Lifestyle Care Management Ltd

Clarendon Nursing Home

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 inspection took place on 25 and 26 October 2016. The inspection was unannounced.

This was the first inspection of the service under the new provider.

Clarendon Nursing Home provides accommodation, nursing and personal care for up to 47 people, some living with dementia. At the time of our inspection, there were 46 people using the service.

There was a registered manager in post. 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 at the service felt safe. Staff knew how to respond to abuse and had completed safeguarding of adults training. The service provided a safe and well maintained environment for people, visitors and staff. Risk assessments supported people's needs. There were sufficient numbers of staff to meet people's needs. There were procedures and checks in place to ensure only suitable staff were employed. The management of medicines was safe. The service was managing infection prevention and control by following appropriate guidance.

Staff were provided with regular supervision and training to support people with their care needs. People were supported to have a healthy diet and to maintain good health. The service was working within the principles of the MCA. We saw evidence of completed mental capacity assessments, best interests meetings care records. Staff had completed MCA training.

People's comments about staff were generally positive. Care planning arrangements considered people's individual needs and preferences. We observed good practice and incidences of warm and compassionate care. People's choices and decisions were respected. Staff providing care and treatment respected people's privacy and dignity. People's independence was supported. People and their representatives were involved decisions around their care and treatment.

People received personalised care and support that was responsive to their diverse needs. Care records and support plans identified people's needs, risks and goals. People and relatives were confident that they could raise concerns with staff and there was a complaints system in place. There was a programme of activities for people who could attend group activities. There were no activities in place for those who could not make group sessions. We were told an additional activities coordinator had been recruited and was waiting to start.

People, relatives and staff spoke positively about the management team and said they were approachable. Staff meetings were held regularly giving staff the opportunity to feedback their thoughts about the service.

There were systems in place to assess and monitor the quality of service provided. Records relating to the provision of care were fit for purpose.

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 were safeguarded from the risk of abuse. Risks to people were identified and management plans supported staff to manage them safely. There were sufficient numbers of suitable staff to meet people's needs. Medicines were managed safely.

Is the service effective?

Good

The service was effective. People were cared for by staff who received training to develop the skills they needed, they were effectively supported in their role. People with specific dietary and health needs had advice from health and social care professionals. Meals were provided that were safe and nutritious and took into account people's needs. People's liberty was not restricted unless it had been authorised.

Is the service caring?

Good

The service was caring. People were cared for and supported by staff who were kind and caring. The service recognised people as individuals and responded to their preferences in a person centred way. Staff were respectful and thoughtful in their approach.

Is the service responsive?

Good

The service was responsive to people's needs. Before people were admitted assessments were undertaken to identify individual's needs to ensure the placement was appropriate. Needs assessments were used to develop care plans and provide safe and appropriate care and treatment. People were asked for their views and understood how to make a complaint or offer feedback. Activities were available although people felt these could be improved. The provider had plans to address this.

Is the service well-led?

Good

The service was well led. The manager was registered with CQC. Staff spoke positively about the management team and regular staff meetings gave staff the opportunity to feedback their thoughts about the service. There was a system of reviews, checks and audits to assess and monitor the quality of service

provided to people.

Clarendon 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 25 and 26 October 2016 and was unannounced.

The inspection team comprised two adult social care inspectors, an inspection manager, a specialist advisor, 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.

Before the inspection, we reviewed the information we held about the service and statutory notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care. We reviewed the provider information return (PIR).This form asks providers to give key information about the service, what it does well and improvements they plan to make. We used this information in the planning of the inspection. We also reviewed previous inspection reports and information from people visiting the service.

We met with 20 people living at the home. We spoke with 10 people to hear their views about their care. Some people were not able to comment specifically about their care experiences, so 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 living with dementia. We also spoke with three relatives who were visiting.

In addition, we spoke with 16 members of staff from all areas of the service including the registered manager, deputy manager and area manager. We reviewed 14 care files and six staff files. We also looked at records relating to the management of the service. During our visit we had discussions with a visiting health professional to obtain their views of the service provided to people.

Good

Is the service safe?

Our findings

We spoke with staff about safeguarding adults from abuse. It was evident they knew how to recognise various types of abuse and the processes for reporting suspected abuse. Staff had completed safeguarding training. Posters provided by the local authority about safeguarding were displayed prominently in public areas throughout the building. These posters provided contact telephone numbers for anybody wanting to report abuse. We checked our records and saw that the service had complied with legislative requirements by notifying us promptly of safeguarding concerns when they arose.

