them to the management team. We saw the management team monitored these events on an ongoing basis, and took action to keep people safe. For example, following a report of one person's difficulty in swallowing their tablets, contact had been made with their GP to organise liquid medicines. The provider's internal quality team and the senior management team also had oversight of any adverse incidents and accidents at the home, to assist in the monitoring of these.

People expressed mixed views about the adequacy of staffing levels at the home. Some people told us there were normally enough staff on duty to meet their needs in a timely manner. For example, one person said, "They (staff) come quickly if I press the call bell. They come almost a minute after I ring the bell." Other

people reported delays in staff response to their call bells, particularly in the mornings. One person told us, "I've waited up to half an hour some mornings before someone comes, because they're rushed off their feet." People's relatives felt the staffing levels maintained at the home ensured their family members' needs could be met safely. One relative told us, "There always seems to be plenty of staff around." Most of the staff we spoke with felt the staffing arrangements were safe and appropriate to people's needs. One staff member told us, "They (management team) try their very best to keep staffing levels right." However, two members of staff pointed towards a lack of staffing in the late evening. During our inspection, we saw there were sufficient staff to respond to people's needs without unnecessary delay, and that call bells were generally answered promptly.

We discussed the issues raised regarding staffing levels with the registered manager. They explained that they assessed and monitored their staffing requirements based upon dependency levels at the home. The provider had encountered ongoing difficulties in recruiting permanent nursing staff. As a result, regular use was made of agency nurses, particularly on nights, whilst recruitment efforts were ongoing. The management team worked with two preferred staffing agencies to obtain regular agency staff and promote continuity of care. They were in the process of altering staff shift patterns to increase the number of staff available to support people each morning. They had not identified any need to increase staffing levels in the late evening.

All prospective staff underwent pre-employment checks to confirm they were suitable to work with the people living at the home. These included an Enhanced Disclosure and Barring Service (DBS) check and employment references. The DBS carries out criminal record checks to help employers make safer recruitment decisions. We saw the management team also requested confirmation of all agency staff's pre-employment checks from the relevant staffing agency. The provider had developed a formal disciplinary procedure to deal with any conduct issues once staff were in post.

People were satisfied with support staff gave them to take their medicines, and people's relatives had no related concerns. One relative told us people's medicines were "very strictly managed" by staff. The provider had put in place systems and procedures to ensure people received their medicines safely and as prescribed. The nurses managed and recorded the administration of people's medicines through an electronic "Med e-care" system. Periodic competency checks were carried out on the nurses to ensure people's medicines were being handled safely and appropriately. People's medicines were stored securely in medicines trolleys to prevent unauthorised access. Care plans set out the specific support and assistance people needed to take their medicines safely. An individual assessment of people's ability to self-administer their medicines had also been completed. No one living at the home was self-administering their medicines at the time of our inspection. "PRN protocols" had been produced to provide the nurses with clear guidance on the circumstances in which people were to be offered "as required" medicines.

Good

Is the service effective?

Our findings

People and their relatives felt staff had the knowledge and skills to meet people's individual care and support needs. One person told us, "The staff have got to know me very well. They give me the assistance I need." A relative said, "Everything [person's name] needs, they have got here." A local GP commented positively on the competence of staff and their ability to "look after people's needs well."

All new starters completed the provider's induction training, to help them settle into their job roles. During this period, they learned about the history and values of the organisation, completed the provider's mandatory training, and read the provider's key policies and procedures. New staff also worked alongside more experienced staff for a period of at least one week. The provider's induction incorporated the requirements of the Care Certificate, and new staff were allocated a mentor to help them complete this. The Care Certificate is a set of minimum standards that should be covered in the induction of all new care staff. Staff told us their induction training had been a useful introduction to their new job roles. We saw agency staff also received a formal induction to the service, and the agency staff we spoke with confirmed this.

Following induction, staff participated in a rolling programme of annual refresher training, and any intervening training identified by or agreed with the management team. Recent training activities had been focused upon improving the clinical skills of the nurses working at the home. On this subject, a nurse told us, "[Registered manager] has been pushing our personal development." Staff spoke positively about the training they had received, and their ability to request additional training, as required. One staff member told us, "The training's really good. We're kept up to date with all of our training. It's regular and if there's anything you need to know about, they fit you in for it." Three members of staff referred to the particular benefits of their recent training on Parkinson's disease. One of these explained, "It gave me a view of how people are affected by the disease and how to look after them." We saw the management team maintained up-to-date training records to help them keep on top of staff training needs.

