Seagry Care Limited

Ferndale Residential Care Home

Inspection report

8 Stein Road
Emsworth
Hampshire
PO10 8LD
Tel: 01243371841
Website: www.example.com

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 7 December 2015 and was unannounced.

Ferndale House Residential Home provides care and accommodation for up to 17 people and there were 16 people living at the home when we inspected. These people were all aged over 80 years and were all living with dementia.

All bedrooms were single. Four of these bedrooms had an en suite toilet. There was a communal lounge and dining area which people were observed using. There was also a conservatory which people used as a dining area or for activities. A passenger lift was provided so people could access the first floor.

The service had a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

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.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

People received their medicines safely.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed and decisions made in their best interest and in line with relevant legislation.

There was a choice of food and people were complimentary about the meals. The provider consulted people about the food and meal choices.

Staff were skilled in working with people who were living with dementia and had access to a range of relevant training courses to enable them to meet people's individual needs.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks. A GP commented that the staff worked well with them to meet people's health care needs.

Staff were observed to treat people with kindness and dignity. People were able to exercise choice in how they spent their time. Staff took time to consult with people before providing care and showed they cared about the people in the home. Staff were skilled in providing end of life care to people.

Each person's needs were assessed and this included obtaining a background history of people. Care plans showed how people's needs were to be met and how staff should support people. Care was individualised to reflect people's preferences.

Staff supported people with activities and there was an activities programme which included entertainment and gentle exercise.

The complaints procedure was provided to people and their relatives. People said they had opportunities to express their views or concerns. There was a record to show complaints were looked into and any actions taken as a result of the complaint.

Staff demonstrated values of treating people with dignity, respect and as individuals. People's and stakeholder professionals' views about the quality of the service were sought. Staff views were also sought and staff were able to contribute to decision making in the home.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service which the provider used to make any improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

Is the service effective?
The service was effective.

Good

Staff were trained in a number of relevant areas and received regular supervision.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards (DoLS).

People were supported to have a balanced and nutritious diet. Special dietary needs were catered for.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?
The service was caring.

Good

People were treated with kindness and dignity by staff who took time to speak and listen to people.

People were consulted about their care and their independence and privacy was promoted.

People's preferences and choices regarding their end of life care were acted on.

Is the service responsive?
The service was responsive.

Good

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

There was an activities programme for people.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?
The service was well-led.

Good

Summary of findings

The provider sought the views of people, staff, and stakeholder professionals regarding the quality of the service and to check if improvements needed to be made.

Staff demonstrated a commitment to treating people with dignity and as individuals.

There were a number of systems for checking and auditing the safety and quality of the service. The registered manager was effective in communicating and leading the care staff team.

Ferndale Residential Care 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. The inspection checked 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 7 December 2015 and was unannounced.

The inspection team consisted of an inspector and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the 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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with nine people who lived at the home and to five relatives. We also spoke with three care staff, the chef, the registered manager and the provider of the service.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for eight people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a GP who reviewed people's care needs. This person gave their permission for their comments to be included in this report.

This was the first inspection of this service since being registered on 4 November 2014. It was inspected on 19 November 2013 when the service was operated by a different provider. There were no concerns raised at that inspection.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and that they received safe care. Relatives also made comments that people were safe at the home. For example, one relative said, "They're a lot more safe and secure - and happy - than when they were at home." Relatives commented that sufficient staff were provided to meet people's needs. One relative, for example, said, "From day one I felt assured as to the standard of care, ratio of staff to residents, leadership and training."

Staff were trained in procedures for reporting any suspected abuse or concerns. Staff said they would report any concerns to their line manager and knew how to access safeguarding procedures in the home. These contained guidance on reporting such concerns to the local authority safeguarding team. The service had policies and procedures regarding the safeguarding of adults, including a copy of the local authority safeguarding procedures. The registered manager had enhanced their knowledge of safeguarding procedures by attending a one day training course with the local authority regarding the process of investigating allegations and concerns of abuse.

