Shaw Healthcare (Group) Limited

Maitland Park Care Home

Inspection report

Maitland Park Road
Maitland Villas
London
NW3 2DU

Tel: 02074246700

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13 July 2017

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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

We inspected Maitland Park Care Home on July 11 & 13 2017. This was an unannounced inspection. Maitland Park Care Home provided accommodation and nursing care to 60 older people, some whom were living with dementia. There were 59 people living at the home when we visited. At the last inspection on December 2014 the service was rated as Good.

The service did not have a registered manager at the time of our inspection. The service had a manager who had been in place since June 2017. They had started the process of applying to become the registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's needs were assessed and their preferences identified as much as possible across all aspects of their care. Risks were identified and plans in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. Medicines were stored and administered safely.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. We saw people were able to choose what they ate and drank.

People's needs were met in a personalised manner. We found that care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the manager was approachable and open. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and relative meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Maitland Park Care Home

Detailed findings

Background to this inspection

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

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning team that had placements at the home, the local Healthwatch and the local borough safeguarding team.

This inspection took place on 11 & 13 July 2017 and was unannounced. The inspection team consisted of two inspectors, two pharmacist inspectors, nursing dementia specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who lived in the service and three relatives during the inspection. We also spoke with two friends of people who used the service. We spoke with the manager, the quality manager, three nurses, five team leaders, four care workers, the senior cook, two activity co-ordinators, the maintenance person, one domestic worker, two administrators and one visiting external activities person. We looked at 13 care files, staff duty rosters, six staff files which included recruitment and supervision records, a range of audits, minutes for various meetings, 30 medicines records, accidents and incidents, training information, safeguarding information, health and safety folder, and policies and procedures for the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One relative said, "Feels safe. [Relative] is getting good care." Another relative told us, "We feel quite safe and content. [Relative] is looked after." A third relative said, "Oh yes definitely. [Staff] look after [relative] well." A friend of person who used the service felt the service was safe. They said, "Yes, because staff are monitoring here." Another friend told us, "Safer here than at home on their own."

The service had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise any concerns and would be provided with support from the manager and provider. One staff member told us, "We have to report to the manager and record." Another staff member said, "I would take [information] to the manager."

The manager told us and we saw records that showed there had been safeguarding incidents since the last inspection. The manager was able to describe the actions they had taken when the incident had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as medicines including self-administration, communication, breathing, eating and drinking, personal hygiene and dressing, toileting, skin integrity, mental state and cognition, lifestyle and social interests, sleeping and night time routine, pain management, end of life, sexuality, and manual handling. Each assessment had clear guidance for staff to follow to ensure that people remained safe. For example, one person had been assessed with challenging behaviour. The guidance for this person stated, "[Person] mentioned that she hears strange voices when she is alone. This may start causing her to moving from one point to another. Staff to speak with her and offer her something to drink." The care records confirmed staff had followed this guidance. Another example, one person had been assessed with a risk to falls. The guidance for this person stated, "[Person] is partially blind in the left eye. Staff to ensure that [person's] bedroom and walk area are free of clutter, obstacles and hazards to maintain her safety." Staff we spoke with demonstrated that they were aware of risks to people and that the guidance had been followed.

Staff we spoke with knew who was at high risk of choking. Printed information was available that gave staff information about the risks to that person. For example, one person had printed signs available which had the recommendations from speech and language therapy team (SLT). The information on display also included guidance and recommendations on the person's food and drink intake and what to do if the person was choking. Nursing staff we spoke with knew how to refer to SLT team. People would be referred to SLT team if they were having eating, drinking and swallowing difficulties. Records showed the SLT team notes and input were clear and staff took action on recommendations promptly.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded.

There were sufficient numbers of staff to ensure people's safety. Staff told us the staffing levels worked well and they were able to meet people's needs. We observed that staff were prompt in responding to alarm calls from individual rooms and made time to spend with people outside of personal care tasks. One staff member said, "Ratio is based on one to four staff. However staffing was increased for those who have higher needs." Another staff member told us, "We do have enough staff. They are recruiting new staff. We have agency staff for one to one care. Bank staff when they are needed." The manager confirmed staffing levels were arranged in accordance with people's care needs which were regularly assessed and reviewed in consultation with the nurses and care staff. Records and observations confirmed this. One person said, "They [staff] have time for everyone." A relative told us, "What they got here now [staffing levels] they cope." However some relatives felt at times staffing numbers could be increased. One relative said, "They are short staffed." Another relative told us, "It varies at different times. Appears to be adequate. Would like one more member of staff."

