Park Homes (UK) Limited

Allerton Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Our inspection of Allerton Park Care Centre took place on 6 February 2017 and was unannounced. At the previous inspection in August 2015 we had found two breaches of legal requirements regarding dignity and respect and staffing. At this inspection we found improvements had been made to meet these requirements.

Allerton Park Care Centre provides nursing care for up to 50 people including some who are living with dementia and some who have mental health needs. There were 49 people living at the service when we visited. Accommodation is provided in two units over two floors with lift access between the floors. There is a communal lounge and dining room on each unit as well as toilets and bathroom facilities. A central kitchen and laundry are located on the ground floor.

The home had a registered manager. 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. The registered manager had tendered their resignation and was due to leave the service. However, a new manager had been appointed who was due to commence employment two weeks after our inspection. On the day of our inspection the registered manager was on leave and the service was supported by the area manager and the provider.

Safeguarding policies and procedures were in place and appropriate referrals made to the local authority and Care Quality Commission. Staff had received safeguarding training, were able to recognise signs of abuse and understood how to report this. Detailed risk assessments and management plans were in place to mitigate risks to people.

Although some areas of the premises looked tired and requiring refreshing and some bedrooms looked more homely than others, a refurbishment plan was in place to address these. Some areas had new flooring and dementia friendly signage with memory boxes in place. However, the service needed to ensure all people had access to personal toiletries in their rooms. Maintenance checks were in place and any maintenance issues addressed.

People's monies were kept safely although transaction management needed to be more robust.

Medicines were managed and administered in a safe manner.

Accidents and incidents were reported effectively and actions taken as a result documented.

Staffing levels were sufficient to support people safely. Staff employed had checks in place to ensure their suitability to care and support vulnerable people and appropriate staff training was up to date. Supervisions and appraisals were in place to ensure staff received support in their roles. Staff told us morale was good and they received good support from the management team.

Evidence of consent and best interest decisions were visible in people's care records and the service was acting within the legal framework of the Mental Capacity Act 2005.

People's health care needs were met and referrals were made to health care professionals appropriately.

People were supported to consume a varied diet and supplements were in place where people were at risk nutritionally. Referrals were made to the dietician where required.

Interactions between staff and people were positive and staff were kind and caring in their manner. We saw staff knew people well and people were happy and relaxed in their presence.

People and/or their relatives were involved in the planning of their care. Advocates were involved where people lacked capacity and did not have any relatives to speak on their behalf.

Plans of care were clear and easy to follow and personalised according to people's needs. However in some cases these required further details of specific needs to increase person centred care planning. Reviews of care records were regular and reflected people's changing needs.

A varied activities programme was in place according to people's choice. The activities co-ordinator respected if people did not want to take part in the activity on offer and alternatives suggested.

People's preferences were respected such as where they wanted to sit, what they wanted to eat and what activities they wanted to take part in.

Complaints were taken seriously and well managed. The complaints procedure was on display at the service.

A range of quality audits were in place to monitor and improve the service and to ensure the provision of high quality care. The provider had oversight and conducted meetings with senior staff to ensure the smooth running of the service.

Staff were unanimous in their praise for the registered manager and provider and said they received good support in their roles. We saw the provider and senior management team had a visible presence in the service. Morale was good and there was a positive atmosphere in the home.

Staff meetings and surveys were conducted as well as meetings for people living at the service and their relatives. Quality surveys and communication with people showed their views were listened to and actions taken as a result of feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although equipment checks were in place, we found some free standing radiators in use without anything in place to protect people from the hot surface temperature of these devices.

Medicines were safely managed and administered.

Safeguarding policies and procedures were in place and staff understood how to report safeguarding concerns.

There were sufficient staff deployed to keep people living at the home safe. A robust recruitment process was in place.

Is the service effective?

Good

The service was effective.

The service was acting within the legal framework of the Mental Capacity Act 2005.

Staff understood and responded effectively to behaviours that challenged.

People's nutritional needs were being met. People told us they enjoyed the food and were offered choices at all mealtimes.

Is the service caring?

Good

The service was caring.

People told us they were happy living at the home. The atmosphere was relaxed and inclusive.

Staff appeared kind and caring and knew people's individual care and support needs.

Is the service responsive?

Good

The service was responsive.

A range of activities were on offer according to people's wishes.

Care records were clear and largely person centred. Regular reviews reflected people's changing care and support needs.

Complaints were well managed, people understood how to complain and the complaints procedure was clearly displayed in the home.

Is the service well-led?

Good

The service was well led.

A range of quality assurance and audit systems were in place. These showed actions taken to drive improvements within the service.

