St Andrews Care GRP Limited

Lansbury Court Nursing Home

Inspection report

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Date of inspection visit:
08 September 2016
12 September 2016

Date of publication:
03 October 2016

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 9 September 2016 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 12 September 2016 and was announced.

Lansbury Court provides care for up to 56 people some of whom have nursing care needs. All bedrooms are on the ground floor. The service is in two units Lansbury and Castle Dene House which is specifically for people who are living with a dementia.

At the time of the inspection there were 52 people using the service.

We last inspected Lansbury Court Nursing Home on 16 June 2015 and found the provider had breached a number of regulations we inspected against. Specifically the provider had breached Regulations 11, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not always acting in accordance with the requirements of the Mental Capacity Act (2005) and associated code of practice. The provider had not ensured staff had received appropriate support, training, supervision and appraisal to enable them to carry out their duties. There was not always an accurate, complete and contemporaneous record of care and treatment provided to people.

During this inspection we found that the registered provider had implemented actions and improvements had been made.

A registered manager was registered with the Care Quality Commission at the time of the inspection. 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 and their relatives said the staff were caring. We observed warm, compassionate relationships. There was lots of laughter and relationships were respectful. People told us they felt safe and staff understood how to safeguard people and report any concerns. Staff understood the principles of the mental capacity act and where people had authorised Deprivation of Liberty safeguards care plans were in place.

People said they had no complaints and were happy with the service they received. A complaints procedure was in place and included investigations and outcomes.

Two activities co-ordinators were in post and a programme of activities was on display. Some people and relatives felt there could be more to do but others said there were plenty of diverse activities available for people if they wanted to join in.

Health and safety checks were in place in relation to the safety of the premises. Personal emergency evacuation plans were in place and staff knew how to evacuate people if they needed to.

Risks to people and staff had been assessed and plans were in place to minimise the risk. All risk assessments had associated care plans which were personalised, detailed and supported people to maintain their independence. People were supported with their nutritional needs, and if needed, had access to healthcare professionals such as dieticians, speech and language therapy, consultants and GPs.

Medicines were managed safely. Risk assessments and care plans were in place, and there were specific protocols for people who were prescribed 'as and when' required medicines.

Staffing levels were assessed using a dependency tool and staff felt there were enough of them to meet people's needs. Recruitment procedures were effective and included references and disclosure and barring service checks.

Staff had attended training relevant to their role; they also attended regular supervision and had an annual appraisal.

Quality assurance systems were in place and included surveys and audits. An overarching action plan had been developed which meant there was a plan in place for the continuous improvement and development of 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 told us they felt safe. Staff understood safeguarding and told us they would report concerns.

Risk assessments were in place, and reviewed to minimise the risk to people.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained and attended regular supervision.

Mental capacity assessments and best interest decisions had been completed.

People were supported with nutrition and health care.

Is the service caring?

Good

The service was caring.

People told us they were happy and well cared for.

We observed warm, compassionate and caring relationships between staff and people.

Information on advocacy services were available and some people had been supported to access them.

Is the service responsive?

Good

The service was responsive.

Care plans included the detail staff needed to support people to maintain their independence.

Activities were in place if people chose to be involved in them.

A complaints procedure was in place.

Is the service well-led?

Good

The service was well-led.

A quality assurance system was in place, and audits identified area for improvements.

Staff told us there were no improvements needed other than to the décor. A refurbishment plan was in place.

Lansbury Court 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.

The inspection took place on 8 and 12 September 2016. Day one of the inspection was unannounced.

The inspection team was made up of one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority, commissioners of the service; the local authority safeguarding team; healthwatch and the local clinical commissioning group. No concerns were raised.

During the inspection we spoke with six people who lived at Lansbury Court Nursing Home. We also spoke with five visitors. We spoke with 11 members of staff, including two care staff, one senior care staff, one nursing staff, four ancillary staff and the administrative manager. We also spoke with the registered manager and the operations manager.