In addition to formal training, staff had regular opportunities to meet with a line manager, on a one-to-one basis. During these meetings, they received feedback on their work and any additional support needs they may were discussed and agreed. One staff member explained, "[Nurse's name] always asks me what I want to say, what I think, whether I'm happy or have any concerns and what needs to improve at the home." The registered manager also provided 24-hour on-call management support to respond to any urgent requests for guidance or advice for staff.

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.

We checked whether the service was working within the principles of the MCA. We found the registered manager and staff had a good understanding of people's rights under the MCA. Staff had received training to

raise their awareness of the purpose and implications of the MCA. One staff member told us, "It's about whether people have the capacity to make their own decisions. We can't take that power away from them, and have to give them choices. We can point out the risks, but the final decision is theirs." Staff understood the need to discuss any significant changes in people's mental capacity with the management team. We saw evidence of mental capacity assessments and best-interests decision-making in the care files we looked at. These related, for example, to a decision regarding the introduction of falls prevention equipment, the administration of a specific medicine, and the assistance provided to encourage a person to drink. Where people had given others permission to make decisions on their behalf, the management team had obtained proof of the documents confirming power of attorney. Do Not Attempt CPR (DNACPR) decisions were recorded in line with current guidance, and readily accessible within people's care files.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted DoLS applications for people living at the home, based upon an individual assessment of their capacity and care arrangements. At the time of our inspection, a number of these assessments were still being processed by the relevant local authorities. Where DoLS authorisations had been granted, the registered manager reviewed any associated conditions to ensure these were being complied with.

The majority of people and their relatives we spoke with confirmed people had enough to eat and drink at the home. One person told us, "I have too much too eat!" A relative said us, "The kitchen staff are fantastic and know what [person's name] likes. They (person) can have as much as they like to eat. There's always jugs of water in their room and juice." However, another relative expressed a concern about their family member's fluid intake. We discussed this with the registered manager, who assured us this person had appropriate access to drinks. During our time at the home, we saw the people cared for in their rooms had drinks available and within reach. People were supported to choose from a range of breakfast options, and two main options for lunch and the evening meal. One person explained, "You can ask for something else (to eat), if you don't want what's on the menu." A relative told us, "[Person's name] always chooses and is always very happy with the choices offered." People were also supported to choose where they wanted to eat. One person explained, "I please myself about where to have meals, but I usually have it in here (person's room)."

People's dietary and nutritional needs were assessed upon admission and kept under review. The recognised Malnutrition Universal Screening Tool (MUST) was completed as part of this process. Where necessary, the management team involved the local speech and language therapy team and dieticians in the assessment and management of people's dietary and nutritional needs. A speech and language therapist spoke positively about their experiences of working with the nursing and care staff at the service. They told us staff listened to and followed their advice, were keen to learn and were proactive in contacting the service whenever people's needs changed.The catering manager confirmed they had the up-to-date information they needed about people's individual nutritional requirements and their food and drink-related preferences. During our inspection, most people chose to eat in their rooms, whilst a small number of people ate in the communal dining areas. We saw people had their meals in a relaxed, unrushed atmosphere, and had access to appropriate eating aids. Where people needed physical assistance to eat, this was provided in a patient and gentle manner.

People and their relatives told us the management team and staff helped people to access healthcare services, as necessary to maintain their health. One person told us, "They (staff) would get a doctor in, if I needed one." Another person said, "[Doctor's name] comes to see me. They've known me for years; they're only downstairs." Staff accompanied people to healthcare appointments, where this was required. One

person explained, "From time to time, they (staff) take me out in the wheelchair to see the dentist." The nurses ensured people's day-to-day needs were met by, for example, carrying out blood glucose monitoring and insulin administration, where appropriate, for those with diabetes. A local GP spoke positively about the manner in which staff managed the diverse health needs of the people living at the home. In ensuring people's health needs were met, the management team and staff liaised with a range of community healthcare professionals. These included the Parkinson's disease nurse specialist, district nurses, community psychiatric nurses and continence advisors. On this subject, a local GP told us, "On the whole, it works well. They (staff) ask for advice and assistance when appropriate." We saw details of people's medical histories and long-term health conditions were recorded in their care files, to ensure staff understood their current health needs.

Good

Is the service caring?

Our findings

At our last inspection, people and their relatives told us there was a lack of consistency in the care and support staff provided. The approach nurses took to leading and delegating to care staff was inconsistent and, as a result, care staff were not always clear about their responsibilities.

At this inspection, people and their relatives did not highlight any significant inconsistencies in the standard of care and support provided. In addition, care staff told us were clear what was expected of them. We saw procedures were in place to ensure key responsibilities and tasks associated with people's personal care were allocated to care staff in an organised manner.