Formal handovers took place between shifts on each floor so that staff were aware of incidents that had happened on the previous shift and how individuals were feeling and behaving. Later in the morning the nurses met with the registered manager and/or deputy to discuss any incidents, what was happening and anything of note in or outside of the service.

We found that the building was a safe place for people, staff and visitors. The interior of the building was well maintained. Inside the building we found a number of improvements had been and were being made by the provider. Equipment used in providing the regulated activities was in good condition and well maintained. The service employed a person to carry out a dual role of maintenance and housekeeping. They carried out minor maintenance and arranged for external contractors to deal with more complex issues. We saw a number of improvements had been made to the interior of the building and bedrooms were in the process of being refurbished and redecorated one at a time. There was an ongoing long term programme of refurbishment planned.

We found risk assessments had been completed as part of people's care and support plans. One relative told us, "Staff help and make sure [my relative] always has softer textured food to reduce risks from choking." Needs assessments were carried out before people came to live at the service. These assessments included the identification of risks to people's health and wellbeing which were developed when people came into the service and was an ongoing process. Risks such as choking, use of bed rails, moving around the home, skin integrity, falls and malnutrition were identified, assessed and recorded. People at risk of malnutrition had their weight monitored and if people lost weight referrals were made for specialist advice. Where people were identified at risk of developing a pressure ulcer preventative measures were put in place such as providing a pressure mattress and cushion and encouraging food and liquid intake. These were two examples of how the service managed risks. All risk assessments were reviewed periodically or in response to changes in needs.

Staff told us they were happy with staffing levels. People told us here were usually sufficient numbers of staff to meet people's needs. Some relatives told us staffing levels appeared lower when regular staff were unavailable at weekends. One person using the service told us, "There is always a shortage of staff at weekends." Another person said, "They are short of staff." One person said, "I think there are enough staff, maybe a few less at weekends."

We looked at staff rotas which tallied with staff on duty. The manager told us there were 46 people using the

service on the three floors of the building. During the day, three nurses and nine care assistants were on duty to meet the needs of people using the service.

At night the staffing levels were much lower, there were two nurses and four care assistants with one of them 'floating' to provide assistance where and when needed. We considered people's needs against numbers of staff at night time. We found the personal care needs of people on the ground and first floors were high. 12 people required two care assistants to help with personal care to promote safe manual handling procedures. A large number required personal care throughout the night and repositioning. On the top floor, people were living with dementia and /or other significant needs. The routines indicated that staff had to adhere to a task based approach to ensure people needs were met during the night. In light of this and the comments about the weekends we asked the registered manager to complete a needs analysis for people using the service to ensure staffing levels were appropriate. We were immediately provided with a recent dependency audit tool which scored people against 13 categories of needs. The provider based the service staffing levels on the dependency audit.

Day time care staff were supported by domestic, laundry and catering staff. There was also an activities coordinator and an administrator. This ensured nurses and care assistants could concentrate on providing care and treatment. The registered manager and deputy manager were both registered nurses and provided clinical support when needed.

We examined a random selection of staff files and six to specifically check recruitment procedures. We found the service had processes in place to ensure appropriate people were employed. These included checks with the Disclosure and Barring Service to ensure applicants were not barred from working in this environment. There was also evidence of identity documents, references and full work histories.

Medicines were managed safely. We checked a random selection of medicines against records. The records we check tallied with the quantity of medicines held by the service. We also checked controlled drugs and medicines returns. Medicines administration records were completed correctly and were up to date. Where people were taking medicines that required regular medical checks this was referred to in medicines records and care plans. A GP told us staff were vigilant, requested medicine reviews and were good at prompting and identifying when a medicine review was required. The GP told us staff provided feedback about people's responses to medicines prescribed.

Medicines were stored in appropriate medicines trollies on each floor. The ground floor room was air conditioned and had appropriate hand wash facilities and a medicines refrigerator. However, it was also used as a nurses' station and for the storage of care records which could cause distractions for staff dealing with medicines. The first floor medicines room was actually a cupboard large enough to store a trolley but was poorly lit. On the top floor, the medicines room was very warm. We checked temperature records and saw the temperature was always at the top end of recommended parameters and occasionally exceeded them by a degree. We discussed these matters with the registered manager and area manager who agreed to reconsider how and where medicines were stored.