Staff told us they were well supported by the management team and morale was good.

People's opinions were sought through meetings and quality surveys.

Allerton Park Care Centre

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.

Our inspection of Allerton Park Care Centre took place on 6 February 2017 and was unannounced.

The inspection team comprised of three adult social care inspectors.

As part of our inspection planning we reviewed the information we held about the home. This included information received from the provider such as notifications and the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had returned the PIR in a timely manner and we took this information into account when making our judgements. We also contacted the local authority safeguarding and contracts/commissioning teams.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with four people who used the service, four care staff, the cook, the activities co-ordinator, the deputy manager, the area manager and the provider. We looked at elements of eight people's care records and other records which related to the management of the service such as four staff files, staff rotas, training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safeguarding policies and procedures were in place and appropriate referrals had been made. We saw staff had received safeguarding training and were able to tell us about various forms of abuse and what they would do to report this. We spoke with four care staff who demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they felt able to raise any concerns with the management team knowing that they would be taken seriously. We looked at the safeguarding file and saw records of safeguarding incidents which had occurred since the last inspection. The reports were well recorded providing details of the incident and any investigation as well as the action taken to keep people safe. We found safeguarding incidents had been referred appropriately to the local authority safeguarding team and notified to the Care Quality Commission.

We saw a high number of accidents/incidents had been documented, with 13 accidents in January 2017 and 18 during December 2016. However, accidents were reported fully, actioned, including notifying outside agencies such as the local authority or Care Quality Commission and analysed for trends and lessons learned as a result. For example, we saw where risk assessments had been put in place following one person's falls, their care plan had been updated as well as referrals made to the falls team.

We looked round some parts of the building and inspected a random selection of bedrooms and bathrooms. We found a number of maintenance works which required attention including broken lights, two bedside cabinets with missing drawers in one shared bedroom and a window which did not shut fully in another person's room. We reported these to the provider who arranged for the maintenance person to address immediately.

Our tour of the home identified some areas required refurbishment and redecoration. For example, many of the doors and walls had paint missing and the wood and plaster was gouged as if they had come into contact with equipment such as wheelchairs and trolleys. Some bedrooms were comfortably furnished and personalised, yet others were stark in comparison with few personal effects. The provider showed us a detailed refurbishment plan for the service which would address these areas and we saw some areas such as the lounge area in the residential unit were undergoing refurbishment to create a more homely atmosphere. Some areas had new flooring and we saw dementia friendly signage and memory boxes in place.

We found a marked difference in the temperature in some areas of the home, some rooms were comfortably warm whereas others were cool in comparison and the radiators were barely warm. We saw two free standing radiators in use, one in a lounge and the other in a person's bedroom. Both radiators were turned on and when we touched them the surface temperature was so hot we could not keep contact for more than a few seconds. We told the provider who removed these devices straightaway. The provider told us there had not been any problems with the heating. We saw a gas safety certificate which showed the central heating was satisfactory when checked in April 2016. We asked the provider why these devices were being

used and they told us risk assessments had been completed. However, when we looked at these risk assessments we found they were not being followed as they stated portable heaters should be kept away from people who used the service and should not be used in areas where people could knock them down. The risk assessments had not been reviewed or updated since January 2015. The provider agreed this had been an oversight and told us they would review these. From our discussions we felt assured this would be done.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on equipment such as lifts and hoists as well as the fire, water, electrical and gas systems. A system was in place for staff to report any issues with the building to ensure they were repaired.

We saw the food standards agency had inspected the kitchen in April 2016 and had awarded them five stars for hygiene. This is the highest award that can be made. This meant food was being prepared and stored safely.

We saw detailed risk assessments were in place in people's care records with management plans in place to mitigate risks in relation to their health, independence and wellbeing. There were assessments in place which considered the individual risks to people such as choking, nutrition and hydration, mobility and personal care. For example, we saw how one person had been found to be at potential risk of harm from self-neglect and poor personal hygiene. We saw the risk assessment identified the person could potentially become aggressive to staff during personal care interventions. We saw from the care plan and our direct observations staff delivered appropriate and measured care whilst protecting themselves from harm.

We conducted an audit of people's personal money being held for safe-keeping by the provider. Whilst the goal of the provider was to ensure people retained financial independence as much as possible, some people required support to do this. We saw people who might lack capacity to manage their own money were assessed in accordance with the code of practice issued with the Mental Capacity Act 2005 (MCA) and their best interests were fully considered. We carried out our audit with two members of staff who had responsibilities for the safe handling of people's money. The provider's policy and practice was designed to ensure safeguards were in place to protect the financial interests of the person, particularly in respect of anyone who had been assessed as lacking capacity under the MCA 2005. Whilst the provider kept secure written, reconcilable records of all transactions, service user's products and items purchased were not individually stored but kept in a large communal cupboard. Our discussion with a nurse and two care staff identified that on occasions toiletries were being pooled for the common benefit of all service users. The staff we spoke with assured us arrangements would be put in place to allow staff to keep purchases separately identified for each person.

