Newlife Care Services Limited

Mountview

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Mountview is based in Stocksfield, Northumberland and provides accommodation and personal care and support for up to 10 people with learning disabilities. At the time of our inspection there were ten people in receipt of care living at the service. This inspection took place on 3 and 4 November and was unannounced.

Our last comprehensive inspection of this service was in August 2015 where one breach of Regulations under the Health and Social Care Act 2008 was identified, namely Regulation 12, Safe care and treatment. At this inspection we found improvements had been made and the provider was now meeting legal requirements.

A registered manager was in post who had been registered with the Commission since April 2016, in line with the requirements of the provider's registration. 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.

Each person that we spoke with told us, or indicated (where they were not able to communicate with us verbally), that they felt safe and comfortable in the presence of staff. Policies and procedures were in place to protect vulnerable adults from harm and abuse. Staff were trained in safeguarding and they were aware of their own personal responsibility to report matters of a safeguarding nature.

Risks that people were exposed to in their daily lives and their environments had been appropriately assessed and measures put in place to mitigate these risks. Positive risk taking was promoted throughout the service and risk assessments were appropriately drafted, reviewed and updated.

Health and safety checks and the servicing of equipment within the home was carried out regularly to support people to remain safe. Any accidents or incidents that occurred were investigated and measures put in place to prevent repeat events. Emergency planning had been considered and guidance was in place for staff to follow should a range of eventualities occur.

Staffing levels were appropriate at the time of our visit and ensured that people's needs were met. Recruitment procedures were robust and enabled the provider to recruit staff of the correct calibre and skill sets to support the people in receipt of care from the service. Vetting checks were carried out to ensure that staff were not barred from working with vulnerable people. Training, supervision and appraisal of staff was carried out regularly. Staff said they felt supported in their roles.

The management of medicines was safe and people received the right medicines they needed, at the right times.

People's care was person-centred and appropriate to their needs. Their general healthcare needs were met.

Evidence was available to demonstrate that people were supported to access routine medical support, such as that from a dentist or optician, as well as more specialist support, such as that from a speech and language therapist should this be required.

Staff displayed an in-depth knowledge of people and their needs. They relayed information about people's needs and steps they took to support them, which tallied with our own observations and documented information held within people's care records. People's nutritional needs were met and managed well. Where necessary, food and fluid charts were used to monitor that people ate and drank in sufficient amounts to remain healthy.

Staff and people enjoyed good relationships and staff treated people with dignity and respect. People were supported to live as independently as possible and social inclusion and community involvement was promoted.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken and records about such decision making were maintained.

Care records were well maintained and regularly reviewed. Pre-admission assessments and detailed care plans and risk assessments were available to staff so that they had the information they needed to support people appropriately.

A complaints policy was in place and other feedback channels existed for staff, people, relatives and external healthcare professionals to express their views. These included meetings and surveys. The registered manager was well thought of amongst the staff team and had an in-depth knowledge of the service and people in receipt of care.

Quality assurance systems were in place although these could have been more detailed in places. The provider had overlooked the submission of some notifications, related to other incidents, in line with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have made a recommendation about this and are dealing with this matter outside of the inspection process.

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.

Risks that people were exposed to in their daily lives and within the environment had been assessed and plans were in place to reduce these risks.

Staffing levels were appropriate to people's needs.

Medicines were handled safely and people were appropriately safeguarded from harm and abuse.

Effective cleaning and infection control systems were in place.

Is the service effective?

Good

The service was effective.

People received care that met their needs.

Staff were trained and appropriately supported and appraised in their roles.

The Mental Capacity Act was appropriately applied.

Is the service caring?

Good

The service was caring.

Staff and people enjoyed good relationships.

People were supported to maintain their dignity and they were treated with respect.

Independent living was promoted as much as possible.

People were informed about and involved in their care.

Is the service responsive?

Good

The service was responsive.

People received care that was person centred.

Care records were well maintained and contained detailed information about people's needs.

Activities and social inclusion were promoted.

No complaints had been received since our last inspection and feedback channels were in place to measure service satisfaction levels.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some notifications had not been reported to the Commission when they should have been.

