Care South

Dorset House

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?	Good

Overall summary

This unannounced comprehensive inspection took place on 24 and 25 August 2015.

Dorset House is a care home without nursing for up to 52 people. There were 41 people living there during our inspection, many of whom were older people who were living with dementia. Accommodation is located on the ground and first floors of a building that was erected some years ago to house a local authority care home. The two floors are connected by a passenger lift as well as stairs. There is a large enclosed garden at the rear, with lawns, paved areas, seating, flower and vegetable beds and trees. Sizeable parking areas are situated to the front and side of the building.

There was a registered manager, who had been in post for several years. 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.

Staff were familiar with people's care needs, which were set out in care plans that reflected people's individual needs. Assessments and care plans were regularly reviewed and updated.

Summary of findings

People's individual risks were assessed and kept under review, with plans in place to manage these. Staff also responded to manage risks as they arose.

There were enough staff to meet people's care needs, although they were very busy. People told us that usually the care staff assisted them at their own pace but on occasion they did feel rushed.

Care staff were aware of how to respond to and raise concerns about possible abuse. They knew how to blow the whistle on poor practice.

Risks associated with the premises and equipment were monitored and managed. The premises and equipment were serviced to ensure they remained safe to use.

The home was kept clean and we received feedback from regular visitors that it smelt fresh. However, during the inspection, there was an unpleasant smell coming from some of the downstairs carpets in communal areas. The areas were being cleaned with special chemicals in an attempt to get rid of the smell.

Arrangements were in place for the safe storage and recording of medicines.

Staff received the training and supervision they needed to be able to meet their responsibilities safely.

The home was meeting the requirements in relation to the Deprivation of Liberty Safeguards (DoLS), which are part of the Mental Capacity Act 2005. DoLS ensure that care homes and hospitals only deprive someone of their liberty in a safe and lawful way, when this is in the person's best interests and there is no other way to look after them.

Where there were no grounds to doubt a person's capacity to consent to their care, consent was obtained from them or the person to whom they had granted lasting power of attorney for health and welfare. Where people lacked the mental capacity to make decisions about aspects of their care, staff were guided by the principles of the Mental Capacity Act 2005 to make decisions in the person's best interest.

People and relatives told us there was a selection of food and they had plenty to eat and drink at mealtimes and in between. People made menu choices in ways that suited them. Individual dietary and hydration needs were met and action was taken if people were at risk of malnutrition.

People were supported with their health conditions and saw healthcare professionals, such as doctors, when needed.

People and relatives said that staff treated them with kindness and dignity, respecting their preferences. Throughout the inspection, staff spoke with people in a kind and encouraging way, often using humour that people responded to positively. They knew people well and used their preferred names. People's privacy was respected.

People were kept informed of what was happening. They, and their relatives where appropriate, were consulted during the planning and review of care.

Visiting times were not restricted, and there was a lounge that could be used for privacy during visits.

Complaints were addressed promptly, in line with the provider's complaints procedure. Where necessary, changes were made as a result of individual complaints. Complaints were also analysed every three months for any themes that might suggest further changes were necessary.

People described the home as a well organised and happy place. The culture of the home was open, informal and friendly and there was a strong sense of community. The staff team was well established.

There was a system of quality assurance in operation to identify any areas in which quality was compromised and drive improvements. This included staff supervision, observation and appraisal, as well as a programme of audits.

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.

People and their relatives had confidence that they were safe, with enough safely recruited staff on duty to keep them safe and provide the care they needed.

Risks were assessed and managed to help people stay safe.

Medicines were stored securely and managed safely.

Good

Is the service effective?
The service was effective.

Through supervision and training, staff had the skills and knowledge they needed to care for people effectively.

There was a choice of food. People had plenty to eat and drink at mealtimes and in between. Special diets were catered for.

People saw doctors and other healthcare professionals when they needed to.

Good

Is the service caring?
The service was caring.

People were treated with kindness and dignity. Staff knew people well and responded promptly when they were distressed.

People and relatives were kept informed about what was happening and were consulted in care planning and reviews.

People's privacy was respected and they were treated with dignity.

Good

Is the service responsive?
The service was responsive.

