Care UK Community Partnerships Ltd

Hartismere Place

Inspection report

Castleton Way
Eye
Suffolk
IP23 7BH

Website: www.careuk.com

Date of inspection visit:
21 March 2017

Date of publication:
26 May 2017

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

Hartismere Place provides accommodation and nursing care for up to 60 people. It also provides Rehabilitation services. (The purpose of rehabilitation is to help people who have experienced deterioration in their health, and have increased support needs to relearn the skills required to keep them safe and independent at home.)

The service is divided into four units; Beech and Oak (on the ground floor) and Willow and Ash (on the first floor). When we inspected on 21 March 2017 there were 44 people using the service. This was an unannounced inspection

There was not 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. The registered provider had ensured there was a covering manager in place whilst a new permanent registered manager was recruited.

People's care plans reflected people's individual care and support needs. Further work was needed to ensure people's views and wishes in relation to their 'end of life' preferences were recorded. Information on people's life history was not consistent across the service, but the management team were aware and were taking action to address this.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

Risks to people using the service were assessed reviewed, recorded and managed appropriately. Detailed risk assessments were in place for people using the service.

There was adequate servicing and maintenance checks to equipment and systems in the home to ensure people's safety.

We saw friendly and caring interactions between staff and people. People received care that respected their privacy and dignity and promoted their independence.

The service was meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). Staff understood the need to obtain consent when providing care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Appropriate arrangements were in place to ensure people's medicines were obtained, stored and administered safely. People were referred to other health care professionals to maintain their health and well-being.

An appropriate complaints procedure was in place. Complaints were responded to promptly. The covering manager and deputy manager were seen to be accessible to people.

There were processes to monitor the quality and safety of the service provided and to understand the experiences of people who lived at the service.

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 protected from the risk of abuse because staff knew how to recognise abuse and how to report concerns.

Risks were identified and reviewed in a timely manner.

People were supported to manage their medicines safely.

Is the service effective?

Good

The service was effective.

People received support from staff who had received appropriate training to give them the knowledge and skills to meet people's needs. Where staff required additional training, this had been identified and further training was planned.

The service was working within the principles of the Mental Capacity Act 2005. Staff sought people's consent before providing care and support, and records reflected this.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Good

The service was caring.

The atmosphere in the service was relaxed and people were listened to.

People were supported to see their relatives and friends.

People's dignity and privacy was respected and maintained.

Is the service responsive?

Good

The service was responsive.

People's care had been planned and reviewed to reflect their

needs and preferences. Care plans needed to be developed further to fully reflect people's end of life wishes and preferences. Information on people's Life history was also not consistent across the service, but action was already being taken to address this.

There was a range of activities for people to take part in if they chose to.

People and relatives felt confident to raise concerns or complaints. Their feedback was valued and used to make improvements to the service.

Is the service well-led?

Good

The service was well-led

People and relatives were complimentary about the management team. They were responsive to our feedback and took prompt action to rectify areas we found as requiring improvement.

The service had a positive, person-centred and open culture.

In addition to people's feedback, the management team used reviews, audits and unannounced visits to monitor the delivery of care. This helped to ensure that it was consistently of a good standard.

Hartismere Place

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.

The inspection took place on 21 March 2017, was unannounced and undertaken by two inspectors, a specialist advisor in elderly care, 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 our inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us, for example, people living with dementia.

During the inspection we spoke with nine people living at the service, three relatives, one social care professional and three health professionals. We spoke with the covering manager, deputy manager, operations manager, and 11 members of care and catering staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed 12 people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe living in the service. One person told us, "Yes I feel very secure. The staff when you call are here within seconds". Another said, "Yes. It's very good here, the staff and everything". A relative said, "They're [staff] looking after my [relative] very well."