We used a Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at five people's care records and five people's medicines records. We reviewed four staff files including recruitment processes. We reviewed the supervision and training reports as well as records relating to the management of the service. We looked around the building and spent time in the communal

areas.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "Oh I feel safe." One staff member said, "Yes, people are safe. They can't get out as the doors are alarmed. The staff look after people well, we can't be having any accidents." We asked the staff member about safeguarding and they said, "I've no concerns about the staff and if I did, I would report it straight away. I've had safeguarding training, and I'm aware of the procedure for whistleblowing."

Safeguarding referrals had been made and investigated appropriately. A log of all concerns was kept up to date and staff had access to relevant procedures and guidance.

Accidents and incidents were recorded and analysed for action to take. A falls management audit was completed which detailed the persons falls history, risk assessment, and equipment in place.
The registered manager said, "All accident forms go to head office and the health and safety team analyse the forms. We identified that one resident was experiencing falls at the same time each day due to fatigue so we have updated the care plan and increased staff support at the time."

Where risks had been identified, risk assessments were in place and associated care plans. Risk assessments included falls risks, risks to nutrition, skin integrity and moving and positioning. Risk levels were reassessed on a monthly basis, and we saw that where people's needs had changed actions had been taken to minimise the risk.

Risk assessments were in place for medicines, as well as a medicine profile and care plan. If people had prescribed 'when required' medicines, protocols were in place. Covert medicines, which are medicines hidden in food, had been agreed as being in people's best interests with involvement from people's GP and family members. A nurse said, "The nursing staff and senior care staff administer medicines. There are two care staff trained, so I'm looking at them doing it as long as they are trained. We also do observations of competency. Care staff administer creams and complete topical medicine administration records (TMARs)." They added, "We audit medicines daily, and monthly audits are done as well."

We observed medicine administrations and noted the medicine administration records (MARs) were completed appropriately with the reverse being used for notes on the administration of 'when required' medicines. Before administration, care plans were checked as were the MAR charts. We did see the nurse used one pot of thick and easy fluid thickener for every person who needed it even though each person had their own prescription for it. We asked the nurse who said, "I'll raise it in supervision as we shouldn't really do it, I know." We also spoke to the registered manager about it who acknowledged that the nursing staff had already been told not to do this and they would reiterate it with all staff.

As oxygen was used in the premises this had been risk assessed and there was appropriate signage in the home.

Information was on display about the fire safety procedure. One staff member said, "We would go to the fire

panel and look where the alarm was going off and make sure people were safe. The doors close automatically, they are fire doors. We wouldn't evacuate people outside but we would make sure they were safe and behind two fire doors." Another staff member said, "I would stay with the residents, phone 999, whoever is nearest the point would check the board for the fire (to detect the zone where the alarm had activated). We'd then move those nearest to fire to the safest point. We practice fire drills with a sign for where the fire is, it's better to do it that way so we have to locate the fire." The fire authority had completed an audit earlier in the year with no concerns noted. Personal emergency evacuation plans (PEEPs) were in place for each person and staff understood the action they should take if the alarms activated.

All necessary health and safety checks were in place, including water temperature checks, fire checks, and electrical and gas safety checks. Risk assessments were in place and up to date in relation to the premises, including lifting equipment, and the kitchen area.

We looked at staffing levels to ensure there were enough staff to meet people's needs. A dependency tool was used to calculate the level of staffing needed according to people's needs. Rotas' confirmed the calculated dependency level was met. Where there were staff vacancies or cover was needed due to last minute absence agency staff were used to cover shifts. The registered manager ensured the same agency staff were used wherever possible to ensure they knew people.

We asked people and staff if they thought there were enough staff. One person said, "There's plenty of staff around, they are there if you need them." One staff member said, "Yes, there's enough staff." Another staff member said, "Yes there's enough staff, it depends how people are really but we have breaks, we are told to have them by the seniors." A senior care staff member said, "Yes, there's enough staff, some new staff have started and some have left but there's enough." They explained the induction included competency assessments, some training before they start working with people and the need to complete observations.