Care plans were personalised, reflecting people's assessed needs. They were kept under regular review and were followed by staff.

There was a range of activities that people could to participate in, if they wished.

Complaints were addressed promptly and, where necessary, changes were made as a result.

Good

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

People and relatives found the home well organised and described it as a happy place.

The culture of the home was open, informal and friendly. There was a strong sense of community and a well-established staff team.

Good

Summary of findings

There was a system of quality assurance in operation to identify any areas in which quality was compromised and drive improvements. Any actions arising from audits were followed up.

Dorset House

Detailed findings

Background to this inspection

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

The inspection took place on 24 and 25 August 2015 and was unannounced. The inspection was carried out by an inspector and an expert-by-experience on the first day and by two inspectors on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection cared for someone who lives with dementia.

Before the inspection we reviewed the information we held about the home, including notifications of incidents since our last inspection in May 2014. As we had brought this inspection forward due to information of concern we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

During the inspection, we met most of the people living at the home, and spoke with five of them and five visiting relatives and friends. Because some people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not readily talk with us. We also observed staff supporting people in communal areas and to eat meals. We reviewed current medicines administration records and focussed on four people's care records, as well as sampling elements of other people's care records. We also checked records relating to how the home was managed, including two staff recruitment files and three staff supervision and training files, the staff training database, the current staff rota, maintenance records and quality assurance records. We spoke with four members of care staff and a member of ancillary staff, the deputy manager, the registered manager and their covering operations manager. We obtained feedback from three health and social care professionals in contact with people at the home.

Good

Is the service safe?

Our findings

People and their relatives had confidence that they or their family member were safe at Dorset House. A person commented, "If I didn't feel safe I'd know where to go to get help". They thought there were enough staff on duty to ensure their safety. For example, a person told us, "No reason to feel any other [than safe]. Seem to be plenty of staff around – what you want in here". When we asked a relative if they felt their family member was safe they replied, "Absolutely. No doubts – 100% confident".

People's safety was maintained by staff who were aware of how to respond to and raise concerns about possible abuse. They knew how to report concerns about poor practice to outside agencies concerned with safeguarding adults. Information about reporting safeguarding concerns was available for staff, who received training in safeguarding adults at induction and every two years. The provider's 'adult protection policy' was detailed and gave correct contact details for the local social services department and police. This policy was dated October 2013. However, since then the local safeguarding adults board has produced updated multi-agency safeguarding policies and procedures reflecting the Care Act 2014. We have drawn this to the provider's attention in order that they can update their policy.

People's individual risks were assessed and kept under review, with plans in place to manage these. Risk assessments covered the areas that would be expected in a care home that accommodates older people, including weight loss and malnutrition, skin integrity and pressure areas, moving and handling, falls and fractures. Where risks had been identified, measures were in place to address them. For example, a person who was at risk of falls had a special mat in front of their seat so that staff would be aware if the person started walking around. Another person's moving and handling plan identified they needed an anti-slip mat under their seat cushion because they tended to slip down in their seat. Their cushion was placed on an anti-slip mat when we saw them. People whose care we focussed on who were at risk of developing pressure sores had the risk control measures specified in their care plan, such as pressure cushions or regular assistance to reposition, in place.

Staff also responded to risks as they arose. We were speaking with a manager when a person, who we had earlier seen wearing shoes or slippers, walked past in bare feet. The manager noticed this and considered whether to encourage the person to return to their room to get shoes, but thought this would interrupt the person or be too far for them. They therefore walked down the corridor with the person, checking there was nothing unsafe on the floor for them to step on.

Risks associated with the premises and equipment were also monitored and managed. A fire risk assessment had been undertaken by a specialist contractor in March 2015. There were regular checks of the alarms, fire doors, emergency lights and fire exits, as well as quarterly equipment and lighting servicing. Taps and showers were tested for the presence of Legionella every six months (Legionella are bacteria that can cause serious illness). Water outlets that were not in frequent use were flushed weekly, to reduce the likelihood of legionella growing. The boiler had been serviced within the past year. Hoists and bath lifts were serviced regularly. Accidents and incidents were recorded and reviewed by the registered manager for any immediate action needed to reduce risks. They were also analysed monthly for any trends that might indicate changes in practice were needed.