Action plans were not used consistently in the monitoring of the service when shortfalls were identified.

People spoke highly of the registered manager.

A range of audits and checks were in place to assess the quality of the service delivered.

Mountview

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 and 4 November 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to our inspection we reviewed all of the information that the provider had sent us since our last inspection to evidence the steps they had taken to achieve compliance with the legal requirements of the Health and Social Care Act 2008. This included evidence submitted to the Commission in the form of reports, risk assessments, statements and examples of audits.

We did not request a Provider Information Return (PIR) in advance of this inspection. A PIR 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 reviewed statutory notifications that the service had submitted since our last visit and obtained feedback about the service from Northumberland contracts and commissioning team, and Northumberland safeguarding adults team. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used the information that we had gathered to inform the planning of this inspection.

During our inspection we spoke with the registered provider, registered manager, three members of the care staff team and four people who used the service. We carried out observations around the premises and reviewed records related to health and safety matters, infection control, medicines management, governance and quality assurance. We also reviewed six people's care records to establish if they were appropriate and well maintained, and we looked at four staff files to review recruitment processes, training and the level of support staff received to fulfil their roles.

Good

Is the service safe?

Our findings

At our previous inspection of this service in August 2015 we identified a breach in Regulation 12 of the Health and Social Care Act 2008, entitled Safe care and treatment. At that time we found people were not protected from environmental risks within the home. They were exposed to the risk of catching an infection due to unsatisfactory levels of cleanliness and there was a failure to assess and mitigate the risk of legionella bacteria developing within the building water supplies. In addition externally the home was not well maintained. At this inspection we found that improvements had been made in all of the areas previously contributing to a breach of Regulation 12.

Window restrictors had been fitted throughout the building which supported people to remain safe. From a security perspective, the fitting of window restrictors had also significantly reduced the risk of third parties entering the home undetected. Externally the windows and their frames had all been sanded down and repainted. This had resulted in the building having a better external appearance. Internally, some redecoration had taken place in communal areas, a minor repair to a radiator had been carried out and some cosmetic damage from a historic water leak had been addressed. Equipment that had been broken at our last visit including toilet basins and seats, had all been replaced and these were fit for purpose. The flooring in the downstairs wet room had also been replaced and this was no longer dirty and attracting mildew. The registered manager told us the provider had an on-going programme of redecoration in place for all of their services and further cosmetic improvements to the home were planned. A new cleaning checklist which provided accountability for staff had been introduced and the standards of cleanliness within the home had markedly improved as a result. The aforementioned improvements had a positive impact on people's environment and their living conditions.

The management of environmental risks within the building had improved. Regular fire and health and safety checks were carried out and fire equipment servicing was carried out by a fire safety company. Other equipment such as hoists and the lift were serviced regularly. An electrical installation safety check had been undertaken since our last visit and the results showed the installation was categorised as 'satisfactory'. In addition, a legionella risk assessment of the building had been completed and regular water temperature checks and sampling of the water supplies within the home were carried out by an external contractor.

Bedroom checks and checks on people's mobility equipment were carried out weekly, and formal health and safety checks monthly. This enabled the provider to ensure that any hazards or maintenance issues were identified and addressed promptly. External doors had been fitted with alarms and staff had been given 'alerters' linked to these door alarms since our last visit, which they wore on their belts to 'alert' them if the doors were opened. This meant that staff could respond promptly and appropriately support and protect people should they chose to leave the building. Our findings demonstrated that the provider had taken appropriate steps to reduce the risks within the environment of the home and measures were in place to ensure people remained safe.

Accident and incidents that occurred within the home were well recorded and details about actions taken were noted on a structured form. Where actions needed to be taken to prevent repeat events, these had

been put in place. Referrals to Northumberland safeguarding adults team and other relevant healthcare professionals had been made in response to accidents and incidents where this was appropriate. A monthly analysis of accidents and incidents that had occurred was completed to identify any trends and where any changes to the environment, or people's care, may be needed. This showed that measures were in place to promote people's safety and reduce the risks they were exposed to in their daily lives as much as possible.