Risks to people were assessed and recorded. There were corresponding care plans so staff had guidance on how to support people to reduce the risk of injury or harm. These included risks related to falls, the risk of skin pressure areas developing, the use of bed rails, malnutrition and behaviour. Risks of pressure areas developing on people's skin due to prolonged immobility were assessed using a Waterlow score assessment. This gave a score of the risk of pressure areas developing. Where a risk was identified, there was a record of the intervention needed to prevent this. This included the use of specialist equipment such as pressure relieving air flow mattresses and air cushions as well as how often pressure areas needed to be checked. Records showed these checks on pressure areas to skin were carried out. Similarly, risk assessments regarding falls showed how people were to be supported and when equipment was needed such as pressure mats which alerted staff if people got out of bed in the night. Care plans, including risk assessments were reviewed on a regular basis so any changes in people's needs regarding risks could be identified.

A dependency tool was not used by the provider to calculate the staffing levels needed to meet people's needs, but the registered manager said they knew people's needs well and when staffing levels needed to be increased. The registered manager added that the provider made resources available to ensure additional staff could be provided when people's needs changed. Staffing levels were provided as follows: from 8am to 8pm, three to four care staff with two staff on 'waking' duty at night. Staff said they considered there were enough staff on duty to meet people's needs but one staff member felt the number of times agency staff used at night was too high. The registered manager told us the service planned to recruit additional staff for night duty so the use of agency staff could be reduced. Where agency staff were used the provider used the same three agency staff so they knew people's needs. The provider also confirmed agency staff were 'highly qualified' and always worked alongside permanently employed staff. Additional staff were provided for cooking, catering, cleaning and laundry. We observed staff were available to support people and help people when needed. There were sufficient numbers of staff to look after people safely. A health care professional told us they considered the service had sufficient staff to look after people.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There was a record of staff being interviewed to assess their suitability for the post.

People were supported with their medicines. Designated staff handled and administered medicines. These staff were trained in medicines procedures and were assessed as being competent to do so by the registered manager.

A record was maintained of any incoming medication stock. The service used a monitored dosage system whereby medicines were supplied by the pharmacist in blister packs instead of original containers. A record of medicines administered to people was maintained on a medicines administration record (MAR). The MARs and the blister packs of medicines showed staff administered medicines as prescribed. Staff recorded their signature on the MARs each time they administered medicines.

Where people had 'as required' medicines to be administered where specific symptoms were exhibited, the guidance for staff to follow about this was not always in sufficient detail. For example, one person had guidance

Good

Is the service safe?

about when to administer medicine when they were agitated or aggressive. This guidance prompted staff to try and distract the person to see if this calmed them. If this did not work then the medicine could be given after consulting the registered manager. For another four people the guidelines referred to the use of 'as required' medicines when they exhibited symptoms such as aggression or agitation. However, there was no record or further details of what this would entail. Despite this, a staff member described in detail what one of these people's behaviour was, how the staff would try to calm and distract the person before deciding if the 'as required' medicine was needed. Staff knew the symptoms to consider when 'as required' medicines might be needed and this ensured people received their medicines as appropriately. However this information this was not always recorded clearly. Following the inspection the provider confirmed the guidelines for 'as required medicines' were amended in light of our findings.

Medicines classed as controlled drugs were stored appropriately. A controlled drug register was maintained for these medicines where the quantity of medicines was recorded, the amount given and a remaining balance of medicine. This involved two staff who recorded their signature to acknowledge they had handled and administered the medicines. We checked the stock of medicines and the recorded balance of controlled medicines which were found to tally.

Checks were made by suitably qualified persons for equipment such as the passenger lift, gas heating, electrical wiring, hoists, wheelchairs, the call points, fire safety equipment and alarms, legionella and electrical appliances. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises in the event of an emergency such as fire.

Good

Is the service effective?

Our findings

People told us they were supported by skilled staff who knew how to look after them. For example, one person said, "The staff work hard. They will do anything for you." A relative spoke highly of the skills of the staff, "As a result of their excellent training and the example set by the manager, staff provided every assistance to my husband whilst encouraging independence wherever that was practical."

Staff told us they had access to a range of training courses such as in the moving and handling of people, first aid, the Mental Capacity Act 2005 as well as recognised training in care such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. The provider confirmed 14 of the 18 staff were trained to NVQ level 2 or 3. The registered manager was trained to NVQ level 4 as well as having the Registered Manager's Award (RMA) and being a NVQ Assessor and Verifier. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff said the training was of a good standard and equipped them for their role. Staff demonstrated they were enthusiastic about learning. For example, one staff member said, "I love all the training we get. I learn from the manager too."