The service had robust staff recruitment procedures in place. Records confirmed that checks were carried out on prospective staff before they commenced working at the service. These included employment references, criminal records checks, proof of identification and a record of the staff's previous employment. One staff member told us, "They [provider] had to do a [criminal records] check before I started." This meant the service had taken steps to help ensure suitable staff were employed.

The service had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK who ensure nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards. This meant a safe recruitment procedure was in place.

At this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people who used the service.

Medicines were stored securely in locked medicines cupboards or trolleys within each treatment area, with the exception of a medicines trolley on the top floor. We found this trolley was not tethered to a wall during the daytime, which meant there was a risk that it could be moved without supervision.

Current fridge temperatures were taken each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. This assured us that medicines requiring refrigeration were stored at appropriate temperatures.

People received their medicines as prescribed, including controlled drugs. We looked at 30 MAR charts and found one gap in the recording of medicines administered, which provided an overall level of assurance that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate charts for people who had patch medicines prescribed to them (such as pain relief patches), warfarin administration records and also topical medicines. These were filled out appropriately by staff. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this (in line with national guidance).

Medicines to be disposed of were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff.

Observations showed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw 15 PRN forms for pain-relief/laxative medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit.

We looked at medicine records for people who were administered their medicines covertly. We found that they had a best interests meeting and the appropriate authorisation to enable them to have their medicines covertly. However, we found that the provider did not seek input from a pharmacist to ensure that the medicines were appropriate to be crushed. We brought this to the attention of the provider who told us they would seek the appropriate input from the pharmacist. This assured us that people in this location were administered medicines covertly in an appropriate manner in accordance with legislation and recommended guidance.

Medicines were administered by nurses or team leaders that had been trained in medicines administration. Discussions with staff assured us that staff had a caring attitude towards the administration of medicines for people. For example, if a person refused their medicines initially, staff would try to administer their medicines a short time afterwards.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including safe storage of medicines, fridge temperatures and stock quantities on a daily basis. A recent improvement made by the provider included ensuring that all administration of warfarin (an anticoagulant) were witnessed by two people, to ensure they were administered correctly. This had been highlighted from two previous medicines errors and showed the provider had learned from medicines related incidents to improve practice.

The premises and equipment were managed in a way intended to keep people safe. The home environment was clean and the home was free of malodour. Regular checks were carried out on hoists, emergency lights, bedrails, alarm systems, windows, water quality and temperature, wheelchairs, and fire equipment. The service had an in-house maintenance person and a system in place to report and deal with any maintenance issues. One relative said about the home, "It's clean." Another relative told us, "It's lovely and bright. Keep it lovely and clean." However we noted and a relative told us that the garden furniture needed to be repaired and maintained. A relative told us, "It looks ugly."

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they were supported by staff who had the skills to meet their needs. One person told us, "The staff are very efficient and reliable." One relative told us, "The carers are excellent." Another relative said, "The carers are brilliant." A third relative told us, "They [staff] are very good. No complaints at all."

Staff received regular supervision. Records showed that staff received supervision every two to three months. Topics covered in supervision sessions included training, goals, people who used the service, and policies and procedures. A staff member told us, "I've been well supported here. I started with little experience of care but been supported through. I am getting good training and supervision." Another staff member told us, "They ask if I want to improve my qualifications. They tell me if I am going in the right direction." A new member of staff said, "I've had my first supervision. Talked about concerns and anything I want changed." Staff also received an annual appraisal where their work performance was formally assessed.

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. One staff member told us, "I was encouraged to go for the training." Another staff member said, "We all have to do e-learning yearly. We do training upstairs like MCA and food hygiene." Records showed the training included dementia, moving and handling, safeguarding adults, health and safety, infection control, accident, emergency first aid, medicines, behaviours that challenge, person centred care planning, fire safety, food hygiene, allergens, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

New staff had been provided with induction training so they knew what was expected of them and to have the necessary skills to carry out their role. Records confirmed this. One staff member told us, "Induction helped with how things worked." Another staff member said, "The induction was holistic about the care we offer." A third member of staff told us, "The first week was shadowing and some training. I was not allowed to do anything but observe."