Some staff had been recruited since the last inspection and we saw the recruitment procedure remained effective. Application forms were completed, with records kept of interviews followed by the receipt of satisfactory references. Satisfactory disclosure and barring service (DBS) checks were required before staff started in post. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults. DBS checks were completed every three years to ensure staff remained suitable to work with vulnerable adults. Nursing and midwifery council (NMC) checks were completed on all nursing staff.

Good

Is the service effective?

Our findings

During our last inspection in June 2015 we found breaches of regulation. Staff were not always acting in accordance with the requirements of the Mental Capacity Act (2005) and associated code of practice. The provider had not ensured staff had received appropriate support, training, supervision and appraisal to enable them to carry out their duties. During this inspection we found improvements had been made.

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 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. DoLS applications had been appropriately made and care plans were in place so staff knew about the restrictions. For people who had recently moved into Lansbury Court mental capacity assessments and best interest assessments were completed which assessed whether a DoLS application was needed. If someone had been assessed as lacking capacity DoLS applications had been made on the day of move in. A log was kept of expiry dates and new applications were made in a timely manner.

One staff member said, "If people can't make decisions for themselves they would need someone to speak up for them about their finances and health. DoLS is about things being in their best interest, it might be medication so we have to have a written decision that it's in their best interest as they need it." They added, "Other professionals would be involved." They went on to say, "We always explain what we are going to do and involve people."

Mental capacity assessments and best interest decisions were in place for people who lacked capacity to consent to bed rails.

Staff told us they had attended training in mental capacity and DoLS. One staff member said, "I've done medication, moving and handling, health and safety, customer service training, dignity, first aid. It's all face to face and online, we get certificates as well." They added, "I've done mental capacity and DoLS, diet and nutrition, dementia awareness, fire awareness and continence training. There's nothing more we need, I'm happy with the training it's all on site and done by an internal trainer." Another staff member said, "My training is all up to date, moving and handling, dementia, safeguarding, mental capacity, dignity in care. I don't do medication so I haven't had the training but there's nothing I need that I haven't had." One senior care staff member said, "The training is good, I've done customer service which is new, I've never done it

before. The content is good. I've done a dignity course which is new. I know they are looking at courses in men's health, diabetes and hearing loss."

A training matrix was in place which detailed mandatory training such as moving and handling, safeguarding, medication training and observation and mental capacity and DoLS. Some staff had also completed additional training in understanding and managing behaviours that may challenge, diabetes, continence awareness and falls. Nursing staff had completed competencies in areas such as continence, food and drink, medication, pressure care, the prevention and management of pain and record keeping. Where some staff had not attended training or it was due for renewal this had been booked. Staff were also booked to attend an end of life distance learning course.

New staff had completed a thorough induction. The registered manager said, "Induction is linked to the care certificate which is completed if staff don't have an NVQ. There are self-directed workbooks for staff to complete and training. This is reviewed by the training executor who signs it all off." One staff member said, "I had an induction, I did training and workbooks and shadowed a member of the care staff then they ticked things off that I'd accomplished." An ancillary staff member said, "My induction was a walk around, fire points, machine use, training and two or three days to do my competencies. There's always training, I did exams in handling and lifting, health and safety, dementia awareness, safeguarding, mental capacity, dignity, fire and infection control." A nurse told us, "I worked alongside another nurse, and did all my training and online training."

Staff had regular supervision which was used to offer support and discuss development opportunities. The registered manager said, "Supervision is every two months or so, the standard is six a year including appraisal." One staff member said, "Yes we have supervision, if something goes wrong everyone has it. We have team meetings as well and can add to the agenda." This meant staff were working together to prevent any future incidents and communication lessons learnt. They added, "[Registered manager] has been really supportive to me and the clinical lead, anything I want to know they will explain and show you."

Another staff member said, "I have supervision every two months, it's very helpful either with a nurse or [registered manager]. (I) also have an appraisal and team meetings were we can raise issues or concerns about people, day to day stuff as well. Everyone is supportive and helpful." A senior care staff member said, "We have supervision and appraisals. It's supportive, and frequent, I get what I need from it."