Staff received safeguarding training and had a good understanding of the types of abuse they may come across in their work. However, some were unsure of who to contact outside of the organisation if they had continued concerns that were not addressed. One staff member said, "We work with vulnerable adults and anything that we do not feel is being done correctly or needs to be reported, we go to management. I am not sure who I would contact if I suspected my manager [of abuse]". Another staff member said "I have just done safeguarding training online. If I suspected abuse, I would let someone know and tell the person that I can't keep it secret. If I suspected management, I would go to head office. But aside from that, I am not sure".

There was an absence of a flow chart for guidance on who to raise safeguarding concerns to which staff could refer to if needed. Our concerns were raised with the clinical lead, and before the end of the inspection this had been addressed with contact details and flow charts at all relevant staffing locations.

We received mixed feedback about staffing levels in the service. One person said, "Yes I press my buzzer and they [staff] come and help me. They [staff] help me wash and dress. They [staff] are pretty quick mostly". Another said, "Occasionally there are not enough staff. They come and talk to me about extra things, but I say there's no point if there is not enough staff to do the basics. I know most of them but there are staff shortages".

We asked staff their views. One staff member told us, "We are sometimes short staffed but it has got better recently. Everyone has pulled together more as a team and we support each other. We have a good team on Oak". Another said, "I still don't feel there is enough staff on Beech. I feel we need at least three [staff] but there is usually only two [staff]".

We spent time on each of the units to observe staffing levels, and how quickly staff responded to people when they required assistance. Our observations during the inspection were that staff responded to people in a timely manner, spent time chatting with them, and there was a calm atmosphere on each of the units. However, we noted on Beech unit that staff were not always visible, and people also told us there were not enough staff. One person told us, "Always short of staff. I can't blame the staff, sometimes you have to wait. When you ring the bell they sometimes come and tell me they're with someone else and will come back as soon as they can. I can't wait for the toilet you see, that's often the problem". A relative said, "They seem to be short of staff in the mornings. The impact of being short staffed is things just won't get done or get done properly".

We discussed our findings with the management team, who confirmed that the dependency tool they were using provided them with a calculation of suggested staffing levels and we saw that this aligned with the rota. They had also been reviewing the current staffing levels by observation and feedback from staff.

Following the inspection they informed us that they had considered our feedback and in response to this, staffing levels on Beech unit had been increased to ensure staff were able to respond to people in a timely manner.

People's individual care records described risks that could affect them in their daily lives, such as medical conditions, mobility, choking, skin integrity and moving and handling needs. Risk assessments contained detailed guidance on how to minimise risks to people. These were updated on a monthly basis, or sooner if this was required. Outcomes of risk monitoring informed the care planning arrangements, for example weight loss prompted onward referrals to dietetic services. Staff were knowledgeable about the people they supported and were familiar with the risk assessments in place. One staff member said, "I think that the risk assessments and care plans tell us what we need to know. We do read them as there is time in the afternoon".

People lived in a safe environment. Risks to people injuring themselves or others were limited because equipment, including electrical equipment and hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

People were protected by robust procedures for the recruitment of care workers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

There were safe medicine administration systems in place and people received their medicines when required. Where people received medicines 'as required' protocols were in place to guide staff on when to offer these. One person said, "No problems with my tablets, they come like clockwork". Another said, "They give me them [medicines] on a spoon, I can take them easier then".

Medicines were stored securely, with appropriate facilities available for controlled drugs and temperature sensitive medicines. Staff recorded that people had taken their medicines on medicine administration records (MAR) which we saw were completed accurately with no gaps in entries. Regular auditing processes were in place which helped to ensure any potential discrepancies were identified quickly and could be acted on. This included additional training and support where required.

One staff member told us, "I have done medication training and we do [pharmacy] and E-learning (computer based training) annually. My competency is observed and I am witnessed three times giving medication before I am deemed competent". However a review of the training received by staff recorded as being competent to administer medication, identified that not all staff had received an annual update and assessment for competency, in line with NICE (National Institute for Health and Care Excellence) guidelines. We brought this to the attention of the covering manager and following the inspection, they confirmed that all staff competencies had been completed, which included all new starters.