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and

Deprivation of Liberty Safeguards (DoLS). The manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the manager was able to explain the process he would follow in ensuring best interest meetings were held involving relatives and other health and social care professionals. The service informed the Care Quality Commission (CQC) of the outcome of the applications. We saw evidence of these principles being applied during our inspection. Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. Relatives told us that staff members always asked their consent before helping them. This consent was recorded in people's care files. One relative told us, "They [staff] do ask like with activities. They ask and let [relative] think about it." Another relative said, "They [staff] ask 'would you like to do this [relative] or do that'." This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Records showed people's needs were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences and likes/dislikes were recorded in their care plan. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored regularly. If there were significant changes they would advise the GP and referrals made to a dietician. One staff member said, "One resident has been referred to a dietician and is on a protein drink on the advice of the dietician. She is not taking the drink as much so has been re-referred to the GP." Records confirmed this

People and their relatives told us they liked the food. The senior cook was aware of the people who were on specialised diets and explained the meal preferences for these people which was reflected in the care plans we looked at. We saw drinks were offered throughout the day and during the mealtimes to people. The senior cook told us that people could ask for alternatives to the food choices for that day. There was a rolling four week food menu in place which included at least three hot meal options which including a vegetarian option and desserts. People told us and we saw records that showed people had requested an alternative meal not on the food menu. On the day of the inspection the main meal on offer was fisherman's pie and pork and pepper goulash. Staff told us and records confirmed people were asked their food option the day before. However at the lunchtime meal people were still given a choice by being shown a pictorial menu to choose from. The food for people who were at risk of choking was presented well and all blended separately allowing people to experience and taste the different flavours. One person did not like the food options given to them. We overheard a staff member say to the one person, "We can go to the kitchen for something else." One relative said about the food, "Very good. [Relative] enjoys the food." Another relative told us, "I think the food is good. It has gotten better. Always got fruit." A third relative told us, "[Food] very good. I stay for lunch. There is a choice." One person said, "I eat whatever I'm given. It's always very nice."

As part of our inspection, we carried out an observation over the lunch time period. The lunchtime was relaxed and we saw people could eat in the dining room, lounge area or their own bedroom. We saw where people needed support to eat this was done in a relaxed manner by staff, going at the pace that suited the person and remaining with them until they finished their meal. We overheard a person say to a staff member, "I am so lonely." The staff member sat next to the person and said, "Will you feel better if I sit next to you?"

People in the home were supported to see health professionals when required. A GP carried out a visit on a weekly basis and staff identified people who needed to be reviewed. We observed on the second day of the inspection the GP visiting people in the home. Records were kept in people's care files to show when healthcare professionals had visited the person. This included GPs, district nurses, podiatrists, dentists, chiropodists, opticians, speech and language therapists and dieticians. One person said, "I saw the doctor

today." One relative told us, "They [staff] would get a doctor in if not well." A friend of person who used the service said, "The doctor has seen [person]. [Person] has had podiatry, dentist and eyes tested." Another friend told us, "The doctor was doing the rounds and comes to see [person] which was nice."

Good

Is the service caring?

Our findings

People and their relatives told us that they were well treated and the staff were caring. One person said, "[Staff] very helpful. If you need something you can ask them." The same person told us, "Very good living here. It's comfortable." One relative told us, "One of the best homes." Another relative said, "They [staff] have been wonderful. [Staff] have been very caring." A third relative told us, "No complaints about the staff. Very good. Quite happy with the care that [relative] gets." A friend of person who used the service told us, "I find staff always attentive and caring. When I raise questions they are listened to and met."

The atmosphere of the service was friendly and peaceful. Staff regularly talked to people and asked if they needed anything. Observations showed people enjoyed the interactions. One relative told us, "The ethos is caring and focused on the residents." One staff member told us, "This is their home." Another staff member said, "It is a homely place to work."

Staff knew the people they were caring for and supporting. Each person using the service had an assigned key worker. A keyworker is a staff member who is responsible for overseeing the care a person received and liaising with professionals or representatives involved in the person's life. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member said about key working, "I am a keyworker for three people. It involves looking after the resident and doing their shopping. One client I take the bank."