We observed lunch time on both Lansbury and Castle Dene units. Staff were attentive to people's needs but respected their wishes if they said they didn't want help with their meal. Staff did however observe people and return to them if they saw they were having difficulty. People who needed one to one support with their meal received this in a respectful way, although we did see one staff member who didn't engage with the person as actively as other staff. For example, they didn't speak to the person to see if they were ready for any more food, or engage in general chit chat during the meal. We observed the same staff member later and they were more engaged with people, offering explanations and chatting. We spoke with the registered manager and regional manager about this who acknowledged the observations.

Pictorial menus were on display in both units however, in Castle Dene this had not been kept up to date. A kitchen assistant said, "It's the activity coordinator who changes it." The unit manager said, "Oh, that's confusing isn't it." We spoke with the registered manager who said, "The activities coordinator isn't in today but it should still be changed, I'll deal with it."

One visitor said, "The food is okay from what I've seen." A person said, "The food is good, it's all right anyway." Another person said, "The food is canny (good), it's nice." We spoke to a kitchen assistant who

said, "All the information on fortified diets and things are in the kitchen, the cook directs us on day to day to basis as to who needs what." We saw diet notification sheets were available to the cook and kitchen assistants. The cook explained there were alternative options offered to people such as soup or sandwiches as well as the main choices on the menu.

Care plans evidenced that were appropriate people had been supported to access external healthcare such as dieticians, speech and language therapy (SALT), district nurses, tissue viability nurses, GPs and consultants.

Good

Is the service caring?

Our findings

.We spoke with people and their relatives and visitors about whether they thought Lansbury Court was caring. People said they were happy with the care they received. One person said, "Good staff, lovely girls. They pop in at night which is good. I'm happy. The girls are lovely. We have a laugh and a joke." Another person said, "I'm alright, family come in every day. I like the staff and get on well with them, they look after me well." They added, "They get me up, I can have a lie in if I want its fine, the staff are kind, you get to be friends with them. I've no complaints at all, everything's fine."

Another person said, "I like it here, the staff are canny, good staff, they do the job as best they can." Another person said, "I'm well looked after, really nice girls, we went out to the beach yesterday. I like to get out." They added, "I'd advise anyone to come in, the beds are clean I'm well looked after, its lovely and clean, the girls are nice and friendly."

Relatives also told us they were happy with the care their family member received. One relative said, "You couldn't get better staff. The unit manager is spot on, the staff are lovely, they are like an extended family. [Family member] is happy here and that's all we want." They added, "This is a caring home, it ticks all my boxes. The staff do care. I can go home with an easy mind knowing [family member] is well cared for." Another relative said, "My [family member] has only recently moved in, the care has been nice, it's fine actually. Communication has been good." They added that another relative had met with the registered manager who had provided some advice in relation to their family member's care. They went on to say, "Everything is fine so far, we pop in and out every day and the staff pop in to make sure [family member] is ok and had their tablets and everything."

A visitor who was spending time with a friend said, "I'm happy with the care, no complaints at all." One person's relatives said, "We are very happy with the care, you couldn't get better. Communication is very good; staff will ring and keep in touch. We are involved in conversations about care, it's done step by step."

A staff member said, "I love it here, it's a lovely home, the staff the residents, everyone is friendly." Another staff member said, "I love it, I just love chatting with people they've had such amazing lives." They added, "The best bit is hearing people's stories and their history. We have 'My Life' in the files and record everything to tell people's history, it's really interesting, I love sitting talking to people and listening to their history, it's really important."

We observed staff engaged proactively with people in a warm and caring manner. There were lots of smiles and laughter from people, and staff were very attentive to people's needs.

On the Lansbury unit we observed staff had a continual presence in the lounge area and spent time chatting with people about their previous jobs and family life. Spending time with people engaging in activities or offering support with drinks. On Castle Dene unit we observed staff were attentive to people's needs, and supported people in a calm and reassuring manner.

We observed staff offering choice to people and respecting their decision, such as if they wanted to spend time in the lounge or their bedroom or if they were ready to go to the dining room for a meal.