Most radiators were covered, including the uncovered bathroom radiator we had seen at the last inspection. However, at this inspection we found another uncovered radiator behind a bathroom door; this could only be seen when the door was closed. We showed this to the registered manager, who said they would arrange to have it covered.

On both days there was an unpleasant smell coming from the carpet in some downstairs communal areas. The registered manager and operations manager were aware of this and were taking measures, in terms of special cleaning materials, to tackle the smell. The building was otherwise clean. Visitors and regular professional visitors commented that there were no unpleasant smells.

There were sufficient staff on duty to keep people safe and provide the care they needed, although one person told us that on occasion staff seemed rushed in providing care: "If they're busy when they're helping you dress they can make you feel rushed". However, another person commented that although they noticed staff were busy their own care did not feel rushed: "They don't rush me but they do themselves". Care staff told us they were able to meet their responsibilities within existing staffing levels but that 'an

Good

Is the service safe?

extra pair of hands' would make this easier. This was consistent with our observations. For example, over lunch on the first day, we observed a staff member seated with someone, assisting them to eat their meal. The staff member was attentive and followed the person's pace but sometimes had to intervene with people at the adjacent table when they needed reassurance or prompting.

Staffing numbers were determined in negotiation with the provider. The home was not full and the registered manager explained that they only accepted new admissions whose needs could be met within existing staff resources. In addition to care staff, the provider employed activities coordinators, kitchen and dining room staff, laundry staff and domestic staff. There was an expectation that night staff would also attend to laundry and some cleaning tasks, but they told us they would always attend to people's care needs above this.

Most staff had worked at the home for a number of years. Recruitment procedures required that new staff only started working unsupervised after the required checks had been undertaken, including references and Disclosure and Barring Service criminal records checks. The staff files we looked at contained the recruitment information required by the regulations.

Medicines were managed safely. They were stored securely and there were appropriate arrangements in place for recording them. We checked some medicines and found amounts in stock tallied with the medicines records. Medicines administration records (MAR) were mostly pre-printed and were filed with people's photographs and details of any allergies. Any handwritten items were double checked and countersigned by another member of staff to ensure they had been recorded correctly. Staff had initialled MAR to record medicines had been given as prescribed or had recorded the reason why a medicine had not been administered. There was a system for recording the blood monitoring results and dose of warfarin. Warfarin is a medicine that can be dangerous in the wrong dose and requires special attention as the dose can vary.

One person did their own injections for a health condition. They did this under staff supervision to ensure they were administering the correct dose. Staff did not sign the MAR as they had not given the injection. Instead, they recorded in the daily care notes that they had checked the injection. The registered manager told us they would consider a recording system that was more convenient and straightforward for staff so they could be sure there was a record of each occasion that staff had supervised the injections.

Good

Is the service effective?

Our findings

People spoke positively about how living at Dorset House had improved their quality of life, as did relatives. One person said, "I came in down and out and now I feel better". In a similar vein, a relative told us, "When they came in my relative was incontinent, had short term memory problems and had had pneumonia. Initially they were wheeled everywhere. They [staff] quickly knew them and got [person] back on their feet. Now, using their trolley, they can even go to the loo by themselves. The patience of the staff in working with them has given them confidence to get them walking. All the carers are good". Another relative said, "Since they've been here my relative has not been in so much pain".

Staff had the skills and knowledge they needed to care for people effectively. The staff we spoke with were positive about the opportunities they had for training and confirmed they were encouraged to undertake nationally recognised qualifications in care. Staff undertook five days' induction training when they started working for the provider. This covered various topics including moving and handling, fire awareness, safeguarding, food hygiene, infection control and first aid awareness. Staff who administered medicines were trained to do so and their competence was checked periodically. They were expected to complete refresher training in these topics at intervals set by the provider. Staff were also able to undertake courses to learn more about conditions and situations that they were likely to encounter, including Parkinson's disease and end of life care.

Staff assisted people with confidence. For example, we saw two staff assisting to transfer from a lounge chair to a wheelchair using a hoist, as the person was unable to bear weight. They were having difficulty as despite the person's non-slip mat they had slipped in their seat. They worked out what the problem was, reassuring the person as they went, and the person smiled broadly as they were lifted.

