Mr Harold Hilton & Mrs Margaret Smith

Franklin House Limited

Inspection report

Franklin House
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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

Summary of findings

Overall summary

This inspection took place on the 2 and 3 June, 2016. Our visit on the 2 June was unannounced.

We last inspected the home in April 2014 where we found three breaches of the regulations reviewed. These were in relation to Deprivation of Liberty Safeguards (DoLS), risk assessments for people who used the service and quality assurance checks. During this inspection we found the home to be compliant with all the regulations we inspected.

Franklin House is a privately owned care home situated on the fringe of Oldham town centre, with easy access to local amenities, shops and public transport. The home provides residential care for people over the age of 65, offering both long-term and respite placements and specialises in caring for people with dementia. It has 38 single rooms, all with en-suite facilities and the accommodation is at ground level. There is a large enclosed garden in the centre of the home with raised flower beds, shrubs, garden furniture and a summer house which is easily accessible to wheelchair users.

When we visited the service a registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 had a good understanding of the procedures needed to keep people safe and what action they should take in order to protect vulnerable people in their care. Risk assessments had been completed to show how people should be supported with everyday risks, such as risks to their nutrition and these had been reviewed regularly.

People we spoke with felt there were sufficient, appropriately trained staff available to support people in the home and our observations during the inspection confirmed this. Staff responded promptly to people's needs. Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting with vulnerable people.

Medicines were stored correctly and were administered by staff who had received appropriate training and been assessed as competent to safely administer medicines.

Environmental checks of the home were up-to-date. Although the home was well-maintained there were some communal areas that would benefit from redecoration. The owner of the home told us that there was an on-going programme of redecoration and refurbishment, including a new roof and new corridor toilets. A treatment room for visiting healthcare professionals was also planned.

The home was clean and free from unpleasant odours and systems were in place for the prevention and control of infection. Bathrooms and toilets contained adequate supplies of soap and paper towels and we

saw that staff used personal protective equipment (PPE) appropriately.

Staff had undertaken a variety of face-to-face training to ensure they had the skills and knowledge required for their roles. Staff supervision was undertaken regularly by the registered manager and deputy manager.

People's nutritional needs were closely monitored and the food looked appetising. There were sufficient staff available to help those people who needed support with eating.

The home was working within the principles of the Mental Capacity Act (MCA) and where people were deprived of their liberty to receive care and treatment the appropriate deprivation of liberty safeguards (DoLS) authorisation was in place.

People told us the staff were kind and our observations confirmed this. Care plans were 'person-centred' and were reviewed regularly. Through talking to staff and relatives we found that people were treated as individuals and that staff really knew each person and responded to their needs in a caring way.

The home had taken part in the 'six steps end of life training programme' which had helped staff have a better understanding of the needs of people approaching the end of their life and the needs of their families. The home had created a dedicated 'family room' for the use of relatives of those who nearing end of life.

People were supported to maintain good health and where needed specialist healthcare professionals, such as dieticians and district nurses were involved with their care. Families told us that they were informed promptly of any changes to their relatives' health.

The service had a complaints procedure in place and people we spoke with knew how to make a complaint if they needed to. The home had not received any complaints since early 2015.

Quality assurance processes such as regular audits of care documentation and environmental audits, for example of cleanliness of the kitchen, were in place to ensure that the service delivered high quality care.

We observed a calm and happy atmosphere in the home with staff working well together as a team. Staff and relatives found the registered manager approachable and we observed that she had a 'hands on' approach and helped out with caring for people who used the service, as well as managing the service.

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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.

Arrangements were in place to safeguard people from harm and abuse.

Medicines were stored and administered safely.

Staffing levels were sufficient to meet the needs of people using the service.

The home was clean and systems were in place for the prevention and control of infection.

Recruitment processes were robust and protected people who used the service from the risk of unsuitable staff being employed.

Is the service effective?

Good

The service was effective.

Staff had received training in a variety of subjects which enabled them to carry out their roles effectively. All new staff received an induction.

Regular supervision was carried out which ensured that the standard of care provided by staff was monitored and any problems identified were managed appropriately.

People's nutritional needs were closely monitored. The food was of a good quality.

Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) authorisations were, where appropriate, in place.

Is the service caring?

Good

The service was caring.

People we spoke with were complimentary about the staff and

said they were caring.