Risks that people were exposed to in their daily lives had been identified and strategies devised and documented in care records about how to reduce these risks. For example, people had risk assessments in place related to epilepsy, going swimming and how they should be supported with moving and handling. There was evidence within individuals' care records that these risk assessments were reviewed regularly and staff told us that as people's needs changed, these assessments were updated. Positive risk-taking took place and was managed safely. For example, people were supported to access the community and pursue activities that they enjoyed. People's care records evidenced that care reviews took place involving outside professionals including GP's, local authority care managers and other health and social care professionals such as district nurses and psychiatrists. This meant that multidisciplinary teams looked at people's care, the risks associated with it and if care provision was safe.

A business continuity plan was in place which contained a list of emergency contact details for staff and guidance about what procedures they should follow if a range of different scenarios occurred, such as a fire or a loss of utilities. Personal Emergency Evacuation Plans (PEEPs) were held within people's care records, which gave staff instructions about how to support each individual to exit the building, should this be necessary. A specific night emergency plan was also in place which provided staff with a list of contact numbers for staff to use if necessary, such as those for the local hospital, pharmacist and NHS direct.

Not all people who lived at the service were able to communicate with us verbally, but they used non-verbal methods to communicate with us, which included using eye contact, gestures and actions, when we asked them for feedback about the service. Each person that we spoke with told us, or indicated, that they felt safe and comfortable in the presence of staff. One person said, "I am happy. I like it here. I am safe". We observed staff interactions with people and saw that they delivered care safely.

We discussed the safeguarding of vulnerable adults with members of the staff team and the registered manager. We found they were all aware of their own personal responsibility to report matters of a safeguarding nature both internally within the provider organisation and externally to the local authority safeguarding adults team. They understood that investigations into safeguarding matters were necessary to ensure measures were in place to protect people from harm and abuse. The provider had robust systems in place for managing people's money and recording their financial transactions. When we carried out a sample check of two people's money, we found the amounts present, tallied with remaining balances.

Staffing levels were appropriate at the time of our visit. There were enough staff readily available to assist people when they needed help and support. People had regular contact with staff and we saw that their needs were met in a timely manner. Most people were in the communal areas of the home throughout our visit. Night time staffing levels consisted of one waking staff member and one member of staff who slept in the building and could be called upon if necessary. In addition, the registered manager confirmed that management (deputy or registered manager) were on call at any time and if they could not be contacted, the regional manager would be available should night staff require assistance or advice.

Staff files demonstrated that recruitment procedures were robust and protected the safety of people who lived at the home. Application forms were completed and included details about staff's previous employment history. Potential new staff were interviewed, their identification was checked, references were

sought and Disclosure and Barring Service (DBS) checks were obtained before staff began work. They were also introduced to people who lived at the home during the recruitment process to see how they interacted with people and how people responded to them. This meant the registered provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were appropriately qualified and physically and mentally able to do their job.

The management of medicines within the service was safe. Detailed records existed about medicines booked into, and signed out of the home, for example if people stayed away overnight. The storage of medicines was appropriate and the temperature within the medicines cupboard was taken daily to ensure that medicines were stored within temperature limits set by manufacturers and therefore remained safe for use.

Medication Administration Records (MARs) were well maintained and reflected that staff signed to confirm when they had administered a particular medicine at a particular time. Some people did not have specific medication care plans in place but other people did. Some further work was also needed to develop a plan of care for individuals who had been prescribed any medicines to be given 'as and when required'. We discussed this with the registered manager and deputy manager, who both said that they would implement this straight away. 'When required' medicine care plans are important as they give staff detailed information about specific medicines that people might need on an ad hoc basis and the personal signs that they may display which would indicate they need to be offered them. For example, people may be prescribed 'when required' medicines for constipation or pain relief.

Good

Is the service effective?

Our findings

People's feedback, and our own observations, confirmed that people received effective care. One person said, "They (staff) are good" and another told us, "They help me". Relatives and healthcare professionals had recently completed questionnaires giving feedback about the standard of care that they saw being delivered. All of their comments were positive and reflected that they believed people were well looked after and their care needs were met. They described a welcoming and professional staff team. Healthcare professionals commented that they enjoyed good working relationships with the management and staff of the service, and relatives said they were kept fully informed about their family member's needs and any other important changes or matters.