Good

Is the service effective?

Our findings

Staff received training relevant to their role. This included safeguarding, dementia care, MCA/DoLS, and diabetes. One person said, "Staff seem to know what they are doing, they've had some sort of training definitely". A relative told us, "They [staff] appear to have the skills. That's from everything I see and hear".

Previously we had received concerns from health professionals that staff working in the service were lacking skills and knowledge in specific areas, for example, palliative care (care for the terminally ill). The covering manager told us how they had reviewed and prioritised staff training to ensure that staff were equipped with the necessary skills and knowledge they needed to carry out their role and do their job effectively. They confirmed with us that relevant training had been arranged. This included palliative care, dementia care (including behaviours which may challenge staff) annual medicine competencies, and moving and handling. The dementia training included members of the management team, and prioritisation of staff working on the dementia unit.

Training had previously consisted primarily of E-Learning (computer based training), but was now being supported by more face-to-face training which some people find more effective in terms of their learning style, and also provides an opportunity for questions, or further discussion to ensure understanding. Additionally, a full time clinical lead had been appointed and was having a positive impact on how systems were working in the service. One staff member said, "[Clinical lead] is so supportive, good knowledge and makes us [staff] feel appreciated". A relative told us, "I engage with the home and the staff. The staff are trained well and look after my [relative]".

Staff seeking to expand their role or learn new skills were encouraged to do so. For example, the receptionist had recently become the lifestyle co-ordinator (providing activity to people) within the service as they wanted a new challenge and told us this was going very well. Another member of staff said, "Since I raised that I would like to gain more experience with the acting manager, I now work on all the different units [in the service]".

Each staff member had an induction on commencing employment at the service and shadowed staff to gain knowledge of the role. One staff member said, "I had an induction. I was shown around, shown the fire procedures and safety checks to complete. I went to another service and shadowed the lifestyle co-ordinator there". Agency staff also undertook an induction programme, and the covering manager told us that they used regular agency staff to ensure continuity of care. We saw two agency staff interacting positively with people on the unit. One agency member of staff said, "I come here often so I know people well, you get to know the systems and the documentation they use".

Staff meetings and supervisions were held, although some supervision sessions had not been held for a while. These sessions focus on providing a forum for staff to discuss their progress, reflect on their work, and identify training needs. The covering manager was aware that some staff were overdue, and informed us that any outstanding supervisions had been scheduled in for staff. One staff member told us, "Staff meetings are held three monthly and I had a supervision session last week. We discussed what I think has gone well,

what I could improve and my well-being. I find them helpful and to have time with my manager." Another staff member said, "I had supervision a few months ago. We have a monthly senior meeting and care staff meeting". This ensured that relevant information was shared with the staff team.

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 decision 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

DoLS applications had been made to the local authority as required to ensure that any restrictions on people were lawful. People's care records made reference to their mental state and ability to make decisions. Records included documents which had been signed by people to consent to the care provided as identified in their care plans. Where one person's DoLS had expired, the acting manager had applied for another and was waiting to hear from the Local Authority.

Staff understood the principles of the MCA. One staff member said, "Always assume that someone has full capacity and if I think that they don't, speak to my senior or a family member to support the person to make a decision". Another staff member said, "Never assume that someone does not have capacity as they should still be given choices such as showing them the options so that they understand".

People's records showed that fluid intake, hydration and nutrition were being monitored. There was a colour code system which identified any resident who had not received sufficient hydration. We saw that food and fluid intake was reviewed by the clinical lead and target amounts adjusted according to their individual needs. People's weight was being monitored monthly, sooner if a concern had been raised, or if this was identified through the code system. Changes to dietary needs were promptly notified to the head cook, who also met with each person monthly to discuss their preferred food options. Where people required it, food and drink was fortified to provide additional nutrition such as high calorie milkshakes and cream shots.

