Borough Care Ltd

Cawood House

Inspection report

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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

This was an unannounced inspection carried out on 4 October 2016.

We last inspected Cawood House in May 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Cawood House provides accommodation and personal care for up to 42 people. Care is provided to older people, including people who live with dementia or a dementia related condition. At the time of inspection there were 41 people living at the home.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

Appropriate training was provided and staff were supervised and supported. Staff had received training and had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices where they were able about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way. We have made a recommendation about the use of covert medicines. (Medicine that is placed in food or drink without the person's knowledge).

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Most records were in place that reflected the care that staff provided. We have made a recommendation about care plans.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. A variety of activities and entertainment were available for people. The environment was being refurbished and it was bright and promoted the orientation and independence of people who lived with dementia.

People told us they felt confident to speak to staff about any concerns if they needed to. Staff and people

who used the service said the registered manager was supportive and approachable. People had the opportunity to give their views about the service. Feedback was acted upon in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided.

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.

People told us they felt safe. Staff were appropriately recruited. They were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Risk assessments were carried out appropriately to keep people safe.

Policies and procedures were in place to ensure people received their medicines in a safe manner. Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

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

Most best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment. We have made a recommendation about covert medicine use.

People received a balanced diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

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

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

There was a system for people to use if they wanted the support of an advocate. Advocates were made available to represent the

views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. There was good standard of record keeping. Care plans were in place but they did not always provide detail of how people's care should be provided. We have made a recommendation about care plans.

There was a good variety of activities and entertainment to stimulate people and to help keep them engaged.

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

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. The registered manager and management team promoted the delivery of more person centred care for people.

People were complimentary about the registered manager and staff team. They told us there was an open and positive atmosphere in the home and people and relatives were consulted about the running of the home.

The home had a quality assurance programme to check on the quality of care provided.

Cawood House

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 4 October 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We contacted the local safeguarding teams.

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

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with eight people who lived at Cawood House, three relatives, the registered manager, two deputy managers, seven support workers including one senior support worker, the activities organiser, one member of catering staff and one domestic. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for four staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered

manager had completed.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Comments included, "I feel quite safe here", "Staff come straight away, if I call" and "Staff are around if I need them."

We considered there were sufficient staff to meet people's needs. The registered manager told us staffing levels were determined by the number of people using the service and their needs. We were told people's dependency levels had been taken into account to ensure sufficient staff over the 24 hour period. At the time of our inspection there were 41 people who lived at the home. Staffing levels included 2 senior support workers and six support staff who worked from 8:00am-4:00pm, two senior support workers and four support staff from 4:00pm-10:00pm and three waking night staff from 10:00pm-8:00am. These numbers did not include the management team who were also available during the day and provided an on-call service for advice overnight.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. Two safeguarding alerts had been raised since the last inspection. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Staff had an understanding of safeguarding and knew how to report any concerns. Records showed and staff confirmed they had completed safeguarding adults training. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and they knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. One staff member told us, "Any safeguarding concerns I'd report to the senior or manager."

Individual risk assessments were in place and there was a system of regular review to ensure they remained relevant, reduced risk and kept people safe. Evaluations included detail about the person's current situation. The risk assessments included risks specific to the person such as for moving and assisting, mobility, nutrition and pressure area care.

People received their medicines in a safe way. We observed part of a medicines round. Medicines were administered by the senior support worker. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

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

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

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

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

Good

Is the service effective?

Our findings

Staff were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up to date with training and that training was appropriate. Staff comments included, "We get plenty of training", "There are opportunities for development", "There are opportunities for training I've done diabetes training and basic life support", "I'm hoping to do an National Vocational Qualification (NVQ) at level two (now known as the diploma in health and social care)", "I've done dementia awareness training", "I do e-learning training" and "We do practical and e-learning training."

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. We were told new staff could shadow another member of staff for two weeks. Staff meeting minutes from July 2016 recorded induction had extended from three to five days and new staff were to follow the Care Certificate as part of their induction. This ensured they had the basic knowledge needed to begin work. Staff told us initial training consisted of a mixture of face to face and practical training. One staff member told us, "I had an induction and shadowed another member of staff when I started."

The staff training records showed and staff told us they had received other training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as eating and drinking well, the Care Certificate, mental capacity and deprivation of liberty, diabetes awareness, dementia care, computer awareness, equality and diversity, basic life support, management training and protecting personal information. Champions in dementia care and nutrition were appointed from amongst staff members to promote and raise awareness of these areas of care amongst the staff team.

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "The manager does my supervision", "We have supervision every few months" and "I had supervision last week" Staff told us they were well supported to carry out their caring role. All staff said they had regular supervision to discuss the running of the service and their training needs. They said they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance.