People and their relatives felt staff adopted a caring attitude towards their work. One person told us, "They (staff) are very nice people here, especially the nurses. [Nurse's name] is my favourite."
Another person said, "I get on well with the carers. They are very kind." A relative told us, "They (staff) are very, very kind; that's more important than anything else." During our inspection, we saw staff spoke with people in a warm and professional manner. They showed concern for people's comfort and wellbeing, as, for example, they brought electric fans into the communal areas to help people stay cool in the hot weather conditions. At lunch, staff also took the time to confirm people were in a comfortable position to eat at the dining room table.

During our inspection, we saw staff consulted with people about routine care decisions, such as what they wanted to eat or how they wanted to spend their time. The provider had put other procedures in place designed to encourage people to share their views, and to be involved in decision-making that affected them. These included regular residents' meetings and the distribution of periodic feedback surveys. One person told us, "We have residents' meetings about once a month. We can have our say. I was talking to [registered manager] today; she does listen." People's feedback and experiences were taken into account and, where possible, acted upon. For example, a new ramp into the garden had been constructed on the basis of feedback from people living at the home. The registered manager indicated they had the facility to produce information in alternative formats, such as large print, to further encourage people's involvement. We also saw that information about local advocacy services was included in the home's "service user guide" and on display in the home itself.

At our last inspection, we found people's confidential information was not always stored securely in the home's main office. Since our last inspection, the provider had installed new keypads to improve the security of the home's offices. At this inspection, we did not identify any concerns regarding the potential for people's personal information to be accessed by unauthorised persons.

People and their relatives were satisfied with the measures the provider and staff took to promote people's privacy and dignity. During our inspection, we saw staff met people's personal care needs in a dignified manner, and respected their decisions about their routine care. The staff we spoke with understood the importance of treating people with dignity and respect, and were able to give us examples of how they achieved this on a day-to-day basis. These included knocking before entering people's rooms, protecting

their modesty during personal care, and seeking their consent to care. In recognition of people's right to keep in contact with family and friends, there were no unreasonable restrictions upon visiting arrangements at the home.

Good

Is the service responsive?

Our findings

At our last inspection, we found a lack of specialist equipment was resulting in significant delays in the support people received to get up in the morning. In addition, a lack of slings meant that, on occasions, these had to be shared with others for whom they had not originally been supplied.
The provider had not ensured that people received personalised care and treatment to meet their needs. This was a breach in Regulation 9 of the Health and Social Care act 2008 (Regulated activities) Regulations 2014.

At this inspection, we found the provider was meeting the requirements of Regulation 9. Since our last inspection, the management team had reassessed the specialist equipment required to meet people's mobility needs in a flexible manner. As a result, the provider had purchased an additional hoist and a number of additional slings, each named for use by a specified individual. However, two of the people we spoke with still referred to delays in the support they received to get up in the morning. One person told us, "They (provider) haven't got enough staff or hoists."

Staff confirmed they had access to sufficient mobility equipment. One staff member told us, "We've got an extra hoist now. It's made a huge difference." However, some staff referred to the disruption caused by a stand aid hoist having been out of service pending repair. We discussed these issues with the registered manager. They assured us the mobility equipment provided was adequate, and that staff accommodated people's preferred morning routines to the best of their ability. The registered manager explained a stand aid hoist had been out of service for a short period in May 2017, but had since been repaired and was shortly due to be replaced.

People's relatives were satisfied with the level of involvement they had in their family member's care and support at the home. One relative told us, "I've been here so much, my involvement has almost been constant." Another relative said, "I always call into the office and have a word." People and their relatives were actively involved in the initial assessment of people's individual needs when they moved into the home. People's "named nurses" then consulted with them and their relatives, as required, when reviewing their care plans on a monthly basis. The management team made themselves available to people's relatives on a day-to-day basis. Relatives' meetings were also held on a quarterly basis, as a further means of encouraging their views and suggestions. People were also allocated "key workers" whose responsibility it was to act as a key point of contact for people and their relatives, ensuring people's individual needs and requirements were met.

We saw people's care plans included details of their personal backgrounds, interests and preferences, along with staff guidance on their individual care and support needs. Staff recognised the need to work in accordance with people's care plans, and said they had the time to check these when required. During our inspection, we saw staff adjusted how they supported and communicated with people to suit their individual needs, including the assistance they gave individuals to eat their meals safely and comfortably.