Medicines were administered to people by staff trained in the administration of medicines. We observed the morning medicine round and looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge and room temperatures were taken daily and recorded. The treatment room was locked when not in use. Medicines administration records (MARs) were completed and contained no gaps in signatures and any known allergies and

intolerances to medicines were recorded.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs Act 1971. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date. We saw records for people who were prescribed creams included body maps which showed where the cream was to be applied.

We saw all 'as necessary' (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given. We saw nursing staff recorded the effect of the PRN medicine and where a variable dose was prescribed the dose was recorded.

We carried out a random sample of seven supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed. We saw evidence of effective auditing of medicines. The manager conducted audits of MAR sheets and stock control mechanisms.

Staffing levels were sufficient to ensure the safety of people who used the service. We saw staffing levels were regularly assessed and reviewed. A staffing tool was used which took into account people's dependencies as well as occupancy levels and we saw this tool showed staffing levels were adjusted accordingly. For example, when dependency levels were high the staffing hours had been increased. The provider told us they preferred to over staff the home to ensure the safety of people. We saw staff were able to spend quality time with people during our inspection and did not appear rushed or hurried in their approach. This demonstrated sufficient staff were deployed on the units.

The recruitment files we reviewed showed robust recruitment procedures had been followed. Application forms detailed the applicant's employment history and qualifications. Criminal record checks had been obtained from the Disclosure and Barring Service (DBS) and references had been received before staff commenced in post. There were detailed interview records as well as job descriptions and proof of identity documents. We saw effective systems were in place to check all nurses were registered with the Nursing and Midwifery Council (NMC) and that this registration was maintained. This assured us thorough checks were in place which helped ensure staff were suitable to work in the care service.

Good

Is the service effective?

Our findings

All new staff completed an in-house induction and we saw evidence of this in the staff files we reviewed. The provider told us the induction included a two week shadowing period where new staff worked alongside a more experienced staff member. They said all new care staff were enrolled on NVQ courses once their induction was complete which was confirmed in records we reviewed and by staff we spoke with.

The provider told us staff received on-going training which was regularly updated. Some training was provided via eLearning and there were also face to face sessions with in-house trainers who had completed the 'Train the Trainer' courses in subjects such as safeguarding, infection control, medicines and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The service had a training matrix in place and we saw training was up to date or booked. Staff we spoke with told us they were satisfied with the level of training on offer although one staff member told us they would like more training to be offered in subjects such as dementia.

We saw nurses were supported to maintain their professional development and skills and the provider showed us a revalidation file which had been set up to support nurses in gathering the evidence they needed to maintain their nursing registration.

The provider told us all staff received regular supervision and annual appraisals. We saw evidence of this in the staff files we reviewed and found the supervision records were detailed and reflected in-depth discussions about the staff member's role. Staff we spoke with confirmed these took place regularly.

We saw staff handled behaviours that challenged by using various strategies such as de-escalation and breakaway techniques. These were employed to good effect, for example one person was becoming increasingly agitated and a staff member recognised this and suggested they go for a walk. The person became less agitated and returned having clearly enjoyed time away from the home. The staff member later told us this was a strategy which helped calm the person.

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 so that they can 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 saw 15 people had DoLS in place, of these granted authorisations we saw 12 had attached conditions. We saw where the supervisory body had attached conditions to the authorisation these were being met. For example, the provider was required to have an agreed arrangement with one person to control their alcohol intake. We saw the person's care plan

recorded the agreement and our subsequent discussion with them evidenced the arrangements were well received.

We saw four people were having their medicines administered covertly. Our inspection of the documentation to create a legal framework to comply with the needs of the MCA and good clinical practice demonstrated the provider had an excellent understanding of the requirements. Our observation of the administration of medicines to one person demonstrated the precise arrangements were being enacted. For example, the plan required the nurse to attempt to administer the medicines with the person's knowledge, only when this failed was the nurse progress to covert methods. We saw this took place. Furthermore, the practice of covert medication administration was under regular review, the outcome of which was recorded in detail with any changes to prescribed medicines being recorded in a letter from the GP.