Staff were also supported in their roles through regular supervision meetings to reflect on their work with a more senior staff member. Training needs were identified through the supervision process and through annual staff appraisals.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS). The home was meeting the requirements in relation to DoLS, which are part of the Mental Capacity Act 2005. DoLS ensure that care homes and hospitals only deprive someone of their liberty in a safe and lawful way, when this is in the person's best interests and there is no other way to look after them. They require providers to apply to a 'supervisory body' for authority to deprive someone of their liberty. The registered manager understood when DoLS authorisation was necessary, following a Supreme Court judgement in 2014 that clarified this. Where necessary, they had applied to authorise deprivations of liberty and to renew the authorisations.

The provider's DOLS policy forwarded to us following the inspection did not reflect the 2014 Supreme Court judgement. This was an area for improvement.

Where there were no grounds to doubt a person's capacity to consent to their care, consent was obtained from them or the person to whom they had granted lasting power of attorney for health and welfare. Staff respected people's right to make unwise decisions, for example, about their diet. where there were no grounds to doubt their capacity to do so.

Where people lacked the mental capacity to make decisions about aspects of their care, staff were guided by the principles of the Mental Capacity Act 2005 to make decisions in the person's best interest. Whilst such best interest decisions were based on the least restrictive option for person, the provider's paperwork did not readily guide the decision maker to consider this. This is a matter for the provider's consideration.

People and relatives told us there was a selection of food and they had plenty to eat and drink at mealtimes and in between. One person said, "Always been nice food. If you don't fancy it you can refuse; they would bring you something else. They tell you what you're going to have and that's good enough. We can have snacks – I'll have a cup of tea and a tart. They'll bring it". Another told us, "You see mostly empty plates at lunch time. There is a menu on the table. You tell them what you'd like. If you didn't like anything, they would see what was in the kitchen and bring something else. If anyone needed food in the night I can guarantee they would get something". A relative said, "They like plain food and can have whatever they want even if it's not on the menu. When I was with them this morning when tea was taken round, they asked for cornflakes, which came straightaway".

Good

Is the service effective?

People made menu choices in ways that suited them. Some liked to choose meals the day before as they sometimes preferred to eat cooked breakfast and lighter meals later on. Others chose during the morning. People living with dementia, which meant they could have difficulty remembering their choice, were shown plated meals at the time.

People's particular nutrition and hydration needs were met. There were concerns that one person might become dehydrated and staff monitored and recorded how much they drank. The monitoring charts contained target daily amounts and were totalled to help staff ensure the person drank enough. People were weighed regularly and action was taken where a high risk of malnutrition was identified, such as contacting the GP and giving prescribed food supplement drinks. A person who needed a high protein and fortified diet had the required meals and food supplements.

People confirmed they saw healthcare professionals when they needed to, including doctors, district nurses, community mental health nurses and chiropodists. For example, a person said, "If I needed a doctor they would call them in". Relatives told us their family members were supported to maintain their health. One said, "The GP comes in to keep the balance of treatment right. Their [person's] legs must be elevated and the leg kept clean; the staff ensure that. The staff are knowledgeable about medicines and they told us about things that the GP says he doesn't want them to have". Healthcare professionals said that staff responded to health issues appropriately and followed instructions.

People who were able to moved freely around communal areas. There was strategically placed seating in the corridors, and we often saw people sitting there watching staff and other residents. People could choose to spend time in their bedrooms or in several lounges, including the lounge upstairs that was sometimes used for entertaining visitors. They told us they could also spend time in the garden, when the weather permitted this.

Good

Is the service caring?

Our findings

People and relatives told us that staff treated them with kindness and dignity, respecting their preferences. For example, a person said, "They do respect you and we do the same to them. They treat us like we live here and they are friends". Another person said, "I'm as happy as I can possibly be. They've always got their eye on you – by the second day they knew I had one sugar in my tea". A further person told us, "They [staff] listen to you. They are understanding". A relative commented, "Staff interact well with residents and empathise… are all kind and looking after their comfort. They speak to them 100% in the correct way. They are under pressure but also joyful and reassuring". A different relative said, "I've been impressed with staff. They always seem to have time, not rushed. They respect my relative, asked if she wanted to be called by her first name or Mrs [surname]. They always knock on the door and they wait".