People had support to participate in social activities at the home. These included visiting musicians and

artists, arts and crafts activities, coffee mornings, fun exercise sessions and group games. The provider employed a full-time activities coordinator to organise and lead activities provision. They divided their time between group activities and spending one-to-one time with people cared for in their rooms. The activities coordinator produced a weekly programme of activities for people and their relatives and encouraged their participation in these. One person told us, "[Activity coordinator] is very good; they work hard. I like the needlework and I write a lot of letters and read." Another person told us they enjoyed reading the day's newspaper and watching television. During our inspection, we saw people enjoying different activities. These included outdoors bingo, listening to a visiting harmonica player and watching sport on television. People's religious beliefs and practices were also taken into account, and Holy Communion held at the home on a monthly basis.

People and their relatives knew how to raise a complaint about the care and support provided. They told us they would approach a member of staff or the management team directly. The provider had developed a complaints procedure to promote consistent handling of complaints. Information about how to complain was also clearly displayed on a noticeboard within the home itself. We looked at the record of a recent complaint received by the registered manager about the conduct of a member of staff. We saw the complainant's concerns had been investigated and acted upon, and the complainant advised of the outcome of their complaint. The provider encouraged people and their relatives to provide more general feedback on the service through, amongst other thing as, the distribution of six-monthly feedback surveys. These surveys had last been issued in January 2017, resulting in largely positive feedback on the service.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we looked at the "repositioning charts" completed for four people who had been assessed as being at risk of developing pressure sores. These charts were designed to record the physical assistance staff gave people to reposition themselves in bed, where they were unable to this themselves. The purpose of this repositioning was to reduce the risk of skin breakdown and pressure sores. We found that the information recorded on these charts was incomplete. This included a failure to stipulate the intervals at which repositioning should be carried out, and a lack of consistency in the repositioning records maintained for each individual.

We discussed this with the registered manager. They assured us staff were carrying out this integral aspect of pressure sore prevention on a consistent basis. However, they acknowledged that the information recorded on the repositioning charts we checked was incomplete and inaccurate. They informed us this was a known issue, which had previously been addressed at staff meetings. The registered manager assured us they would reinforce the provider's record-keeping requirements upon care staff and nurses, to ensure these charts were fully and accurately completed moving forward.

At our last inspection, we found the need for improvements in people's care had been identified but not always acted upon by the provider. In addition, the culture, leadership and communication within the service had not been established to fully promote a consistent standard of care.

At this inspection, we found the provider had made a number of significant improvements in these areas. People, their relatives and staff commented positively on the overall management of the home, and described an open and inclusive culture within the service. They told us the management team were approachable, kept them informed and were receptive to their opinions and suggestions. A relative explained, "I always know I can email [registered manager] if something is of concern to me. The nurses also phone me if there is anything I need to know about." A staff member told us, "They (management team) are very approachable and if you've got something to say they're open to new ideas." People's relatives and staff had confidence in the management team's ability to respond to any issues or concerns in a fair manner. A relative told us, "I have confidence and trust in the management team." A staff member said, "If you've got a problem and you talk to them (management team), they'll deal with it."

Staff were clear what was expected of them, and felt well supported by the management team. One staff member explained, "I like them (management team) very much. They support me and every time I have a problem, they solve it that day." Staff felt able to challenge the management team's decisions or conduct if they needed to. The provider had produced a whistleblowing policy to encourage staff to come forward with any serious concerns about how the home was run. Staff meetings were organised on a regular basis, proving a forum for staff to share their views with management as a group.

During our inspection, we met with the registered manager. They understood the duties and responsibilities associated with their post, including the need to submit statutory notifications in line with their registration with us. The registered manager confirmed they had access to the ongoing support and resources needed

from the provider to improve and develop the service. They explained they kept themselves up to date with current best practice by, amongst other things, attending events organised by the Royal College of Nursing (RCN), local authority and local clinical commissioning group (CCG). The registered manager also attended the provider's monthly manager meetings to share information on developments and good practice.

The provider carried out a range of audits and checks to assess, monitor and improve the quality of the care people received. These included a rolling programme of audits by the registered manager, the operations manager and the provider's internal quality team focused upon key aspects of the service provided. Action plans were created based upon the outcomes of these audits to enable the management team to address any identified areas for improvement. In addition, the registered manager monitored any adverse incidents involving people at the home on an ongoing basis. The deputy manager also carried out daily checks on the handling and administration of people's medicines and associated record-keeping.

The provider's quality assurance activities had resulted in a number of improvements in the service. These included a move towards more person-centred care plans, which better documented the involvement of people and their relatives in care planning. Training provision for nursing staff had also been improved to increase their clinical skills and ability to provide person-centred care. Staff had also been provided with additional training to enable them to provide more specialist care for people with Parkinson's disease. The provider had also broadened the range of social activities available to people.