Staff were patient and spoke to people in a kind and sensitive way.

Staff understood how to respect people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care was provided in a way that was responsive to meet the individual needs of people who lived at the home.

Care plans and risk assessments were detailed and 'person-centred' and were reviewed regularly to ensure the information was up-to-date.

There were systems in place to enable people to make a complaint about the service.

Is the service well-led?

Good

The service was well led.

The home had a registered manager who was supported by a deputy manager and the home owners.

Staff we spoke with told us the manager was very approachable and supportive and our observations confirmed this.

There was a calm, happy atmosphere in the home and staff worked well together as a team.

Quality assurance processes, such as audits, ensured that standards were monitored regularly.

Franklin House Limited

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 was planned to check whether the provider was 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 was an unannounced inspection and took place on 2 and 3 June 2016.

The inspection was carried out by one adult social care inspector. Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us without delay. We also reviewed the inspection report from the previous inspection and contacted the Local Authority (LA) to ask if they had any concerns about the service, which they did not. We also reviewed information submitted to us by the provider in the 'provider information return (PIR). This document asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received. Therefore we examined people's care records and observed the care and support provided to them in the communal areas to capture their experiences.

During our inspection we spoke with one person who used the service, three relatives, the owners, the registered manager and deputy manager, three care staff and the cook.

We looked around the building, observed how staff cared for and supported people, reviewed records and looked at other information which helped us assess how people's care needs were met. We observed a lunchtime meal and watched the administration of medicine to check that this was done safely.

As part of the inspection we reviewed the care records of four people living at the home. The records included their care plans and risk assessments. We looked at three staff files to check that the recruitment process had been carried out correctly. We also reviewed other information about the service, such as the

training programme, quality assurance process, policies, complaints and compliments.

Good

Is the service safe?

Our findings

People who used the service told us that Franklin House was a safe place to live. One relative said ''Yes, I know she's safe here'' and a person who used the service said ''I've never had any concerns with the staff''. All staff received annual 'safeguarding vulnerable adults' training and those we spoke with were able to describe what 'safeguarding' meant and could give examples of different types of abuse, such as emotional and physical abuse. The registered manager understood her responsibility in reporting safeguarding concerns to the Care Quality Commission and the local authority safeguarding adult's team, who had recently introduced a log for low and medium harm incidents which the home were required to complete and submit to them on a monthly basis.

Staff employed by the service had been through a thorough recruitment process. We inspected three staff personnel files and found that they contained all the relevant documentation, including two references and confirmation of identification. All staff had Disclosure and Barring (DBS) criminal record checks in place. These help the service provider make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions.

People we spoke with felt there were enough staff to meet the needs of the people living at Franklin House and our observations during the inspection confirmed this. One relative we spoke with said ''There are always staff around''. A person who used the service told us that if she pressed her call bell at night to summon assistance, she did not have to wait long for help to arrive. The registered manager told us that she did not use agency staff, as the majority of regular carers were able to work extra shifts to cover for staff absence or to accompany people who used the service to hospital appointments.

We reviewed the care files of four people living at the home and saw that risks to people's health, such as moving and handling, had been assessed and appropriate information to help staff manage the risks had been written in their care plans. This helped to ensure that risks to people who used the service were minimised and people were kept safe.

We inspected the premises and saw that although the majority of the home was well-maintained, there were some areas that would benefit from redecoration. We discussed this with the owners, who told us that there was an on-going programme of redecoration and refurbishment. During the inspection we observed toilet facilities being replaced. The home employed two maintenance workers who looked after the fabric of the building on a day-do-day basis. Any maintenance problems identified by staff were logged in a maintenance record and dealt with in order of priority. During our inspection we noticed that one of the radiator covers in the communal area was not secured to the wall, which could have posed a risk to someone if it had been knocked. We asked for this to be rectified immediately, which it was.

The home had a large enclosed garden containing trees, shrubs, decking and garden furniture, which people who used the service were able to access easily and was suitable for wheelchairs. During our inspection we saw that some areas of the garden looked neglected and the smoking area contained two buckets full of dirty water and cigarette butts. We brought these to the attention of the registered manager who advised us

they would be cleaned away, which they were.