The service was adhering to the Department of Health Codes of Practice for the prevention and control of infection in care homes and the requirements of the Control of Substances Hazardous to Health Regulations (COSHH). This was how the service managed infection control and prevention to protect people, visitors and staff from the risk of infections. The communal areas (including bathrooms and toilets) and the bedrooms we visited provided a clean and appropriate environment to facilitate the prevention and control of infections. Staff had access to a plentiful supply of personal protective equipment (PPE) and hand wash facilities. COSHH materials were appropriately stored. Laundry was segregated through colour coded

laundry bags. Staff had completed relevant training on the prevention and control of infection and the use of COSHH materials.

Good

Is the service effective?

Our findings

People were cared for by staff who had the knowledge and skills they needed to deliver safe and effective care. One person using the service told us staff provided the care they needed, they said, "Staff are aware of how we are, they know if I'm poorly." New members of staff completed an induction and if they were new to providing care or lacked qualifications they were required to complete the Care Certificate. This sets out explicitly the learning outcomes, competences and standards of care expected to ensure they are caring, compassionate and provide quality care.

Staff told us they completed regular training and refresher training that was relevant to their roles One member of staff told us, "You have to do the training because they check it." We checked training records and saw staff training attendance was at a high level in a wide range of subjects including topics such as basic life support, dementia awareness and safeguarding adults.

Staff were also supported, on occasion, to obtain further qualifications relevant to their roles. One member of staff told us the registered manager was supporting them to enrol on a Qualifications Competency Framework (QCF) Level III in Health and Social Care. QCF replaced National Vocational Qualifications. We checked staff records and found 16 members of staff had Level II or Level III QCFs or NVQs in Health and Social Care. Four members of staff were waiting to enrol on a Level II course. Further training increased the knowledge and awareness of staff when providing care to people using the service.

Staff told us they felt well supported by the registered manager and senior staff members. They had regular one to one supervision sessions with a senior staff member every seven to eight weeks with an annual appraisal. The manager provided supervision to qualified nurses. One staff member said, "I feel well supported and can approach management at any time for advice." Another staff member said, "We've got better now since the deputy manager came; the team is more complete, we work together and I know where to go for support." Another member of staff told us they had regular supervisions and felt comfortable with approaching the managers for support in between supervision meetings.

People were provided with sufficient food and drink to meet their needs. Staff assessed people's risk of malnutrition using a malnutrition universal screening tool (MUST). These assessments were reviewed monthly which meant staff could monitor people's conditions and take action when necessary. There were discrepancies on the frequencies of the care reviews and assessment tools for some people which we brought to the manager's attention. The deputy manager was in the process of auditing care records and highlighted those requiring actions to ensure they were updated. Some people saw dieticians for dietary advice and the guidance given was recorded in people's care records. For people at risk of malnutrition or dehydration food and fluid levels were monitored with records of the foods and drinks they consumed. We saw these were completed accurately so staff could use them to monitor the person's condition. Staff knew which people had particular needs in relation to their diet, for example they knew who required pureed meals or those suitable for people with diabetes.

Menus were displayed and the food served for lunch looked appetising, portion sizes were good. The main

hot meal was served in the evening. Specialist diets, such as those for people with diabetes or low salt were catered for and people's individual likes and dislikes were known. People who required support were assisted in an unhurried and dignified way. In the kitchen there were records of individual dietary needs. Kitchen staff spoken with had a good knowledge of people's requirements, for example those with swallowing issues that needed their food to be pureed. The chef was aware of those at risk of malnutrition and how to increase people's nutritional intake.

When a person was admitted to the home staff sent a referral to the chef recording the person's allergies and how to support the person with any special dietary requirements. For people who required special diets to manage their diabetes they were offered puddings made with sweeteners rather than sugar. We observed people being supported to enjoy their lunchtime meal. One person told us, "I am happy with meals; in the evening there are up to three choices for the main meal and always something I like." Another person told us they were always offered a choice of meals and told us they were always asked, "What would you like?" We saw that snacks were available for people and people were supported to have plenty to drink during the day.

We saw aids and adaptions were used to help people maintain their independence with eating. For example, plate guards and adapted cutlery were used to enable people to eat independently. For people who found it difficult to manage cups and mugs we saw they took their drinks independently using beakers with lids. Two people told us they liked using these as it meant their drinks did not spill too easily. A number of people came to the dining room on the ground floor for lunch, but not enough staff were reassigned from the upper floors to support them. Staff support on this occasion appeared quite stretched and detracted somewhat from the quality of care given.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met .Staff had received MCA and DoLS training and were aware of the implications of this in their practice. Whenever possible they sought people's consent before providing care and support. A health professional told us they had been involved in a best interest decision meeting with relatives for a person who lived in the home. There was information held on the care record to confirm the meeting took place. A new member of staff told us they had not yet received the training but said there were arrangements in place for it to be provided.