Staff treated people in a caring and respectful manner. Throughout the inspection, we saw and heard them talking with people in a kind and encouraging way, often using humour that people responded to positively. When we observed staff assisting people, they worked at the person's pace. For example, a staff member who was assisting someone to eat a meal observed the person waited for the person to gesture that they were ready for another mouthful and responded accordingly. Other staff who were on duty in the dining room at lunchtime sat with people they were prompting and encouraging to eat.

Staff knew people well and were able to tell us about their backgrounds, such as where they used to live and work. For example, a care worker told us they had learned that one person, who was living with dementia and sometimes had difficulty communicating, used to go fishing and liked talking about this. Staff used people's preferred names, including nicknames where people liked this.

Staff were compassionate towards people who became distressed or disorientated. For example, during our structured SOFI observation, a person whose care we focussed on was anxious and sought the company of staff. A member of staff was quick to reassure the person, spending time with them, and seeking to understand what they were saying. The person repeated a phrase over and over and the staff member realised that this was relevant to what was on television at the time. At another time, someone else looked upset and complained of pain to a staff member. The staff member explained to us that the person had a medical condition that could make them feel like this. They offered the person a medicine that could help and gently guided the person to sit in a quieter area.

People were kept informed of what was happening. For example, we observed staff using the hoist to lift someone from their seat into their wheelchair. They explained to the person what was going to happen and continued to reassure them and tell them what was happening as they carried out the procedure. The person looked calm and happy during what can be an unnerving procedure, smiling broadly as they were lifted. Staff also told people when lunchtime was approaching and it was time to get ready for the meal.

Information about people's life history, interests and preferences was obtained from people and relatives as part of the initial assessment when people moved in to Dorset House. People, and where appropriate, relatives, were involved in planning care and in regular reviews. A relative told us, "I very much feel part of the planning process. The review is due soon. I did a very full life history and about past difficulties. I see the care plan". Another relative said, "I have seen the care plan. They say 'I'd like to take you through it – what we are doing and explain changes'".

There were no set visiting times and visitors could come to the home unannounced. Visitors came and went regularly throughout the inspection. We saw visitors choosing to spend time with people in communal lounges, but the upstairs lounge could be used for privacy or for special celebrations.

People's privacy was respected and they were treated with dignity. Staff noticed when people needed assistance with personal care matters and attended to this discreetly, such as reminding people that they might wish to use the toilet before and after meals. Personal care took place behind closed doors.

Good

Is the service responsive?

Our findings

People were positive about the care and support they received. For example, a relative commented, "They are well looked after, well fed, clothes always changed, can go to the loo when they want. They check continually on residents".

People told us there were a range of activities that they could participate in if they wished. For example, someone told us, "There's games, dancing. We tell them what we'd like to do… We have apples in the garden and two of us helped to pick some and that day we had an apple pie. They also have a hairdresser and someone who does nails. We have good entertainment – a mixture and you get to do something you probably would not have done". Another person gave examples of activities that happened, explaining these did not go on constantly: "A lady comes and organises quizzes and has a vast supply of records. They do ball games. There is a big garden and if the weather is nice I like going out. We had lollies and ice cream". A relative commented, "There are plenty of activities going on – bingo, puzzles etc. They try to get people involved". There was a varied activities schedule displayed on noticeboards in communal areas, including things such as exercise, bingo and trips out. During the inspection, we met a dog and their owner who regularly visited the home through their work with a therapeutic pets organisation.

Assessments, including risk assessments, and care plans reflected people's individual needs. These were kept under review and updated as necessary. People's needs were assessed before they moved in to ensure they could be met at Dorset House, for example, within existing staffing levels. Further assessments, including risk assessments, were undertaken once people arrived. Clear, succinct care plans were based on the assessments and reflected people's individual needs and preferences. Assessments and care plans addressed issues that would be expected in a care setting. These included communication, thinking and deciding, moods and emotions and behaviours, coping with pain, moving around and pressure risk, falls, staying safe, eating and drinking, personal hygiene, continence and night care. Recognised risk assessment tools were used to assess the risk of pressure ulcers and of malnutrition.