We looked at a sample of care records for people who had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of involving family members in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

During our observations and through reviewing care documentation, we saw evidence of consent being sought. For example, we saw consent forms signed by people or their legal representative regarding medicines administration, support with personal care and consent to photographs.

We saw menus were displayed in the home using pictures and words and these showed a choice of meals were available. We saw people got up at various times during the morning and were offered a choice of breakfast. We saw some people had a cooked option whereas others chose cereal or toast. At lunch the mealtime was well organised. Some people chose to eat in the dining room whereas others opted to stay in the lounge or their bedrooms. Tables were set with place mats, condiments, napkins, cutlery and jugs of juice. A staff member brought people wet wipes so they could clean their hands before the meal. We saw staff took 'show plates' of the different meals to people to help them choose which option they wanted. We saw people were asked if they wanted the different parts of the meal such as vegetables and gravy and each meal was plated by staff from a heated trolley. We saw staff were present throughout the mealtime but were not intrusive. They checked whether people were enjoying their meals, if they wanted any more or if they needed any assistance. We saw staff sat beside those who needed help and chatted to them while assisting them with their meals. People we spoke with told us they enjoyed the food. One person commented, "I like the food here," and another said, "We don't want for nothing. We even get suppers."

We spoke with the chef who demonstrated a good understanding of people's nutritional needs and preferences. They described how they fortified meals using cream, butter and full fat milk to provide extra calories and nutrition. A variety of snacks were also available between meals which included cakes, crisps, biscuits, fruit and milkshakes. The chef told us staff kept them informed about anyone who was losing weight. We saw staff monitored people's weights closely and these were stable. We concluded people's nutritional needs were being met.

From speaking with staff and reviewing people's care records we concluded health needs were being met.

For example, we saw appropriate referrals had been made to GPs, district nursing teams, dieticians, chiropodists, occupational therapists and the mental health team.

Good

Is the service caring?

Our findings

We observed interaction between staff and people who used the service and found these to be kind and caring. We saw staff engaged differently with people depending upon the person's personality or mood, laughing and joking with some and chatting quietly with others. For example, we saw staff encouraged one person with their food by having a laugh and joke with them which the person responded to in kind, whereas we saw staff crouched down beside another person and quietly spoke with them, stroking their hand while helping them with their meal.

People we spoke with told us the staff were caring and they were happy living at the home. We saw people looked clean and well-groomed with combed hair. Comments included, "It's all right. I like it here", "We don't want for nothing; it's great" and, "I like living here. Staff are good."

People appeared happy and relaxed in the company of staff and it was clear some good relationships had developed. There was a warm, friendly atmosphere at the service. Staff we spoke with knew people well and we saw staff throughout our inspection calling people by their name and talking about relevant subjects with them. For example, we saw one staff member chatting with a person about horse racing and discussing various horses and races. They told us this was because the person had a love of horseracing.

We saw people's bedrooms contained a photograph and the name of their key worker. This gave people a point of reference if they needed to discuss anything with their keyworker or had any concerns.

We looked in one person's bedroom and found they had no toiletries or items to help maintain their personal hygiene. For example, the only item present in their en suite facility was a tube of toothpaste. There was no toothbrush, soap, flannel, hairbrush or any other toiletries in their en-suite or evident in their bedroom. We asked one of the care staff about this and they said the night staff assisted this person to get up in the morning. They thought new toiletries had been purchased for this person but could not explain why there were no other personal effects for this person in their room at the time of our inspection. However, we saw this was rectified immediately upon our discussions and were confident from speaking with staff this was an isolated incident.

Our observations showed staff treated people with dignity and respect, for example knocking before entering people's rooms and shutting toilet and bathroom doors to ensure people's dignity and privacy was maintained. Staff we spoke with were able to give examples of how they respected people's privacy, such as ensuring people were covered with a towel when assisting them with personal care. We saw some staff members had been appointed dignity champions and their photographs displayed in the home as well as posters about dignity and how to engage effectively with people.

We saw evidence of people and their relatives' involvement in the planning of their care. Advocates were in place where people lacked capacity and had no family or relatives to speak on their behalf.

We saw maintaining people's independence was a key focus within the home and achievable goals set to

encourage this. For example, one person's care record showed their goal was to walk again, even if a few steps. We saw staff encouraging people to mobilise independently wherever possible and the use of appropriate aids such as walking frames to aid this.

Records and other documents relating to people's care and support were kept securely in locked filing cabinets. This showed the service respected people's confidential information.

Good

Is the service responsive?