We looked at the training records for staff on duty which showed a number of courses were completed, such as in health and safety, infection control, nutrition, fire safety, equality and diversity, moving and handling, coping with aggression, dementia and end of life care.

Records were maintained to show newly appointed staff received an induction to prepare them for their role. This included aspects of the service's operation as well as policies and procedures such as health and safety, fire safety, and care planning. This meant staff were trained to provide safe and effective care.

Staff confirmed they had supervision and that there was daily management support where they could ask for advice or guidance. One staff member said one to one supervision took place annually and another said it took place twice annually. The registered manager did not have any set guidelines of how often supervision should take place but aimed for at least two one to one sessions per year with each staff member which was recorded in staff member's files. The registered manager stated more informal ad hoc supervision took place which was not always recorded. Staff also had annual appraisals of their work which were recorded. The registered manager acknowledged the need to maintain all records of supervision with staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. Where appropriate people's capacity to consent to care and treatment was assessed. These documented whether people had capacity to make specific decisions about their care. Where people did not have capacity and their liberty was restricted records showed an application was made to the local authority for a DoLS authorisation. Copies of DoLS authorisations were held with people's records. There was a record in people's care plans where any care or support regarded as restricting their liberty was carried out, which showed this was the least restrictive alternative. These included the use of bed rails to prevent people falling out of bed. We noted two gates were used to stop people entering two people's bedrooms. After discussion with the registered manager it was agreed that whilst these were not intended to restrict the two peoples' movement but to prevent other people going into their rooms the arrangement should be recorded in each person's care records and the reasons for it. The arrangement did not use a locking mechanism and people could open the gates by using the latch.

Good

Is the service effective?

Records showed staff were trained in the MCA and DoLS which they confirmed. Staff were aware of the principles of the MCA and DoLS and were able to tell us what the legislation was used for. Staff were observed to consult people before they provided care to them.

Where appropriate people's nutritional needs were assessed using a malnutrition universal screening tool (MUST). These give a score of the level of risk of malnutrition. Referrals were made to health care services where people were at risk of malnutrition. The advice of health care professionals regarding nutrition were recorded in care plans to ensure this was followed. People's weight was monitored and the registered manager was aware of those people who had lost weight and what action was needed to support the them. The use of any supplements to increase the calorific value of food was recorded when this was advised by health care professionals. The chef told us how cream was used in desserts to increase its calorific value.

We observed people at the lunch time meal. People ate in either of the two dining areas. Staff gave people individual support to eat and drink. People said they liked the food and we observed a choice was available to people. Where people were reluctant to eat every effort was made to encourage people and alternative foods were offered.

Relatives told us the registered manager and staff liaised well with health care professionals. For example, one relative said, "Medical care when necessary was sought at an early stage and I witnessed excellent working relationships between the care home staff and the local GP practice and community nurse team." The registered manager described how the staff worked well with the local GP and we saw records of each person's annual medical reviews with the GP as well as a review by the GP of needs associated with dementia. A GP told us the staff and registered manager liaised well with them regarding people's health care needs and made appropriate referrals for assessment or treatment.

We saw adaptations had been made to the environment so that people living with dementia were assisted to find their way around the home by the use of signs, photo displays and memory boards.

Good

Is the service caring?

Our findings

People and their relatives described the staff as kind and helpful. One relative, for example said, "We're happy with everything. The staff are lovely, when we visit we always get a cup of tea – they are good at the little things." One of the people we spoke to said the staff were, "kind, comforting and reassuring." Relatives told us staff knew and catered for people's individual needs and preferences. They said, "The girls do a wonderful job –they are all wonderful. He seems relaxed too; I see him in clean clothes, he eats well; his sleeping is better – I think it's wonderful. The girls tell you what sort of a day he's had; I'm very very happy with everything." Another relative commented, "Without exception, the staff cared for my husband with the utmost professionalism, dignity and loving kindness. Nothing was too much trouble and all possible options were explored to ensure his comfort and well-being."

Staff were observed to treat people with kindness and compassion as well as being patient with people. We spent time observing staff with people in the two dining areas. The staff made eye contact with people and crouched down so people could see them when they spoke to them rather than standing over them. Staff were aware of people's needs and preferences and spoke to people calmly. People were asked by staff how they wanted to be supported.