We looked around all areas of the home and saw the bedrooms, toilets and bathrooms, communal areas and kitchen were clean and free from unpleasant odours. One relative we spoke with commented '' The bedroom is always clean and tidy''. The home employed cleaning staff seven days a week and the daily, weekly and monthly cleaning schedules we checked had all been completed. We saw that food was being stored appropriately and the kitchen fridge and freezer temperatures monitored daily. These procedures helped to minimise the risk of food contamination.

A 'Food Standards Agency' inspection had been carried out in January 2016 and the home had been awarded the highest rating of 5.

Arrangements were in place for the prevention and control of infection. Toilets and bathrooms contained an adequate supply of soap and paper towels and staff had undertaken infection prevention and control training. Staff we spoke with understood the importance of infection control measures, such as the use of personal protective equipment (PPE), including disposable vinyl gloves and plastic aprons. We observed staff using these appropriately. The home had undergone a local authority infection control inspection in February 2015 and received an overall rating of 93%. This was an improvement on their previous infection control inspection where the overall rating had been 54%.

We saw that there were safe systems in place for the storage and management of medicines. Medicines were stored in a treatment room which was clean and tidy and contained the medicine trolley and controlled drug (CD) cupboard. Controlled drugs are prescription medicines controlled under the Misuse of Drug legislation e.g. morphine, which require stricter controls to be applied to prevent them from being misused, obtained illegally and causing harm. The temperature of the treatment room and medicine fridge were checked daily to ensure that medicines were stored at the correct temperature, and our observations of the temperature recording sheet confirmed this.

We observed the lunchtime administration of medicine and saw that it was carried out safely by people who had had appropriate training. We looked at four Medication Administration Sheets (MARs) and saw that they had been completed correctly. Each person had an individual medication file, which contained their MAR sheet, list of their medication and a photograph, which helped to minimise the risk of the medicine being given to the wrong person. No medicines were being administered covertly. This means giving medicines in a disguised for, for example in food or drink, when a person refuses the treatment necessary for their physical or mental health. The registered manager knew that in order to administer medicine covertly she must first hold a 'best interests' meeting and then obtain the appropriate authorisation. Where people were receiving medication 'as required', such as painkillers and there was a variable dose, where one or two tablets could be given, we saw that the dose given was recorded correctly. This enabled staff to monitor and review the amount of pain relief that the person required.

There were systems in place to protect staff and people who used the service from the risk of fire. Fire equipment, such as extinguishers and the alarm system were regularly checked and fire drills were carried out every month.

People who used the service had a personal evacuation escape plan (PEEP), which was updated every few months. It explained how they would be evacuated from the building in the event of an emergency, and contained information about their mobility and any communication problems. There was a 'business continuity management plan' to follow in if there was a power failure, loss of heating, a gas leak, or other major event. Franklin House had an arrangement with another local provider who could act as a temporary

base for people who used the service, if they needed to be evacuated.

Good

Is the service effective?

Our findings

All newly recruited staff completed an induction before they were allowed to care for people unsupervised. This included completing mandatory training on topics such as moving and handling, safeguarding vulnerable adults and infection control and undertaking 'shadowing', where they worked alongside other carers in order to gain experience of caring for people. The registered manager told us that she spent some time with new staff during their induction so that she could observe their work and check that it was of an appropriate standard. All new staff were enrolled on the 'Care Certificate', a national qualification which, when completed, demonstrates they have the skills and knowledge to provide care and support.

Staff undertook a variety of annual face-to-face training which gave them the skills to carry out their roles effectively. This included infection control, moving and handling, dementia awareness, safeguarding vulnerable adults, mental capacity act and food hygiene. The majority of staff had achieved their National Vocational Qualification (NVQ) level 2 or 3 award in health and social care, and the registered manager had achieved NVQ level 5. We saw that staff from the 'visually impaired' team were scheduled to hold a training session for staff in the near future. The registered manager told us that she used CQC residential home inspection reports as learning tools for staff. Through discussions about good and poor care highlighted in reports the registered manager was able to ensure people who used the service received care that was based on current best practice. One staff member said ''We are always doing training''.