Staff told us communication was effective. Staff members' comments included, "Communication is very good," "We have a handover at the start of each shift" and "The senior staff brief us about what's going on and what needs doing." We were told a handover session took place, to discuss people's needs when staff changed duty, at the beginning and end of each shift. A formal verbal exchange of information took place about all people to ensure staff were aware of the current state of health and well-being of each person. Staff told us the diary and communication book also provided them with information.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and had received training in the MCA and the related DoLS. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us 33 applications had been authorised by the local authority.

Staff had some understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Some records contained information about people's mental health and the 'best interest' decision making process, as required by the MCA. However, we were told four people received covert medication. Covert medicine refers to medicine which is hidden in food or drink. Documentation was available to show why this was required, a record referred to the need and showed that it had been authorised by the GP and the registered manager. However, care plans for staff guidance for the use of covert medicine were not in place. We saw the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. "A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

We recommend that the registered manager considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

We checked how people's nutritional needs were met. A catering department, operated by the organisation, provided the catering staff to cook in the service. We saw food was well presented and looked appetising. People were offered a choice and a menu advertised what was available each day. People were positive about the food saying they had enough to eat and received good food. Peoples' comments included, ""The food is very good", "We get a choice of meal" and "There's plenty to eat." Drinks were available during the day with biscuits provided.

Care plans were in place that recorded people's food likes and dislikes. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us they received information from the registered nurses when people required a specialised diet. Written information was available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available. For example, diabetic, vegetarian and soft or pureed diets. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned

produce.

The home was bright, spacious and airy. It was well-decorated and was being refurbished and designed to ensure it continued to be stimulating and therapeutic for the benefit of people who lived there. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms had pictures and signs and bedroom doors were painted so people could more easily identify their room to help maintain their independence. We saw there was visual stimulation to help maintain the involvement and orientation of people with dementia. For example, orientation boards and clocks to inform people of the activities, menus and time and day of the week.

Good

Is the service caring?

Our findings

People who could comment were positive about the care and support provided. Their comments included, "I like it here", "Brilliant care", "I enjoy being here", "Staff are very kind and pleasant", "The care workers are lovely", "It's very good in here" and "I'm quite happy." Relatives we spoke with told us, "[Name] settled in straight away", "Staff are very kind" and "The girls are very good."

Good relationships were apparent and people were very relaxed. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. We saw staff ensured any personal care was discussed discretely with the person. Staff treated people with dignity and respect. We saw staff sat with people at meal times to provide assistance to people who needed support. They knocked on people's doors before entering their rooms. We observed that people looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room. Care plans provided individual information for staff about people's preferences if they were unable to inform staff themselves if they wanted to spend time on their own. Examples included, 'I like to sit and spend time in my room' and 'I like to sit in a quiet area.'

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing two items of clothing or two plates of food so people could choose what they would like to wear or eat. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. A staff member told us, "I'd check their body language to see if the person was in pain."

We observed the lunch time meal. The meal time was relaxed and unhurried. The dining room was bright and there was a lively atmosphere as people talked amongst themselves and with staff. Staff interacted with people as they served them. People sat at tables set with tablecloths and condiments. Specialist cutlery was available for people as needed to help maintain their independence. Tables were set for four and staff remained in the dining area to provide encouragement and support to people. Staff provided prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way. Some visitors assisted their relatives with their meal.

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

We were told the service used advocates as required but most people had relatives. Advocates can

represent the views for people who are not able to express their wishes. We were told three people had the involvement of an advocate.

Good

Is the service responsive?

Our findings

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, activities of daily living, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, pressure area care, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, the speech and language therapist was asked for advice with regard to swallowing difficulties and communication. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. We saw the home scored 100% in the question in the provider survey of 2015, 'Staff understand me as an individual.' Care plans provided some information for staff about how people liked to be supported. For example, some care plans for personal hygiene stated, 'I need the support of one staff to assist with my personal care. I like my hair, nails and make up done', 'I need two staff to support me with my individual needs' and 'I can wash myself with one person helping me.' However, care plans were not broken down to provide details for staff about how the person's care needs were to be met. They did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. The registered manager told us new care plan documentation had been introduced and that this would be addressed. Other information was available in people's care records to help staff provide care and support. For example, 'I like to go out with my brother', 'Even though I need the support of staff I do like to keep my independence' and 'I like the door closed and the small light left on.'

We recommend the registered provider seeks guidance about developing more person centred care plans.