People's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. One staff member told us, "We close the door and cover them with a towel. You ask how they want to be washed." Another staff member said, "I respect privacy by knocking on the door and waiting for a response." One person said, "[Staff] knock on the door before they come in." A relative told us, "I'm very impressed with the level of respect and dignity." Care plans reflected promoting people's privacy and dignity. For example, one care plan stated, "Staff to respect [person's] privacy. [Person] said she is very shy and does not like if people intrude. She expects the staff to always knock her door before entering." One person told us, "I decide what time I get up and what time I go to bed."

People were supported to live as independently as possible. Staff we spoke with shared examples of how they encouraged and supported people to be independent. One staff member told us, "We have a gentleman who does things for himself. He goes downstairs for the paper and comes up again. We take him to the bank." Care plans were written in a way that promoted independence for people. For example, one care plan stated, "[Person] is independent when brushing her teeth. She still has her own teeth." Another example, a care plan stated, "Staff to encourage [person] and give her opportunity to wash herself as much as possible to keep her involved with her personal hygiene needs." Staff were available in the communal areas of the home to support people when they wished. Observations showed a staff member helping a person be independent with sitting down. We overhead the staff member say to the person "Put your two hands here (on table) and support yourself to sit down."

People's cultural and religious needs were respected when planning and delivering care. Discussions with

staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. One staff member said, "I would respect their choice. Every individual has their right and their life." Another staff member told us, "We welcome them here. If they want to meet people from their community we would organise." A third staff member told us, "I don't have a problem. I treat my residents the same way." The provider had a policy called 'sexuality, relationships and the older person.' The policy supported LGBT people living at the service.

People were asked about where and how they wished to be cared for when they reached the end of their life and plans were put in place. Any specialist wishes or advanced directives were documented, including the person's views about resuscitation in the event of an unexpected illness or collapse.

Good

Is the service responsive?

Our findings

Relatives told us they had been consulted about their relatives care needs, both prior to and since their admission. One relative told us, "They [staff] did an assessment." Another relative said, "We did meet up with the manager." A third relative told us, "They [staff] always tell me what's going on." A friend of a person who used the service told us, "They [staff] came to the other care home. It was the senior [staff member] and a mental health worker. The senior [staff member] asked appropriate questions." Information from the pre-admission assessment form and the local authority assessment form was used to develop care plans and risk assessments with people and/or their relatives.

Care plans were in place to meet people's needs and focused on the person and their individual needs, choices and preferences and some contained personal histories. Care files had a document called, "About my Life" which identified specific details about who was important to the person, their past social history, their likes and dislikes and their preferred routines. For example, one care plan stated, "[Person] said she likes to put on perfume every morning, but she has a favourite one. Her favourite perfume is [name of perfume]." Care plans were updated and reviewed regularly by the nurses and care staff. One staff member told us, "Staff do not feel rushed. Have a lot of time to talk with people and provide personalised care." This meant staff knew how to respond to individual circumstances or situations.

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. They included personal hygiene, nutrition and hydration, mobility, medicines, communication, toileting, skin integrity, mental health well-being, behaviours that challenge, expressing sexuality, breathing, night time care, and lifestyle and social interests. Staff knew about people's needs and their backgrounds and the care and support they required. One relative told us, "I've been through the care plan."

People had access to planned activities and local community outings. The service employed two activities co-ordinators. Activities co-ordinators were at the service seven days a week. During the first day of the inspection we observed a music therapy session. People were engaged and playing various instruments. On the second day of the inspection we observed a sing-a-long and a fitness session. Observations showed people were enjoying being involved in the activities. The activities co-ordinator told us they provided one to one sessions for people who did not want or could not attend group sessions. Records confirmed this. Each unit of the home had the activities calendar on display for the month. Activities included afternoon tea, spiritual services, drama classes, bingo, beautician, arts and crafts, keep fit, movies and one to one sessions. The activities co-ordinator told us, "I try to make residents happy and find entertainment. They can relax and enjoy." One person said, "They have activities that I go to." A relative told us, "[Activities co-ordinator] is brilliant. She involves the residents. She has an aura about her." The same relative said, "The music they love. They bring in a young lady to do art." Another relative said, "[Activities] have been very good. They have people in with music and exercises."

Residents and relatives meetings were held on a regular basis to provide and seek feedback on the service. Topics recorded for the meetings included care plan reviews, activities, food menus, research project

opportunities, maintenance of the home and outings. One relative told us, "They do [have meetings] but not many relatives go." A friend of a person who used the service said, "I attended one. I valued that. It was advertised and I was free to come. What was good was the manager was there, activities co-ordinators, team leader and relatives."