Staff displayed an in-depth knowledge of people and their needs. They relayed information about people's needs and steps they took to support them, which tallied with our own observations and documented information held within people's care records. We saw that where people displayed behaviours that may be perceived as challenging, staff were apt at reading these situations and providing the correct level of support to all parties to calm the situation and avoid any potential escalation. Where people were not able to communicate verbally, staff described how they had learned each individual person's unique personality traits, their facial expressions and any noises they made, in order to establish what they may need help and support with. Staff were also able to describe people's moods and how they monitored these. This demonstrated that people were supported by staff who understood them, to whom they could communicate their needs.

People's general healthcare needs were met. Evidence was available to demonstrate that people were supported to access routine medical support, such as that from a dentist or optician, as well as more specialist support, such as that from a speech and language therapist should this be required.

People's nutritional needs were met and managed well. Where necessary, food and fluid charts were used to monitor that people ate and drank in sufficient amounts to remain healthy. They detailed how much food or drink was consumed. People were weighed monthly, to ensure that any significant fluctuations in their weight were identified promptly and investigated. One member of staff told us that a four week rotational menu was in place but that people could have an alternative meal should they not like what was on offer or they changed their mind. They said, "If people don't want something an alternative will be made for them. You do get to know what people like. (Name of person) likes their tea with milk".

Staff told us that communication within the service was good. They said they were kept fully informed and there were communication tools in place to share messages amongst the staff team, such as verbal handovers between changing staff teams and a communication book in which important information was written. The provider had also considered the needs of people living at the home in respect of providing information and gathering feedback. For example, we saw a pictorial complaints procedure and pictorial instructions about how to respond to a fire, were posted around the home. In addition, where the provider had sent out questionnaires to people to gather their feedback about the service as part of their quality assurance programme, these were written in a pictorial form. This showed the provider communicated with

people in a format that met their needs and they could be effectively informed of important information and involved in the service.

Staff reported that communication was good between themselves and the registered manager. The area manager was kept abreast of any key issues at the service via a weekly report submitted to them by the registered manager, unless the matter was more urgent and then they would be notified immediately. The registered manager told us that communication between herself and the area manager was both regular and good.

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. Information in people's care records indicated consideration had been given to their capacity levels and their ability to make their own choices and decisions in respect of the MCA. Applications for DoLS had been made to the local authority safeguarding team in accordance with good practice and the provider was awaiting the outcome of these applications. There was evidence the principles of the 'best interests' decision-making process had been followed in practice. Records retained about these decisions could have been more clearly stored and we discussed this with the registered manager who said that she would review the recording of any best interests decisions made. The registered manager confirmed that no best interests decisions had needed to be made since our last inspection. She informed us of an on-going matter where the best interests decision making process was currently being followed in respect of one person's health and welfare, and she confirmed that a best interests meeting involving healthcare professionals and family was in the process of being arranged. This showed the provider was aware of their legal responsibilities under the Act and it meant that where people did not have the capacity to make decisions for themselves, consent to care and treatment was lawfully obtained.

Staff files showed that staff training was up to date and they had been trained in a variety of different topics relevant to the needs of the people supported by the service. For example, staff had completed courses on moving and handling, first aid, understanding behaviours which may challenge and epilepsy. The registered manager told us that all staff currently working at the home had either completed or were working towards a National Diploma in Health and Social Care.

Staff received regular supervision and an annual appraisal. Supervisions and appraisals are important as they are one to one meetings between staff and their line manager at which discussions take place about performance, operational aspects of the service, training and any personal matters. Appraisals are an annual overview of a staff member's performance over the previous 12 month period. Staff said they felt fully supported by the registered manager.

The environment of the home was suitable for people's needs. A walk-in wet room had been fitted to enable those people who were unable to access a shower cubicle or bath, to bathe with ease. A passenger lift had been installed in the home in recent years to enable people who were unable to use the stairs, to move between the lower and upper floors. People's bedrooms were personally furnished and decorated to their

own taste. They contained people's personal items.

Good

Is the service caring?