Information about the social care needs of people was well-recorded and was given as much importance as the health needs of the person. Detailed information was available for each person with a record of their likes and dislikes, which had been collected from relatives. This was available to help staff and give them

some insight into people's previous interests and hobbies when a person was no longer able to tell staff themselves. People's care plans also provided information about their social interests. For example, 'I like to know when the football is on so I can watch it', 'I enjoy a lager and sitting in the garden', 'I like Do it Yourself (DIY)', 'I like to listen to the radio about gardening', 'I am very chatty', and 'I drink tea and coffee with no sugar.' Information was collected and analysed about the individual activities that people took part in to show their reaction of enjoyment or otherwise. This was a useful account so staff knew whether the person wanted to engage in the activity again. It also contributed to an overall picture of the person's health and well-being. There were numerous examples in records and some included, 'Bridgewater Hall,[Name]really enjoyed the jazz concert and café, however the music did make them emotional during the concert', 'Manchester bars [Name] loved it and [Other] not well due to travel sickness' , 'Trip around Brinnington,[Name] was feeling down and really appreciated being out in the sun', '[Other] loved it, 'happy, happy, happy', 'Manchester Piccadilly, [Name] went by train and had picnic in Piccadilly Gardens then went window shopping all around Manchester. Wonderful trip [Name] came right out of themselves and 'Garden Centre, [Name] literally cried because they thought they had been taken to heaven as liked the garden centre so much.'

An activity lifestyles facilitator was available who provided individual and group activities with people. A varied programme of activities was available that advertised the weekly activities. We saw the programme was developed in consultation with people who used the service. For example, an outing was advertised that stated 'trip to wherever you choose within 80 miles.' Activities included bowling, cake decorating, jenga game, table hockey, music, tell a tale, parachutes, sing a long, walking, catching and one to one exercises. Stimulation and therapy were also available to engage with people who lived with more severe dementia. Sensory stimulation took place with people using scented oils and drawing was also available to supplement the other activities. A sensory, relaxation garden room was available which was equipped with olfactory (smells) and tactile experiences for people. One example we saw was of a seaside experience with sand, water and the sounds of the sea for people. Entertainment and concerts also took place. The hairdresser visited weekly and a regular church service was held. Transport was available and people had the opportunity to go out on regular trips. We saw trips to Whaley Bridge, the Trafford shopping centre, Sefton, Liverpool and Hayfield were planned during the week. Other trips included to the Imperial War Museum, the docks, the local country side, a Bubble festival, canals and many other places of interest. The registered manager told us six people were going on holiday to Blackpool.

Regular meetings were held with people who used the service and their relatives. The registered manager told us meetings provided feedback from people about the running of the home. Meeting minutes from September 2016 showed topics discussed included, fund raising, social events that were to take place in the home in October and menu suggestions for themed culinary nights that were to take place.

People said they knew how to complain or raise any concerns. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the contract they signed when they moved into the home. A record of complaints was maintained and we saw seven complaints had been received, investigated and resolved. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided. Compliments included, "There's lots going on" and "Feels a happy place."

Good

Is the service well-led?

Our findings

A registered manager was in post and they had registered with the Care Quality Commission in December 2015. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The deputy managers assisted us with the inspection, together with other management from the organisation as the registered manager was not available. Records we requested were produced promptly and we were able to access the care records we required. The provider's representatives were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way. They told us about the underlying values they saw as important, including ensuring people were treated with dignity and respect. Care staff were also enthusiastic and clear about expected standards of work and the registered manager's ethos.

The atmosphere in the home was bustling, vibrant and friendly. People moved around different areas and sat and watched the comings and goings around the home. People told us the atmosphere in the home was warm and friendly and relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. Their comments included, "The manager is approachable", "The manager is very nice", "I do feel listened to", "I do enjoy working here" and "The support manager is very approachable."

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. Staff we spoke with were enthusiastic about ensuring people who lived with dementia were encouraged to lead a fulfilled life whatever their level of need.

Staff told us regular general staff meetings took place as well as management and care staff meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues. Meeting minutes from July 2016 showed health and safety, staff performance, key worker duties, training and the running of the service were discussed at the meeting.

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. They showed the action that had been taken as a result of previous audits where deficits were identified. A weekly risk monitoring report that included areas of care such as people's weight loss, safeguarding and serious changes in their health status was completed by the registered manager and submitted to head office for analysis.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. Monthly audits included checks on people's dining experience, staff supervision, medicines management, care documentation, training, kitchen audits, accidents and incidents and nutrition. Annual audits were carried out for infection control and health and safety. The registered manager had introduced other regular audits such as mattress checks and pressure relieving equipment and

environmental bedroom checks. A financial audit was carried out by a representative from head office annually. We were told three monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned. Other audits included checking a sample of records, such as care plans, complaints, accidents and incidents, nutrition and hydration, safeguarding and staff files.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service and their relatives and visiting professionals. People were surveyed about 'staff and care', 'home and comforts', 'choice and having a say' and 'quality of life.' We saw the survey results for 2015 and the 37 surveys returned had been positive. We saw that results were analysed so that action could be taken as a result of people's comments, to improve the quality of the service. The home scored 919 out of a possible 1000 top score in the combined four areas.