Through our discussions with the registered manager and deputy manager we saw that they took the supervision of staff and monitoring of the quality of their work seriously. They commented that a good working relationship with carers meant that if they were experiencing problems staff would approach them immediately, rather than wait for it to be discussed during supervision. The registered manager said ''If they have a problem with anything they will come in and talk to us''. Staff received formal supervision every three months and prior to each session were expected to complete a self-assessment which formed the basis of the supervision discussion. The deputy manager commented that some staff felt these sessions were not always beneficial, as they occurred too frequently and they did not always have anything new to say about their work or role. Consequently, she was in the process of changing the style of supervision so that in future it would include an observation session. This would enable her to work alongside staff and observe and assess the practical aspects of their work.

The Mental Capacity Act (2005) provides a legal framework for making particular decision 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 a particular decision, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that all staff had undertaken training in the MCA, best interest decisions, dementia and Deprivation of Liberty Safeguards (DoLS).

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The Care Quality Commission (CQC) is required by law to monitor the operation of the DoLS and to report on what we find. At the time of our inspection those people who

required a DoLS had the appropriate authorisation in place.

We asked the registered manager how she ensured that people's nutritional needs were met and their weight monitored. She told us that everyone was weighed weekly so that weight loss could be identified early and action taken promptly to prevent further deterioration. She commented ''You can intervene sooner if people are losing weight by weighing them weekly rather than monthly''. A Malnutrition Universal Screening Tool (MUST) score was calculated. The MUST score helps to identify adults who are malnourished, or are at risk of malnutrition or obese. Those people with a MUST score of 1, which meant they were at medium risk of malnutrition, were monitored closely and their food fortified with added calories. Those who were deemed at high risk of malnutrition, with a MUST score of 2, were referred to a dietician and their food fortified and nutritional input monitored. Information about people deemed at risk of malnutrition was communicated to staff at the hand-over meeting, which ensured that they were aware of which people needed support with their dietary intake.

We spoke with the cook who told us she operated a four-weekly seasonal menu. People could have a cooked breakfast if they wished and there was a choice of two meals offered at lunch and teatime. Those people who did not like the food that had been prepared were offered an alternative meal. Hot drinks, juice, milk shakes and snacks were offered between meals. Information about special diets, such as soft or pureed diets, was kept in the kitchen so that the cook knew who required these meals.

We observed the lunchtime meal and saw that it was a pleasant experience for people who used the service, with food served promptly and a happy, relaxed atmosphere in the dining area. Staff interacted in a friendly way with people, for example offering encouragement to those people who needed prompting to eat their food. One person who didn't want to sit at the meal table was asked by a carer ''Would you like me to bring some dinner over to you?'' as she sat in an easy chair. Tables were laid with table clothes and condiments and there were sufficient staff, including the registered manager, available to assist with serving the meal and helping those who required support with eating.

People were offered a choice of main meal and desert and we saw that the food looked appetising and hot. A menu board displayed the choices of food on offer, in pictures as well as the written word, which helped those who might have communication difficulties due to dementia see what food was being served. One person, who was having difficulty choosing their meal, was asked by a carer ''Let me show you, so you can choose''.

We saw that the people living in Franklin House had access to a range of healthcare professionals, such as district nurses, falls team, visual impairment nurses and dieticians. Where a referral to a healthcare professional had been made, information about the referral and its outcome were recorded in the person's care file. From our observations we saw that the registered manager took the health and welfare of people who used the service seriously and was knowledgeable about their health needs. Relatives we spoke with told us that they were kept informed about changes to a person's health. One person said ''They ring me up if she's not well''.

The home had a large communal living space, which was divided into a dining area and a lounge area with television and easy chairs. There was additional seating available in the entrance area. The home had gone some way to make its environment 'dementia friendly' by the use of displays and photographs and the use of picture signage, such as the menu board. Hot and cold taps in the toilets and bathrooms were labelled as such and some bedrooms displayed a photograph of the person whose room it was. People were encouraged to decorate their rooms with their own personal effects, such as pictures and photographs, to make them feel at home.

Good

Is the service caring?

Our findings

People we spoke with were all very complimentary about the care given by staff at Franklin House. One relative said ''I can't praise the staff highly enough'' and a person who lived at the home told us ''The staff are nice and helpful''. One 'Thank you' card we read said ''I could not get anything better. The staff are the best''.

All carers were 'key workers' for two or three people who used the service and were responsible for weighing them weekly, ensuring their personal hygiene needs were met, their rooms tidy and that they had everything they needed, such as toiletries and clothes. We saw that people in the home looked cared for their clothes were clean and appearance well kept. One person we spoke with said '' I can ask for a shower as often as I want''. On the second day of our inspection the hairdresser was attending to people.