Staff were observed paying attention to people who were either unsettled or agitated. The staff were aware of these people's needs and recognised they needed additional time to find out if they could be helped in any way or if they were in discomfort. Records made by staff when they supported people showed staff took action to support people who were in distress. Care plans included guidance of what staff should do to support people who were experiencing anxiety or distress and this guidance was followed by staff. A relative commented on how the intervention of the staff had resulted in their relative being calmer.

Staff were trained in equality and diversity and in person-centred care, which emphasises how people's individual preferences and needs should be met. This was also included in each person's care plan, which demonstrated people were treated as individuals and there was choice in how they spent their time. A GP commented how care was provided in a way which allowed people to maintain their dignity and independence. The PIR stated how people's cultural and religious preferences were acknowledged in how the staff supported people to celebrate religious events.

Staff demonstrated values of compassion and said they provided care based on people's needs, and treated people in the same way they would treat a member of their own family. A GP described staff as kind, patient, affectionate and as having genuine relationships with people, which made people feel they mattered. A relative commented, "The carers and manager took the time to talk to my husband about family, interests and hobbies etc although he struggled to communicate, and they always treated him with patience and understanding however busy they were."

People's privacy was promoted by the staff. We observed staff knocking and waiting before entering people's bedrooms. Each person had their own bedroom so they could spend time in private if they wished and one person told us how they chose to spend time in their room rather than in the lounge. We noted privacy locks on two ground floor toilets were not in place. When we raised this with the registered manager she confirmed this was being addressed.

Where people were at the end of their life they were supported to have a comfortable and dignified death. Details about end of life care needs were recorded in people's care plans. The provider told us in the PIR that the staff ensured those people without a next of kin had their wishes taken account of regarding their end of life care. A GP said staff were skilled in this area and liaised well with health care services to ensure there was a coordinated approach and the right equipment was in place. Staff confirmed they attended training in end of life care. A relative commented on the skills of staff in this area as follows: "The care, vigilance and dignity given to him in Ferndale during his last days and hours was second to none. The manager and staff also gave me so much support and kindness which helped me and my family through the first stages of bereavement and beyond, and my friendship with them continues to this day." A GP also commented that staff liaised well with relatives when people were at the end of their life and added that the staff and manager went "above and beyond" in providing good

Good

Is the service caring?

end of life care which reflected how people wished to spend their remaining days. Particular reference was made by the GP to the preferences of one person regarding their end of life wishes.

Good

Is the service responsive?

Our findings

People and their relatives said care was arranged to meet people's needs and was provided in the way people preferred. For example, one relative commented, "Every effort was made to treat my husband as an individual and respect his needs and preferences so that despite his disabilities he was able to enjoy the best possible quality of life." Another relative commented on the process of their relative moving into the home as, "a surprisingly easy transition – I don't know how they did it, but hey – it was good." Further comment was made by this relative that the staff had met their relative's needs following admission to the extent the person's mood improved considerably. One of the people we spoke to commented how they felt settled at the home and enjoyed the atmosphere created by the activities, "My memory's gone – it feels like I've only been here 5 minutes, but I know it must be more, because all my things are here! I am comfortable here; I sleep like a baby, the food is good, and there's always something going on – I can hear it from my room, so I can go and join in if I want to."

Care records showed people's needs were assessed prior to being admitted to the service so the registered manager could ascertain whether the person's needs could be met. Once admitted to the service the registered manager and staff carried out comprehensive assessments of each person's needs and devised care plans based on those assessments. Care plans were comprehensive and recorded to a good standard with clear guidance on how people should be supported. For example, specific care for personal hygiene was recorded which included details about how the person preferred to be shaved, dressed and any oral care needs. Mental health needs for those living with dementia were assessed and care plans included details regarding memory, orientation, whether the person liked to socialise and their mood. The care plans were personalised to reflect what support each person needed, what the person could do themselves and their preferred daily routines such as when getting up or going to bed.

Staff maintained daily records each time they supported someone so that any changing care needs could be monitored. Where needed charts were completed to monitor specific needs such as behaviour and pressure areas on skin. The care needs were reviewed and updated to ensure they reflected the person's most up-to-date needs. Relatives confirmed they were consulted about these reviews.