People's rights to make their own decisions were respected and promoted. When people had been assessed as being unable to make specific decisions best interests meetings had been held and where appropriate authorisations had been sought. This ensured people's human rights were protected and they were not unlawfully deprived of their liberty.

Staff supported people and took appropriate action to help promote their health care needs. They ensured people had access to healthcare professionals and had choice about the health care support they received. Records showed referrals were made to professionals such as doctors, physiotherapists, dentists, opticians and dieticians. Staff accompanied people to hospital when there were no relatives available to do so and to

other external appointments. As well as having the company of a familiar face this also ensured that a full account of the appointment was documented. Relatives praised the healthcare support provided to their family members and commented that staff were very quick to address any health issues or concerns.

People told us they could see the GP or other health care professionals when they wanted. People were registered with a local practice. There was a weekly GP surgery held at the home. The manager told us they received an excellent service from the GP and there was a good working relationship with staff at the home. If there were any emergencies and a call out was needed the GP on duty responded the same day.

In records we saw that staff had contacted a number of external health and social care professionals. Multidisciplinary records were completed by those who visited and were involved in people's care. A nurse shared with us the range of health professionals involved with people's care. Referrals were appropriate, for example we saw that a physiotherapist had visited a person following receipt of referral from the home.

For people who were receiving bed care we saw staff identified those at risk of developing pressure sores and had suitable pressure relieving mattresses in place. To promote good tissue viability staff changed people's position frequently and recorded this on care logs. Care logs were accurately maintained. One person with a pressure sore was seen by the tissue viability nurse following referral by a nurse at the home. Records showed staff had managed the wound care in accordance with recommendations from the health professional. Daily records maintained by staff reflected progress over a period of time showing a consistent wound care regime was followed. The wound had healed successfully and a positive outcome was experienced by the person. The tissue viability nurse had written in the multidisciplinary records, "Well done staff for managing the wound care so well."

A health professional told us qualified nurses were good as they communicated clearly with health professionals and were able to comment on how individuals responded to health care delivered. Health professionals told us staff requested their advice appropriately and put recommendations into practice in their care routines. This meant people received appropriate care and support for their health and care needs.

Good

Is the service caring?

Our findings

People told us, "Some of the staff are very kind." Another person said, "The staff are OK with me" and "I get out for a smoke." One person commented, "Staff are very good, they are very caring" and "I do feel they care for me here and they ask if you need anything." One person said, "The staff are OK, mostly." Another person told us, "Most of the staff are kind." A visiting relative told us, "I'm happy with the care given. We feel she is being looked after very well. She has a named carer. She is very nice." One person said "They always do their best to help you here". One relative told us, "One weekend day I arrived and my family member had a dirty dress, there was food on it from breakfast." They added, "Staff should be more thoughtful and should not need to be reminded". The person told us this incident was reported to the person leading the shift and dealt with promptly.

Staff were committed to caring for people in a way that was tailored to the individual's needs. The care records had details of people's wishes, for example people's preferred daily routines such as getting up, having breakfast in bed and so forth. People told us staff followed these routines. In addition, people's choices about whether they received care from a staff member who shared their gender was recorded and observed. Staff were seen to make efforts to engage with people. Staff we spoke with understood the needs of people and worked together with colleagues to ensure people had their needs met.

Positive and meaningful relationships had been developed between long standing staff and people. Each person was assigned a named nurse and a care worker was identified as a keyworker. The keyworker took particular interest in their care and support. They provided an initial point of contact for any concerns or requests. For people new to the home and their friends and relatives the key worker provided an instantly recognisable point of contact and reassurance. They also ensured any day-to-day living needs were met such as informing relatives when toiletries were getting low or going out and purchasing such items on their behalf.

We saw people could move freely around the home assisted and supported by staff. This was carried out by staff in a kind manner, staff supported people if they appeared a little unsteady to offer reassurances that there was somebody there to help. Staff used people's preferred names during conversations and asked their permission before undertaking tasks. During our inspection staff were heard chatting to people about general matters such as the current national news.