We observed how staff interacted with people in the home and saw that they were patient and did not rush people who they were assisting. Staff spoke kindly and politely to people and were friendly and smiled. One person who used the service said ''They speak nicely'' and a relative commented '' They are really friendly''. We saw that staff responded promptly to people's needs: one relative commented ''There's always someone there if you need them''. We heard staff laughing and joking with people appropriately and there was a relaxed atmosphere in the home. A relative commented ''The staff are always calm''. A calm approach by staff created a calm and relaxing environment for people who used the service.

We asked staff how they ensured people were treated with dignity and respect. One person said '' Looking after someone's dignity is really important'' and went on to describe how they would protect people's privacy, for example when carrying out personal care. Staff we spoke with understood the importance of helping people to remain independent where possible. One carer said '' If they can do it you shouldn't take it away from them''.

People we spoke with praised the home for its 'end of life care'. One relative said ''the end of life care is second to none''. The home had recently completed the 'Six steps to success – Northwest end of life care programme for care homes', which helps to guide staff in supporting people nearing the end of their lives. Information about the 'Six steps' programme was displayed in the home foyer. The registered manager told us the programme had given her insight into how to approach difficult conversations with relatives, such as discussions about a person's final wishes.

The home had a designated 'family room', which had recently been refurbished and provided amenities for families visiting relatives nearing end of life. The room was tastefully furnished with sofas, a television, a radio and tea and coffee making facilities. A bereavement guide and information about funeral services were available. One person described how staff had been attentive to her relative's personal needs during their last few days, by changing their position in bed regularly to ensure they were comfortable and that they did not develop pressure sores. They said ''The personal care was really good''. One carer we spoke with described how important 'end of life' care was to her, commenting "You get close to people you look after''. We saw a 'Thank you' card which read "I'd like to thank you for looking after (the person) for his last few

months. I couldn't have chosen a better place. Nothing was too much trouble''.

People were free to visit the home at any time, although staff encouraged people to visit outside of mealtimes, so that people who used the service could eat their meals undisturbed. We observed friendly interaction between visitors and staff and one relative we spoke with described the staff as ''Really friendly''.

Good

Is the service responsive?

Our findings

Prior to moving into the home a pre-admission assessment was carried out by either the registered or deputy manager. Occasionally they were accompanied by a senior carer, in order that they could gain experience of the process. The assessment usually took place at the person's home, or if the person was in hospital they were assessed there. People were encouraged to visit the home prior to accepting a place. This enabled people to make an informed decision as to whether or not the service could meet their needs.

We reviewed the care records of four people living at the home and saw they were 'person-centred' and contained descriptions of each individual person's care needs and how they should be managed by staff. Documentation included risk assessments and care plans other monitoring tools such as the MUST and Waterlow score. The Waterlow score gives an estimated risk for the development of a pressure sore and is used as part of a prevention strategy. At the time of our inspection no one living at the home had a pressure sore and the registered manager told us that staff always carried out a skin inspection on people returning to the home after a stay in hospital, to ensure that they had not acquired pressure damage while hospitalised.

Care plans we checked were detailed and personal and had been reviewed monthly. Where people were able to understand the content of their care plans they had signed that they agreed with it. For those who lacked the mental capacity to contribute to their care plan their family had been consulted and agreed the plan on their behalf.

From our conversations with relatives we learned that staff responded well to the needs of people living at Franklin House. One person commented ''They understand dementia''. A visitor described how prior to living at the home her relative had owned a 'fish and chip' shop. When they had come to live there staff had brought them fish and chips to eat. They went on to say that when their relative lived independently they liked to wash up their dishes following a meal. After their admission to the home staff encouraged the person to help with the mealtime washing-up. They commented "They know the individuals''. Another person we spoke with said that staff had ''Bent over backwards'' to find a suitable room for their relative.

The registered manager told us that several people who used the service had been referred to the Age UK 'Life Story' project, which works with older people to record their life histories in words and photographs. We saw one completed book which had been recently presented to the family by Age UK staff. Life story books are a useful tool for reminiscence activities as they aid conversation and can help staff understand the events that have been important for the people they are caring for.