People and their relatives told us they were involved in decision making about their care. Resident and relative meetings were held frequently. The registered manager said, "Head office send physical invites to people twice a year. The agenda is sent to us so we discuss that and add anything else that's relevant. We do other meetings in between times, there's one arranged for this month." A resident and relative meeting was held in June 2016 were feedback was shared with people from satisfaction surveys. Feedback was positive in relation to activities, and dignity and respect but people had raised concerns around the food. The registered manager had acted upon this and had met with the cook and kitchen staff. Actions had also been added to the registered manager's action plan which were recorded as having been met.

Information on advocacy services was on display and some people had been supported to use the services of an advocate.

Good

Is the service responsive?

Our findings

During the last inspection in June 2015 we found there was not always an accurate, complete and contemporaneous record of care and treatment provided to people. During this inspection we found improvements had been made.

Care plans were up to date and had been evaluated on a monthly basis. Care plan audits had been used effectively to identify any improvements that were needed. Care plans for people living in the Lansbury unit contained all the detail staff needed to support people safely and appropriately but some had been written in a more person centre style than others. This had been identified by the registered manager and operations manager and action was included on the overarching action plan. The operations manager said, "We've identified improvements are needed in care planning so we are rolling out a person centred care planning training course, which includes scenarios from which staff would write care plans."

The care plans for people living in the Castle Dene unit were very person centred and included detail on areas where people were independent and were they needed support, be it either prompts or physical support. There was detail that people liked to use their personal toiletries when bathing, the times they liked to get up and retire and how many pillows they liked to sleep with.

Life histories were in place at the front of people's care files and included a short history of people's home and family life, work history and interests. One staff member told us how important it was to have this information so they could spend time chatting with people, learning more about them and reminiscing.

One senior care staff member said, "The new paperwork is easy once you get to know it, everything is together and we only need care plans were we are providing care it's the same for risk assessments."

A nurse said, "It's really down to resident need, things get done when they want it done. The resident of the day is used to evaluate care records. Care staff do daily documentation and it's overviewed by the nursing staff to make sure it links in with the care plans. We use it as an audit mechanism as well." They said, We looked at care records for people who had recently moved into Lansbury Court. A nurse said, "We aim to get them done in six hours." We saw that care plans and risk assessments were in place and for one person a referral had been made to a health care professional for additional support on the day of their move in.

One staff member said, "I don't write the care plans, the seniors do the residential care plans, I do the daily communication on what's been happening and complete the daily charts so turn charts and food and fluid. We know what's been happening as we are with people."

An ancillary staff member said, "We have resident of the day so each day one person's room gets a deep clean as well as doing the other routine cleans." A senior care worker said, "Resident of the day is good, we review the care plan, make sure they are weighed, it means everyone does the care plan as it isn't the same staff each time. Staff are allocated on that day to do the review so everyone gets to know peoples care plans. If it's done by a care assistant a senior checks and signs it off. It works well as an audit tool as well."

A pictorial activities board was on display and showed the activities that were available each day. This included exercise, bingo, reminiscence, a gentleman's club, singing and pampering. An additional noticeboard also advertised a pen friend club, a visiting entertainer and lunch out.

One person said, "I like the singing, you can't beat it." One staff member said, "We could do with more activities." A visitor said, "There could do with more activities, there's bingo on a Tuesday but not much else to do, it could do with singalongs, walks, going out. In October people are going to see Mary Poppins but there could be more to do, outings could be more often." Another visitor said, "Activities co-ordinators are good, activities are diverse they cater across the spectrum, dancing, singing, reminiscence, magazines, outings are available."

The operations manager explained that activities had been identified as an area to improve. Two activities coordinators were in post and provided activities seven days a work. They worked with people on a one to one level and also in group activities. The service action plan had identified that life stories needed to be kept up to date and used to influence choice of activities and activities that had taken place needed to be recorded in more detail with outcomes. We saw improvements were being made in this area.

Thank you cards were display which contained compliments such as, 'Thank you for looking after [family member],' 'You looked after [family member] brilliantly.'

One relative said, "The food was diabolical but we raised it with [registered manager] and they addressed it." They added, "We did have a grievance but it was addressed, staff were very professional about it."

A complaints log was in place and complaints were recorded and investigated. Outcomes were shared with complainants and it was noted whether they were satisfied with the outcome or not.