We observed staff supporting people to be as independent as possible with various aspects of their lives. Staff were flexible and adapted their approach to each individual including those people living with dementia. For example, staff engaged one person in a conversation who had been walking around the corridor. This interaction prompted the person to ask for the bathroom and the care worker supported them. Afterwards the care worker helped the person choose an important item of clothing and we saw that this made the person happy and settled. A care worker said, "If a person is able to wash themselves, we encourage them."

We watched how a staff member responded sensitively to one person living with dementia; the person

spoke with the carer as if they were the relative and became agitated when they could not recollect the event they spoke of. The response from the carer was measured and appropriate. Their approach and kind words reassured the person who resumed taking their mid-morning drink. The care worker acknowledged their training had helped them develop their skills but thought that kindness and compassion were the most important attributes to have when caring for people.

A number of people received bed care due to their medical conditions. One person who was spending time in their room told us, "I love music, the carer came and put the right radio station on for me this morning; gospel music is one of my favourites." We saw staff asked people how they felt throughout the day and one person told us, "Staff always ask if I am okay." One family member told us, "I can't fault the staff at all, although I wish I had them in my home, they really provide great care."

We found people and, where appropriate, relatives were supported to express their views and preferences. They were involved in the planning and delivery of care and treatment by contributing to assessments, care plans and reviews. One person told us, "They do listen to what I say. They are all working in my best interest." Another person said, "Sometimes they involve me in decisions." Where such support was provided it was recorded in people's care records.

Good

Is the service responsive?

Our findings

People told us they received help quickly when they asked staff for assistance such as when they used the call bell system during the day and at night. One person's relative told us they did not feel staff always responded quickly when they rang the call bell for help at weekends. A visitor told us, "Staff look after [my relative] well. They have responded well to any periods of ill health and keep us informed if there is a problem." Another visitor told us, "I am happy with the care; my relative is looked after very well, there are no worries." Throughout the inspection we observed staff responding promptly to call bells.

Care records provided detailed information about the needs of individuals. People received appropriate care because their needs were assessed and care arrangements planned. Senior staff assessed people's needs before they moved to the home to make sure they had the necessary facilities and staff had the skills to meet their needs. The manager told of occasions when the pre-admission assessment determined they could not meet the person's needs. This pre-admission assessment included information relating to previous medical conditions, preferences regarding daily routines, life history, communication including sight and hearing.

The information and results of the assessments were used to create personalised care plans. People were involved in their care planning as far as possible. Following admission to the home staff undertook an ongoing assessment to best identify how people's needs should be met.

Care plans provided detailed information to guide staff and ensure consistent provision of care. We saw support was responsive to people's changing needs and staff recognised how to adjust the care provided depending on how the person was feeling. The management of people's health such as malnutrition, falls and wound care were well documented and regularly reviewed.

We read how one person experienced mental health difficulties and saw there was clear guidance for staff about how to recognise possible triggers, the preventative measures they should take to reduce the person's anxiety and the necessary interventions if this escalated.

Daily records were completed for each person commenting about their health and wellbeing and any notable incidents. Care records reflected how staff leading the shift on each floor acted on observations and called on the necessary health care professionals when needed.

In care records we could see how the care and support provided was responsive to people's needs. Staff were provided with guidance on how best to engage people who had communication needs. For one person, staff were guided to observe body language and maintain eye contact and give reassurance and acknowledge how the person felt. Daily records showed staff identified any changes in people's health and took actions in response. We noted staff knew a person, recently discharged from hospital, was unwell. They involved the GP in seeing the person and reviewing their health care and continued to work well as a team making regular checks on the person.

People's diverse needs were recognised and respected. The care records included information about needs which came from people's culture and religion. Religious services were held in the home and representatives from places of worship visited people if they wished. The home had contact with religious leaders from different denominations. We noted that meals included some items on the menu which reflected the preferences of people from different cultures in the home.

The home had a weekly programme of activities advertised, which included areas such as physical exercises, music and baking. Although there was a programme of activities this was not personalised to meet the individual's needs, especially those who remained in bed. Activities and events did not fully consider their social care needs. One person using the service told us, "We don't do much here except we have church on some days, I prefer to amuse myself." Another said, "There is enough to do. We have quizzes." One person said, "I go to the activities room for entertainment, there are things to do every day." One person commented, "There's not much to do here." Another person said, "There is a varied programme of activities. I choose what I do. Some activities are better than others."