People told us that they enjoyed the food. One person said, "The food's very good. My appetite is right down since I was ill, so I asked for smaller portions which they've [staff] done and that seems to be working". Another said, "The food is great. The hot-pot today was very nice. I go to the dining room for all my meals and there's always plenty to eat".

We observed the lunchtime meal on three of the units. The food looked appetising and was served from a hot food trolley, allowing people to choose their portion size. People were chatting to each other and had a choice of where to sit in the dining room. The atmosphere was relaxed and calm. Staff sat with people eating and chatting over lunch. Staff were offering alternative options where people did not want the food available on the hot trolley, and cooked one person toast at their request. One person was supported to eat in the lounge and was provided with assistance in line with their care plan, including being prompted to slow down when eating.

However, on Beech unit we found that lunch was served very slowly, with people eating at different intervals.

We also observed people who chose to eat in their rooms looking out to see if their lunch was coming. One person said, "I'm just looking to see where my lunch is. They [staff] always serve people in the dining room first and we [people in their rooms] have to wait. 1pm is too late as my visitors are coming soon". We brought this to the attention of the covering manager, who said they would take prompt action to improve this.

People receiving rehabilitation at the service were reviewed weekly at the multi-disciplinary (a range of health and social care professionals) team meeting. A health professional said, "The weekly meetings are very beneficial for all concerned and provide the ability for person centred care to increase. The nursing input is providing more holistic care with improved outcomes".
A GP also visited weekly to review any person where there was a concern raised. On the day of the inspection the GP was at the home assessing a person following a request from the nursing staff, and one person was discharged home. Another person was due to go home the following day, with two more people due for discharge the following week. This demonstrated the effectiveness of the rehabilitation which resulted in people returning home.

There was a handover of relevant information twice a day and a senior member of staff updated the team on any key issues. A handover form was completed to aid effective communication. One staff member said, "There is always room for improvement but most of the time communication is good here".

People had access to a wide range of services. On the day of the inspection there were five visiting health and social care professionals. A person became unwell during the inspection and staff called in the emergency services. Records reviewed showed that people had been assessed or seen by dieticians and occupational therapists. The clinical lead also reported that residents had access to a chiropodist.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, "They [staff] go the extra mile". Another told us, "The staff are so lovely, so kind". A relative commented, "Right from when we first came here to look around with my [relative], the staff were all very approachable and friendly".

There was a warm, friendly and relaxed atmosphere throughout the service. People could choose whether they wanted to spend time in communal areas or have time in the privacy of their bedrooms. People were seen moving freely between their own private space and communal areas. We observed warm and kind exchanges between people and staff. People approached care staff to spend time with them or ask for assistance, and were comfortable in doing so.

People and relatives were involved in the care planning process. This included how best to support the person, and what people liked and admired about them. One staff member said, "We try and involve families in care reviews, some family members live quite a distance away, but some family members have daily input". People's views were taken into account when monthly reviews were held, and we saw that people were asked for feedback on the care they had received in the past month. One person said, "I feel my wishes are very much respected". Another said, "The staff have a good understanding of what I need". A relative told us, "They [staff] are very caring. The staff do keep me informed at all times. They [staff] know they can call me day or night on my mobile".

There was a feedback notice board displayed in the reception area. It detailed forthcoming resident/relatives meetings and the action that had been taken following previous meetings. For example, furniture was rearranged in one lounge to make it more accessible, wheelchairs were removed from bedrooms and were now stored in cupboards, and discussions were held about having pets in the service. This demonstrated that people's views were listened to, and actions were taken forward. An activities forum had recently been introduced for people to have their say about what activities they would like to see provided, and these meetings will continue to be held each month.

People's independence was respected and promoted and people were given choices. Care records noted areas of care that people could independently manage. This included aspects of their personal care, eating, mobilising and activity.

People's privacy and dignity was respected. One staff member said, "I knock on doors, if supporting people with personal care, I cover people with a towel". One person told us that due to a health condition, they needed their room cleaned more frequently and that this was important to them. They told us the staff always ensured the carpet was regularly cleaned to avoid any odours developing in their bedroom. This demonstrated that the service listened to people and tried to ensure that their privacy, dignity and issues that mattered to them were respected.