Our findings

People's feedback and our own observations informed us that people and staff enjoyed good relationships. One person told us, "They (staff) are alright" and another said, "They (staff) are kind".

People and staff enjoyed time sitting together and we saw staff asked people about their day and how they planned to spend their afternoon. One lady had recently had their nails painted and a staff member commented on how pretty they looked. During our visit two people became visibly upset and we observed staff gently comforting and supporting them to feel better and take their mind off what had upset them. Staff knew people well and how to support them in a caring manner.

People were treated with dignity and respect. They were spoken to appropriately and their dignity was promoted. People were clean, tidy and well presented. Staff reflected pride in their work and told us they were happy caring for people whom they had supported for a long time. People were asked about how they wanted to live their lives and they were encouraged to be as independent as possible. Staff gave us examples of how they delivered care which showed they understood the importance of maintaining people's independence and dignity. For example, they told us how they encouraged people to eat their food themselves whenever possible, rather than assisting them with feeding.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People were involved in their care. Some people helped with safety checks carried out around the premises and the registered manager told us that one person had been involved in the interviewing process during the recruitment of a new employee. People told us they were supported by staff on a regular basis to keep their personal living space clean and tidy. This showed that staff empowered people to contribute to their care.

Independent advocacy services could be arranged for people if they so wished. The registered manager told us that most people's relatives acted as their advocates and that no person living at the home at the time of our inspection had an independent advocate in place supporting them with their decision making.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. For example, when people needed medical attention because they were presenting with symptoms of an illness, a doctor's appointment or call out was arranged for them. People told us they were happy with how they were looked after. One person said, "They (staff) are good here" and continued "They look after me".

A keyworker system was in operation within the service where individual staff members were allocated to individual people living at the home. Keyworkers held responsibility for ensuring people's needs were met and that mechanisms were in place to enable them to achieve their goals and aspirations as much as possible. Care records were regularly reviewed and updated by people's keyworkers. Care was very much person-centred. Staff told us they gave people who could not communicate verbally as much choice as possible in relation to day to day decisions and we observed this during our inspection. They responded to people's needs by reading their emotions, expressions and behaviours they displayed.

People's care records contained a summary of their life history, their background, skills, interests, likes and dislikes. A comprehensive set of care and support plans had been developed that reflected their needs, which had been previously assessed. For example, there were care plans related to supporting people with their physical health, finances, accessing recreational activities and independent living skills. There was evidence of pre-admission assessments and of systematic reviews and evaluation to ensure that people's care remained appropriate, safe and up to date. Care monitoring tools such as personal hygiene charts and charts for monitoring people's behaviours were in place, where necessary. In addition, the service used daily evaluation records and had a diary system to pass information between the staff team and to respond to any issues that may have been identified.

External healthcare professionals reflected in questionnaire feedback that the service was responsive to people's needs. Records confirmed that the service had involved general practitioners (GPs) and specialists in people's care when needed, to promote their health and wellbeing.

Some people who lived at the home attended day centres weekly, where they were able to pursue a variety of different activities. The provider had access to a minibus that was shared between this home and a sister service. On one day that we visited a group of people were supported to access the community and luncheon at an eatery. People were supported to maintain close links with their families if applicable and relatives could visit the home at any time. This showed the provider promoted social inclusion and sought to maintain people's mental wellbeing.

A complaints policy and procedure was in place with details about how to complain and the timescales involved. There was also information about how to complain in a written and pictorial format displayed in communal areas, in people's bedrooms and this was held in people's individual care records. This showed the service had responded to people's needs and presented them with information in an appropriate format. Records showed that there had been no complaints received about the service since our last inspection.

The provider had systems in place to gather the views about the service delivered. Surveys had recently been sent out to people's relatives, friends, external healthcare professionals and staff in June 2016, in order to measure the standard of service delivered and to address any concerns raised. These reflected extremely positive feedback about the service. Family and friends results rated the home as excellent or good in answer to a range of questions. They made comments about the caring nature of staff and how well they catered for the diverse needs of all people. One relative commented that staff were welcoming at all times and shared relevant and prevalent information with them. External healthcare professionals commented about the positive atmosphere in the home.