There was a complaints process available and this was on display in the communal area so people using the service were aware of it. Also the home's service user guide gave guidance on how people and relatives could make a complaint. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

Most people and relatives knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions resulting and response to complainant. Records showed there had been four formal complaints for 2017. We found the complaints were investigated appropriately and the service aimed to provide resolution in a timely manner. One person said, "I would tell the staff." One relative told us, "I would write everything down and then find the top person at Shaw Healthcare." Another relative said, "I would go the manager."

Good

Is the service well-led?

Our findings

People who used the service and their relatives told us they thought the service was well managed and they spoke positively about the manager and the senior staff. One relative said, "[Manager] been here a couple of weeks. He is nice. Comes to see the residents. The temporary manager was brilliant."

The service did not have a registered manager at the time of our inspection. The previous registered manager notified CQC on 15 May 2017 that they will no longer be the registered manager. We received an application for the new manager to apply for the position of registered manager on 30 June 2017. Staff told us the new manager was approachable and had made an impact in the short time they had been at the service. One staff member told us, "So far so good with manager. He gives us feedback and we both work as a team." Another staff member said, "The new manager is learning the environment and keeping up. No challenge out of his control." A third staff member told us, "He is good. He is new here. There is no day he doesn't visit all the units and residents. It's fantastic. He wants to change things. He has zeal." A fourth staff member said, "Any issue I can go talk to him. He is very helpful."

A variety of staff meetings took place, such as heads of department, team leaders, activities, housekeeping, kitchen and general staff meeting. Staff said that team meetings were helpful and that all staff had input into discussions about the service. Records confirmed that staff meetings took place regularly. Agenda items at staff meetings included training, recruitment, infection control, health and safety, supervision, activities, and staff awards. One staff member told us, "They talk about if staff have concerns. It's usually every month. There is a poster when the meeting is." Another staff member said, "We did [staff meeting] about a week ago. We discuss anything to do with staffing and concerns. It's good to talk about things." A new staff member told us, "We have had two staff meetings since I've been here. Minutes of the last meeting are shared."

The provider had a number of quality monitoring systems in place. These were used to continually review and improve the service. The manager told us the provider conducted a six monthly audit of the service and the last one completed was June 2017. Records confirmed this. The six monthly audit looked at the premises, medicine competency of staff, care files, activities, and how staff were being supported by the manager. The last audit showed where actions were identified. The manager showed us an action plan they had created showing where actions had been dated and completed.

The home provided monthly reports to the local authority that had placements in the service. Records showed the monthly reports looked at care plan audits and the outcome of these, number of care plan reviews completed, safeguarding, number of falls, number of pressure ulcers, medicine errors, training, number of deaths, and number of placements. The home had quarterly meetings with the local authority to address any concerns from the monthly reports. The local authority confirmed they received the monthly reports and quarterly meetings were conducted.

The manager of the service also completed a three monthly service quality audit. Records showed the last audit completed was May 2017. The audit looked at activities, induction, training, supervision, meeting

minutes, handover, staff files, premises, risk assessments and care plans, medicines and fire safety. Areas of concern from audits were identified and acted upon so that changes could be made to improve the quality of care. This meant people could be confident the quality of the service was being assessed and monitored so that improvements could be made where required.

The quality of the service was also monitored through the use of six monthly surveys for people who used the service and their relatives. The last survey completed was for March 2017. Surveys for relatives included questions about the premises, care plans, communication, choices, food, religious and cultural activities, general activities, and complaints. We viewed completed surveys which contained positive results. Comments included, "Very happy with the standard of care given to me", and "My [relative] is very happy at Maitland Park and feels she can talk happily to staff. She is well fed and looked after."

The provider regularly implemented innovative schemes to promote and improve staff confidence and recognition. For example, the provider held an annual staff awards event called Shining Stars. Staff, people who used the service and relatives could nominate staff members. We saw information and nomination forms available in the communal areas on the Shining Stars award. The next Shining Stars award event was to be held 19 July 2017.

There were policies and procedures to ensure staff had the appropriate guidance, staff confirmed they could access the information if required. The policies and procedures were reviewed and up to date to ensure the information was current and appropriate.