Relatives were permitted to visit at any time, and spoke positively of the service. One relative told us, "I know all the staff well. I come in 24/7, and I'm made to feel welcome. I get myself a drink at the coffee shop.

Another said, "I'm always here, I could be a resident myself". Some visitors had raised an issue about getting into the building at weekends and the fact they have to sometimes wait for a member of staff to let them in. We raised this with the covering manager, who told us they were already aware of the issues and were in the process of addressing this.

Good

Is the service responsive?

Our findings

People told us they felt that staff were responsive to their needs. One person said, "They [staff] help me with whatever I need. Nothing is too much trouble". Another person told us, "Staff are always available, whatever I need".

People's care records included care plans which guided staff in the care that people required and preferred to meet their needs. This included night care routines, eating and drinking, communication and how people mobilised. These clearly documented the level of support the person required with specific tasks. Where relevant, people's care plans contained a 'This Is Me' file which contained important things about a person, such as their routines, behaviours, and food and drink preferences. These enabled other professionals involved in their care to understand the most effective ways to support people and help the person feel more comfortable if they were in an unfamiliar setting, such as hospital.

Care plans reviewed indicated that people's individual care needs were documented effectively. However, people's individual wishes and preferences in regard to their end of life care were not always being recorded. There was therefore a risk that people who may deteriorate suddenly, may miss the opportunity to have their preferences clearly documented in advance. The management team were aware of these concerns, which were raised on the day of the inspection and were being addressed accordingly through increased training for staff.

Information relating to people's life history was not consistent across the service. Having this information supports staff to have meaningful conversations with people about their lives and what is important to them. This is particularly important for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness. The management team were aware of the need to improve this, and in addition the activity co-ordinator had begun to speak with people individually to start building on this.

Where people were receiving rehabilitation in the service, their care plans contained relevant information received from community professionals, the GP and relevant medical history. People's progress was documented, which helped professionals to gauge the point at which discharge home should be considered.

People were supported to take part in activities within the service. One person told us, "If I fancy anything [activities] I go. The staff remind us what's on". A relative said "[relative] is always invited to go along. I think now there is an improvement in activities", and "I think, with dementia, it's important to encourage people and find things for them to do. My [relative] was never particularly musical but loves music now".

We observed staff asking people what they wanted to do after lunch and helping them to go wherever they wanted. We observed a scrabble game with staff and people taking place in the coffee lounge, and an armchair exercise session being run in another one of the lounges. A number of people were reading and socialising in the coffee lounge throughout the day and staff dropped by to chat and join in with conversations.

There was a 'music for health' session being held by an external visitor. This was an interactive workshop which involved movement and singing. There were two staff members involved in this session spending time with people singing and dancing. People attended the session from other units in the service. Where one person was enjoying the session, the staff reminded them about their hair appointment which was due at the same time and re-arranged this at their request so that they could continue to enjoy the music. Staff told us that there were enough activities for people to enjoy. One staff member said, "There are enough activities. There is a lot more going on since the change of activity co-ordinator". Another said, "Now there is enough activities but there wasn't two months ago. There is a lot more on offer now and a variety to suit different people. The cinema room is now being used". (There was a cinema room in the service with a 'pub' that was open on Friday evenings for people to attend).

We spoke to the new activity co-ordinator who told us they worked five days per week, and the service was also looking to secure a further 15 hours at the weekends. They were passionate about their role and told us, "I have lots of ideas; it's been great organising things, like the 1940's themed event last week. I packed a box of vintage items so people could look through and reminisce about old times". People were provided with a list outlining the weeks activities. People who preferred to remain in their rooms were provided with one to one time with staff or the activity co-ordinator, who told us, "One person just wanted to knit, so I got them wool and needles".