'Residents' meetings took place monthly and staff meetings bi-monthly or quarterly. People had the opportunity to feedback their views through these meetings on events, activities, holidays and any other issues of interest. We discussed with the deputy manager that in addition to these subjects, these meetings could incorporate discussions about the service itself, including for example feedback from people about the environment, food and any complaints they may have. They told us they would pass this feedback on to the registered manager. Staff told us that in their meetings they had the opportunity to feedback their views either during staff meetings, at one to one supervision sessions, or by approaching the registered manager directly.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post at the time of our inspection who had worked at the service for many years and been promoted to this position. She had been registered to manage the carrying on of the regulated activity at the service since April 2016.

We were satisfied that overall, notifications about deaths and other incidents were submitted to the Commission in line with requirements. However, we found a number of incidents had not been notified to us as the result of a management and systems oversight. We discussed this with the registered manager and provider who assured us that this oversight would be addressed and would not happen again. We are dealing with this matter outside of the inspection process.

We recommend the provider reviews and re-familiarises themselves with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, entitled Notification of other incidents

The registered manager displayed an in-depth knowledge of people and their needs. It was clear that both she and the overall staff team sought to secure the best possible outcomes for people in receipt of care from the service. People told us they liked the manager. Staff said they enjoyed a professional relationship with the registered manager whom they felt offered them the support they needed. One member of staff commented, "I can go to (registered manager's name) or (deputy manager's name) at any time". Another member of staff said, "I feel I could approach (registered manager's name) with anything".

The registered manager told us she worked in partnership with other agencies and enjoyed open working relationships with the healthcare professionals involved in people's care. The atmosphere within the home was positive and the staff team told us that morale was good. The registered manager told us she was open to staff approaching her at any time to raise concerns, issues, or to ask for assistance. Staff reflected this and said that they could approach the registered manager at any time and they felt comfortable in doing so should this be necessary.

The provider had an overall assurance system in place to ensure that staff delivered care appropriately. Monitoring tools such as food and fluid intake charts were available for use should people's intake need to be monitored. Night staff completed checks on people regularly throughout the night and they were guided by people's overnight needs by a summary of information that was held communally. In addition, there were systems in place to monitor people's changing continence needs; their weight; any future health related appointments; a staff communication book for passing messages between staff; and a shift handover book where any issues that needed to be addressed or actioned were recorded. These tools enabled the registered manager to monitor care delivery and then identify any concerns should they arise.

The registered manager told us no provider management meetings took place but she felt fully supported by the area manager who she had regular contact with. She said that she received regular supervision and appraisal from the company's area manager. Staff meetings and meetings for people took place on a bi-monthly or quarterly basis where a variety of issues related to the operation of the service and people's

individual needs were discussed. Minutes of these meetings reflected what we had been told.

The registered manager told us, and records showed that a range of different audits and checks were carried out to monitor care delivery. These included medication audits, infection control audits, analysis of accidents and incidents, and health and safety audits/checks. A range of different matrices were also used to monitor, for example, supervisions and training requirements for staff. The registered manager told us that she completed a weekly report and submitted it each Friday to the area manager so that they were kept up to date with key issues related to the service that week and they could liaise with the provider if necessary. This report covered information about; staffing levels; training requirements; any accidents or incidents that may have occurred; safeguarding matters; complaints; visits from external professionals; audits completed; and any maintenance and repairs issues.

Some audits and reports had action plans completed and attached to them and we could see that improvements had been made. This was not consistent with all auditing however. We discussed the benefit of using action plans with the registered manager and the provider, who said that moving forward they would consider incorporating these on all audits undertaken.

The area manager completed monthly visits to the home which involved observing staff practice and a walk around of the home. There were also entries on the documentation related to these visits which indicated that reviews of paperwork within the service took place, including checks on notifications, any safeguarding matters and any complaints. We considered however that the records related to these visits were not detailed enough to demonstrate how many people and staff had been consulted about the service, and exactly how many and what type of records had been looked at. The area manager had identified that a number of low level incidents had occurred within the service, but they had not identified that these should have been reported to the Commission in line with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, as referred to above. We fed back our findings about the area manager visits to the provider who advised that these would be revisited and expanded.