Care records included details about people's life history and interests so staff knew what people liked to do. Staff had a good understanding of what people liked to do and any activities they liked to take part in. Staff were observed engaging people in quizzes, games and puzzles, which people responded to positively and enjoyed humorous interactions with the staff. Each person was engaged in some sort of activity or interaction with staff so people were not socially isolated.

There was an activities programme displayed in the entrance hall. The activities included entertainment from musicians and gentle exercises for people as well as a dog specifically trained to visit people in care homes.

Specifically created tactile ornaments were available throughout the home, which people could play with in order to give stimulation for those living with dementia. These included wall mounted boxes of reminiscence items specific to people and were made with the involvement of people's relatives. The provider and registered manager told us how people frequently used these. Bedroom doors had been adapted to look like a front door of a house so people could identify with their room. These were examples of imaginative ways of engaging with people.

People and their relatives said they knew what to do if they were not satisfied with the service and were aware of the complaints procedure. The registered manager told us the complaints procedure was included in the information brochure given to each person and their relative. There was a complaints procedure setting out how any complaint would be dealt with. The registered manager informed us there were frequent discussions with people and relatives which gave them an opportunity to raise any concerns. The registered manager stated there had been one complaint and records of how this was investigated and responded to showed the complaints procedure worked well. A record was also kept of compliments made to the service to capture what they did well.

Good

Is the service well-led?

Our findings

People and their relatives said they were able to give feedback on the service by completing satisfaction surveys. They described good communication channels with the staff and registered manager regarding any concerns or for receiving information. Surveys were also supplied to health care professionals such as GPs and ambulance personnel. The results of the surveys were available at the inspection and showed relatives and professionals were satisfied with the standards at the service. The registered manager told us the results of the surveys were reviewed and used as the basis for any improvements. A local GP who reviewed people's health care needs described the management arrangements as "superb" and that there was a good relationship between the GP practice, the staff and registered manager at the service.

Staff said they were able to contribute to decisions and said their views were listened to. Regular meetings took place with staff and staff said they were encouraged to give their opinion as well as being able to contribute to decision making. Staff described the registered manager as approachable and said they felt able to raise any concerns with her.

Staff demonstrated values of compassion, dignity and respect for people. They were aware of the procedures for reporting any concerns and how people's rights should be upheld. A GP described staff as having a "commitment and passion" for their work.

The home had a registered manager and there was a system of senior care staff who took a lead responsibility for coordinating care for each staff shift. Staff said they had access to management support during the day and night. Staff were motivated in their work and were keen to improve their learning. The registered manager had completed qualifications in management in care and was also an NVQ Assessor, which supported a culture where staff training and development was emphasised. The service was part of the West Sussex Partners in Care and the registered manager had received a Dementia in Care Award and two staff were also nominated for care staff awards. Staff took lead roles to develop specialist areas of knowledge such as infection control which could be utilised in the service. This demonstrated a passion for providing good care and for on-going learning and development to do so.

Regulation 20, Duty of Candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 specifies providers must act in an open and transparent way and must notify relevant people about any incident which must be looked into, investigated and responded to with an apology. The service had a duty of candour procedure, and the registered manager had followed this when dealing with an incident in the home. There were records to show the registered manager had liaised effectively with the local authority safeguarding team and had reported the incident to the person's relative as set out in the Regulation. The registered manager was open and transparent regarding any concerns or incidents and had implemented procedures based on recent changes to legislation such as the Duty of Candour.

The registered manager kept her training up to date and was aware of updates to policies and procedures regarding care and safety from organisations such as the National Institute for Excellence (NICE) and Skills for Care. A communication folder was used to update staff on the latest national policies on best practice. These included, for example, literature on assessing those at risk of choking and safety alerts regarding the use of hoists. Staff recorded their signature to say they had read these policy updates.

The registered manager and relatives commented on the provider's commitment to improving and updating the environment. The registered manager added that the provider made resources available for these improvements and for other aspects of the service such as additional staffing when this was needed.

The registered manager completed regular audits to ensure the safety and effectiveness of medicines procedures, any patterns in people's falls in the home, food and nutrition, infection control and health and safety. These identified areas where improvements were needed.