Good

Is the service well-led?

Our findings

Since the last inspection the manager had registered with the Commission. They understood their responsibilities in relation to submitting statutory notifications.

The vision, mission and core values of the service were on display for people and visitors to read, as was the customer services policy. The registered manager said, "The operations manager has a really good reputation and is building the reputation of the service. Occupancy is higher than it's ever been."

We asked whether staff thought there were any improvements that could be made. One staff member said, "There are no improvements, no, not that I can think of. The staff are the best, we have lovely residents, and we know them well and have good support from management. We know what's happening with the changes [to ownership] and we're really excited about the refurbishment plan." Another staff member said, "The décor and everything like that it's too old fashioned, too dowdy." One person's relatives said, "The furnishings could be improved, we've been told it'll get done but it hasn't yet."

A refurbishment plan was in place which included the heating system, work on which had already started, communal areas in relation to furniture, flooring and redecoration and some of the bathrooms amongst other areas within the service. The registered manager said, "Castle Dene (unit) refurbishment is to include a kitchen diner, it will be full so we need more space created for people in the dining area."

There were plans in place for staff to have champion roles in areas such as dementia, diabetes, and men's' well-being. There were also plans for some staff to complete communication and interaction techniques training programmes.

One staff member said, "We are really listened to, if we've got concerns or want to know about something we are listened to and things happen." A senior care staff member said, "[Registered manager] is supportive, the unit manager is as well. The culture is resident based and positive."

One ancillary staff member said, "[Registered manager] is on the ball, if I need something I can run it past her. There's access to the computer system, it's a very informative building, there's always information around on training and things. I have access to everything I need. I love working here, I enjoy it."

A flash meeting was held each morning with the heads of each department so anything urgent or any concerns could be raised as well as handover of information about people and resident of the day forms being passed to the registered manager.

The registered manager said, "Team meetings are held as needed really but a minimum of every two to three months. Senior managers attend as well. I have general meetings for everyone plus additional meetings for seniors, kitchen staff. I also go to a monthly managers meetings." Staff told us they were able to raise things at the team meeting and the agenda included care plans, skin integrity, health and safety, training and maintenance checks. Managers meetings included the sharing of best practice and lessons

learnt, workshops in relation to quality and improvement, training, recruitment and retention and maintenance and health and safety issues.

Acknowledgement of good practice and achievements was made in several ways, including home awards, thank you emails from the chief executive, reviews of competence and salary and an Oscar's style fun day.

The quality assurance system included surveys completed by people, staff, and visitors. Surveys sought people's view in relation to activities, the laundry service, cleanliness and additional services such as hairdressing and chiropody. Some surveys had individual actions so we asked the registered manager about actions from the other surveys. They said, "I have an overarching action plan which is RAG rated and includes all actions needed from CQC, local authority, compliance visits. It's checked and updated every month." They went on to explain this meant they had one action plan which was a live document to be used for monitoring continuous improvement. RAG rating meant the actions were colour coded as to progress made, ie green for complete, red for action needed and amber for in progress.

A range of audits were also completed including monitoring of infections, skin tears and pressure sores. Care plan audits were detailed and actions were recorded, completion of the actions was not always evident. We spoke to the registered manager who said, "My plan is to do audits of care plans with resident of the day so over the month they are all done. I tend to look at a specific area in detail each time so different things are picked up at each audit." We asked about ensuring the actions were completed, they said, "The action plan is put in front of the care plan and there's a note in the diary. This is signed off as done and kept in peoples care files." They added, "Sometimes the actions are completed there and then if they are audited by the nurse but they should still be signed off. I need everyone to follow the same procedure." We saw that care files contained audits with actions noted as complete.

Medication audits were completed on a monthly basis, as were pressure relieving equipment and finances. Any areas were improvements were required were noted and action taken to address it.

In addition there had been an audit by the internal compliance team and monthly audits from the operations manager. The overarching action plan documented the area of concern, how it had been identified and what action was required. There was also a target date for completion and who was responsible. When actions had been met, the date was recorded together with a short summary of the action taken.