The service employed a full time activities coordinator but there were other demands on the person's role. The activities coordinator spent most of the time on the ground floor undertaking duties as well as fitting in activities. They went to the shops to get some individual items for people and on occasions took people along with them for a walk. We observed a music session where twelve people present in the lounge engaged in singing songs that were reminiscent of their youth. Afterwards we observed this had a positive impact on the wellbeing of those involved, they looked happier and engaged more with each other. We discussed this with the registered manager and they told us they had recruited an additional activities coordinator to improve activities within the service.

We found the service held meetings for people using the service and/or their relatives or representatives every three months or so. This provided the service with an opportunity to explain what was planned for the service and enabled people, relatives and representatives to provide feedback about service provision. This feedback helped the service identify areas where they were doing well and any areas they needed to improve. One of these meetings was planned to take place two days after the inspection.

People and relatives told us they would make complaints to the manager if they needed to do so. A relative said "I've got no complaints." This was reiterated by four other people we spoke with. They said they would feel confident to make a complaint if they felt they needed to but would normally raise any concerns with staff. Staff understood what they had to do if a complaint was reported to them. Any complaints were brought to the attention of the registered manager and there was a process in place for responding to them in line with recognised good practice. Complaints were reviewed at a service and provider level to ascertain if there were any lessons to be learned that could lead to improvements in service provision.

Good

Is the service well-led?

Our findings

People, relatives and staff spoke positively about the registered manager and the management team. One person told us, "The management seems OK" Another said, "The manager seems nice. From what I see, the home is run OK." One person commented, "The manager is a nice person. She comes in to say hello. She speaks politely and gives me time." A relative said, "The manager is fine. She is quite approachable." One member of staff told us, "[The registered manager] is regularly seen around on the floor." Another said, "Things have improved this last year, no doubt." One member of staff said, "I'm well supported by the deputy manager and manager." Another said, "I feel well supported and enjoy working here." Three other members of staff also commented on being 'well supported.'

The registered manager was a registered nurse. The new provider had appointed a deputy manager, who was also a registered nurse, to support the registered manager. This ensured management duties were covered if either had to cover for one of the nurses and introduced additional resilience in regards to staffing and reducing the need for agency staff.

The service had a number of systems to assess and monitor the quality of the service they were providing to people through periodic checks, reviews and audits. In addition, the service obtained feedback from people using the service, relatives, staff and health and social care professionals to identify areas that needed improvement and to assess the impact of the service on the people using it.

We found the registered manager held a daily meeting with nurses where they discussed areas of learning and improvement. Flash meetings took place every day Monday to Friday where the manager met with Heads of Departments to discuss a fixed agenda about what was happening within the service. These included safeguarding, complaints, staff absence, agency staff, health and safety, department concerns, visits from professionals and identified concerns about individual people using the service.

Staff meetings took place every two to three months providing staff with an opportunity to discuss service provision and put forward any ideas for improvement. A staff member told us at team meetings they discussed important items such as how to be more effective in caring for people. Staff meetings also provided the registered manager with the opportunity to update staff about service developments and any important changes in legislation and practice. There was also an annual staff survey where staff could provide feedback anonymously.

Care records including care plans and medicines were reviewed periodically and in response to incidents and changes in people's needs. The deputy manager had started the process of auditing all of the care plans and initiating improvements where required when we arrived to carry out the inspection. There were a number of audits carried out by staff, the management team and on behalf of the provider to monitor and assess the quality of service provision. There was also a monthly return covering all aspects of the service completed by the registered manager and submitted to the provider. The registered manager was required to attend a business meeting with other managers employed by the provider where they discussed experiences. The service was subject to monitoring visits from the local authority.

Any issues identified in reviews, audits and visits generated an action plan to show how the service would address them and prevent reoccurrences. Through staff feedback, checks and audits the service ensured the registered manager and provider were made aware of any issues or problems and were in a position to make improvements that would benefit people using the service.

Accidents and incidents were recorded in an incident book. There was policy and guidance for staff about the reporting of accidents and incidents. Records showed what action had been taken at the time and subsequently. The reports were signed off by the registered manager and submitted to head office. Learning opportunities could be identified at either, or both, service and provider levels. Any concerns or learning identified at head office were fedback to the registered manager.

We found records relating to the provision of care by the service were fit for purpose. They were readily accessible, up to date, legible and accurate. Where appropriate records were stored securely and restricted to those people authorised to see them. This ensured confidentiality of records for people using the service.