Where people wanted to do something, this was facilitated promptly by staff. For example, one person was supported to get some money from the administrator, and one person visited the coffee shop. Staff were attentive to people's needs and we observed that one person had requested some ice cream mid-afternoon, and staff responded to the request immediately.

The service had a complaints procedure for people, relatives and visitors to raise concerns. There was a log of complaints received, which included the response to the concerns raised and the outcome. We saw concerns had been responded to promptly by the covering manager. One relative said, "I wrote a four-page letter to [previous manager] with a range of concerns. I feel the home are responding well to those concerns now. They [management] have made, and are making, improvements which address the issues I raised. Things are definitely improving with the new manager in post".

Good

Is the service well-led?

Our findings

In January 2017, we were informed by the provider that the registered manager was no longer employed in the service. The provider took prompt action to ensure that the service had appropriate management cover, whilst a new registered manager was sought. They had effective oversight of the services operations, and supported on-going developments which improved care delivery.

Prior to our inspection we had received concerns from health and social care professionals that the service was failing to provide effective care as staff were not skilled in areas of nursing practice. There were also concerns around the provision of activity, and it was reported that people had little to do during the day. At this inspection we found that the covering manager had made significant progress to address the areas of concern. There was a service action plan in place, outlining key areas for development, the majority of which had been completed.

A clinical lead had been recruited and had been working full time in the service since December 2016. They had worked hard to improve day to day processes and the culture amongst the staff team, which supported staff to question practice and report concerns. We saw they had left messages on each of the units thanking staff for their contribution and hard work. This motivated staff to continue to provide good care. One staff member said, "The [covering] manager is amazing. They are on the ball and quick to resolve concerns. They are very good. I can't say a bad word about them or the deputy. We have had a tough time but the last three months have been brilliant. Things are improving and there is a dramatic difference since the [covering] manager came here. Care staff feel more appreciated and so they are going the extra mile because of that. I am always told when I am doing a good job. I am passionate and I just want to get people involved in as much as I can."

The culture in the service was relaxed, welcoming and friendly. Staff were clear on their roles and responsibilities. They told us they felt supported by the management team and could go and talk to them if they had concerns. Staff were keen to tell us about things that were happening in the service. One staff member said, "Since the [covering] manager came here, I think staff morale is higher, staff are more friendly and welcoming and I am now feeling part of a team whereas before staff were divided. We are one big team and everyone works together".

Staff were kept up to date with what was changing in the service by way of regular staff meetings. Items discussed included changes happening in the service, sickness absence, dignity, and code of conduct. We also saw that the covering manager had made supportive comments to staff reinforcing a team approach to improvements going forward. Relatives and resident meetings had also taken place. One relative said, "I attended one relative's meeting and thought it was very good". Another said, "Since [covering] manager arrived, the home is trying harder. No qualms whatsoever".

The management team had systems in place to monitor the quality of the service and to identify areas for improvement. Audits included care records, nutrition screening, health and safety, infection control, spot checks on staff at the weekend, and incident/accident reporting. Themes and trends were identified to

reduce on-going risk. For example, a falls audit had identified that one person had an increase in falls following a change of medicines. Where no patterns or trends were identified this was also documented to show it had been analysed. In these cases people were referred to the falls prevention team or other relevant professionals. The service worked in partnership with various organisations, including the local authority, district nurses, local GP services and older people services to ensure they were following good practice and providing a high quality service.

There were systems for gathering people's views and opinions and acting upon them to help improve the service. Surveys and questionnaires were provided to people and relatives, which the service used to monitor practices, views and attitudes. This resulted in changes, such as a minibus being sourced following feedback from relatives. This was being used for a day trip to a local garden centre. The hairdresser now had an appointment system in place to meet people's needs more effectively, and wine had been introduced at mealtimes following feedback from people.

Following the inspection the covering manager informed us that a new registered manager had now been appointed. There was a plan to support the new manager into their role, to ensure improvements put in place over the past three months were continued and sustained.