Our findings

We reviewed four people's care records and found these easy to follow, with plans of care relating to risk assessments. We found some sections of care plans were detailed and showed the care and support required to meet the person's needs. For example, one person's nutritional care plan reflected advice given by the dietician and the need for fortified meals and snacks. Another person had a body map in place and a care plan regarding their skin integrity and the need to check their skin on a daily basis. We saw this had been done.

Although we saw evidence of person centred planning in most people's care records, some other information was generalised and a more person specific approach would aid person centred care. For example, one person's care plan for social interests said to involve the person in activities but there was nothing recorded to show what this person was interested in or how staff were meeting these needs.

We saw care records were reviewed monthly and amendments made at that time or when people's needs changed. For example, we saw risk assessments, care records and body maps amended in one person's care records to reflect a recent fall.

We saw people's preferences were respected, for example where they wanted to eat their meals, what activities they engaged in and food and drink choices. We observed staff asking people what they wanted to do throughout our inspection. For example, one person had not wanted to take part in the activity in the morning and was watching television. A member of staff who was engaging with them with one to one support asked them if they were happy with what was being shown and they requested a change of channel to watch a film they wanted to watch.

The service employed a full time activities co-ordinator and we saw people engaged in a range of activities during our inspection, including board games, reminiscence and rhythm and music sessions. The activities co-ordinator told us the provider supported them with the purchase of some equipment to facilitate activities. We saw a board displayed in the home with a monthly plan of activities such as games, arts and crafts, exercise, ball games, music, pancake making and a pub lunch. A pictorial representation of activities on offer was also displayed. The activities co-ordinator told us this was dependant on what people wanted to do on the day and they altered these according to people's wishes. They told us they were planning to hold a Valentine's tea the following week and people were going to assist with decorating the dining room, help prepare a special tea and play some vinyl records which people enjoyed listening to. We saw photographic displays within the home of people enjoying activities such as outings, parties and rhythm and dance activities.

We saw the complaints procedure was clearly displayed in the service and the service had received three complaints during the last year. People we spoke with told us they knew how to complain although none of them had had any need to do so. Complaints were well managed including acknowledging the complaint through communication with the complainant, investigation and the outcome documented with a follow up letter sent to the complainant. We saw actions taken as a result of complaints including further staff training

and supervisions. Complaints were audited monthly for analysis of any trends or themes. This showed us the service took complaints seriously and learnt from people's concerns or complaints.

Good

Is the service well-led?

Our findings

The home had a registered manager in place although the provider explained they were shortly leaving the service and a new manager had been recruited. The registered manager was on leave on the day of our inspection and the provider and area manager were supporting the service. However, the registered manager rang to speak with us during the inspection to explain what improvements had been made since the last inspection. This showed us they remained committed to showing a continued improvement in the service.

The provider told us they held daily meetings with senior staff and care workers who were leading the shift. This was to discuss any issues and to ensure the smooth running of the home. The 'hands on' approach of the provider was apparent during our inspection and this had a positive impact with staff and people living at the service who all knew the provider by name.

Staff we spoke with told us they felt well supported by the management team including the registered manager and the provider. Morale was good among staff we spoke with and the atmosphere was positive and relaxed. Staff told us they worked well as a team and comments included, "We all get along with each other. I'd go to [registered manager's name] or [provider's name] if I had any issues; they're all approachable," and, "I've seen improvements year after year. [Registered manager] has taught me a lot and been very supportive. The staff are really good. I think they're really good with the clients. Staff morale is ok and staff get on and pull their weight."

Audits were undertaken in a range of areas including infection control, catering, medicines, care planning, accidents/incidents and health and safety. We reviewed some of these audits and found they were up-to-date and thorough with actions identified to drive improvement. We saw a detailed report from an external consultant who had visited the home over three days in September 2016. Their assessment looked at all aspects of the service and highlighted good practice as well as identifying areas for improvements. This showed effective quality assurance systems were in place.

Staff meetings were in place and staff told us these were a good opportunity to discuss any concerns and changes within the service. We reviewed the recent staff meetings and saw a variety of topics were discussed such as safeguarding, events, training and any concerns. We saw examples of actions seen to be taken as a result of any issues raised.

We saw staff surveys had been sent out between October and December 2016 and 15 had been returned. The results had been analysed and these showed generally positive feedback had been received.

Resident/family meetings were held regularly and where people's relatives were unable to attend, the provider contacted them with any relevant details and to discuss any issues. We saw records of these meetings and discussions were documented with actions taken as a result.

A quality assurance survey had been sent to people living at the service and their relatives between October

and December 2016. The results of these were displayed on a notice board in the home and included actions taken as a result of feedback, such as some issues with the laundry systems. This showed us people's opinions were actively sought and listened to.