The home employed a part-time activities coordinator but she was on short-term sick leave at the time of our inspection, so activities were being carried out by staff. The registered manager explained that the activities coordinator normally provided people who used the service with a variety of activities, such as armchair exercises, craft sessions and bingo. In addition, special occasions such as people's birthdays, were celebrated with parties. On the first day of our inspection an outside entertainer provided a 'sing-a-long' and

dancing session and on the second day of our inspection, staff and a visitor helped people to make cards. One relative commented "There's always something going on''. People who wanted to continue practising their faith were able to receive communion from either the Catholic or Church of England priests, both of whom visited the home regularly.

'Handover' meetings were held between staff at the start of each shift and information about changes to the health or care needs of people who lived at the home were discussed and recorded in a 'handover book'. This helped to ensure that changes in the needs of those living at Franklin House were communicated to staff and people received continuity of care.

The registered manager told us that they had not received any recent complaints about the service. The last complaint had been in March 2015 and this had been dealt with promptly and in line with the complaints procedure, which was available in the entrance of the home and included in the service users guide. One relative we spoke with said ''I have never had to make a complaint'' and another commented '' I have never had to complain about anything''.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post, who had registered with the CQC in October 2010. She was assisted in her role by a deputy manager and by the owners of the home. Everyone we spoke with was very complimentary about the way the home was managed and run and about the open and approachable attitude of the registered and deputy managers. One staff member commented "If I had any problems I could speak to them, they are fair and ready to listen to you'' and a relative said "I have good communication with the manager''. One comment made in the 2015 stakeholders survey said "I feel the home, its staff and manager do an excellent job''.

We observed a happy atmosphere in the home and staff made positive comments about working there. One carer commented "I really love my job, I'm happy to come to work'' and another carer said "It's like we are one big family''. From our observations we saw that staff worked well together as a team and that both the registered manager and deputy manager spent time working alongside staff on a day-to-day basis, helping out with meals, administering medication and supporting people who used the service. One carer said "We all get on really well, we've got a good team''.

The registered manager told us that she had a good relationship with the owners and was in daily communication with them through phone calls, emails or text messages. She commented "They are easy to speak to''. The owners responded positively to any reasonable requests for resources and had recently agreed to the refurbishment of the staff room.

We talked to the owners about their improvement plans for the home. The major plan for this year was the replacement of the roof, which had been leaking in several areas. There was an ongoing programme of replacing the home's toilet facilities and the carpets in the corridors had recently been replaced with non-slip wood vinyl flooring. There were also plans to create a treatment room which could be used by visiting healthcare professionals.

People who used the service, relatives and health professionals had the opportunity to comment on the standard of care provided by Franklin House through the annual 'stakeholders' survey'. Feedback from the 2015 survey included comments such as "Franklin House is an excellent and exceptional care home'' and "The residents benefit from an excellent level of care''. One healthcare professional had commented "Consistently very good care and attitudes from staff at Franklin House''.

The service produced a newsletter three times a year to inform people of events and staff changes and the home had a 'Facebook' page where photographs of events at the home were posted.

We saw evidence that staff meetings were held twice a year, which enabled important information about the service to be communicated to staff. The agenda from a recent meeting showed that topics discussed included a reminder to staff to fortify food for those people who were underweight, information about the 'Care Certificate' and 'equality and diversity' training and a reminder that any staff found not wearing PPE while delivering care would be disciplined.

The registered manager reviewed incidents and accidents to make sure risks to people were minimised and notifications of incidents occurring at the home had been made to the CQC in line with their registration requirements. We saw that 'falls' were monitored closely and the appropriate action taken. One person who had fallen several times in one month had been referred to the NHS 'falls prevention team'.

The home had recently had an ''Investors in People'' inspection which concluded that they continued to meet the requirements for the 'Investors in People Standard'. Investors in People provide a best practice people management standard and offers accreditation to organisations that adhere to the Investors in People framework.

We saw that there were quality assurance processes in place, such as audits, which helped the service review and monitor its standards. We saw records which showed that the registered manager carried out monthly environmental audits, for example on the maintenance of the building, the toilet facilities, laundry and kitchen. In addition she carried out regular audits on medicines management and care plans, among others. Where issues were identified by the audits, action plans to rectify them had been implemented by the manager.