There were separate plans for specific health issues that required special attention. Care plans for a person with diabetes set out signs that would alert staff to their blood sugar levels becoming too low or high and actions to take accordingly. This cross-referenced to a care plan for supporting the person to manage and administer their diabetes medicines, as far as possible promoting the person's independence. A person who required the medicine warfarin to help prevent blood clots had a care plan that required staff to monitor for redness of their legs, which could indicate a clot, The warfarin plan set out arrangements for the person's regular blood tests and listed foods and drinks that should be avoided.

People received the care they needed. Staff knew about the care people needed and followed their care plans. People were clean and neatly groomed, which showed they had received any support they might have needed with their personal hygiene. A person who needed afternoon bed rest had this. Where people were at risk of pressure ulcers and had difficulty moving themselves, records showed they had generally received assistance to reposition at the correct intervals. On occasion records reflected that this assistance had been given slightly later than it should have been. However, pressure sores did not arise frequently at the home, which indicated that people were receiving the support they needed. Earlier in 2015, new higher specification mattresses had been provided for all beds to further reduce the risk. Health professionals confirmed that the home readily provided special equipment such as air mattresses, where this was needed to reduce the risk of pressure ulcers.

People and their relatives told us they would feel able to raise concerns or complaints with the home manager and could address minor matters with staff directly. For example, a person told us, "They do help" if they raised any issues with senior staff. Another person explained that they had only complained about the length of time they waited to see a medical specialist. They told us that staff had pursued this when they said they were unhappy with the wait: "They [staff] listen and know what they're doing – they say I'll enquire into that and they do so". A relative described how they felt able to talk with the registered manager or deputy if they had any concerns: "They are both approachable".

The complaints procedure was displayed in reception. There had been six complaints from January to June 2015.

Good

Is the service responsive?

These were acknowledged and investigated in line with the procedure. Prompt action was taken where necessary, such as an apology or matters being addressed with any staff members concerned. The registered manager or deputy had checked that people who had complained were satisfied with the response. Complaints were analysed every three months for any patterns emerging that might indicate that further changes were needed.

Following the inspection, the registered manager forwarded to us the Care South complaints procedure dated August 2013. This stated that people could approach the Care Quality Commission if they were still dissatisfied having raised the matter with the Chief Executive of Care South. However, whilst the Commission is keen to receive feedback about services it does not have legal powers to investigate and resolve individual complaints in adult social care. We have drawn this to the provider's attention in order that they can update their policy.

Good

Is the service well-led?

Our findings

People and relatives we spoke with felt that the home was well run. People's comments included, "I think it is well led" and, "It is well organised with plenty of carers". A relative told us, "[Registered manager] is a very good manager and [deputy manager] an excellent deputy. They are not task driven but person oriented – that is my impression." A further relative said, "I believe it is well led. I've spoken to one or two other relatives and they seem happy and say how good the carers are. It's professional and happy". They described the home as "a happy place - you never see groups of carers chatting together".

The culture of the home was open, informal and friendly. There was a strong sense of community, the home being located in a district with a particular local identity with many of the residents and staff coming from this area. The majority of the staff team had worked at the home for several years.

There was open communication with people, their relatives and staff. Residents and relatives meetings and staff meetings took place periodically. Minutes of the most recent residents and relatives meeting were displayed on a noticeboard.

Staff told us they were able to speak with senior staff, including the registered manager, as they needed and not just at formal supervision and appraisal meetings. They said they felt listened to. They commented that the registered manager would challenge any shortcomings in their practice, but did so in a supportive way.

The registered manager had been in post for a number of years. Having a registered manager is a condition of the home's registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager or delegated senior staff member had notified us of deaths, serious injuries and other incidents as required by the regulations.

There was a system of quality assurance in operation so that the registered manager and provider could identify any areas in which quality was compromised and drive improvements. This included staff supervision and appraisal. As well as supervision meetings with a senior member of staff, staff practice was observed. Staff observations looked at care, compassion, competence, communication, courage (doing the right thing) and commitment.

Quality assurance also included an audit programme. Some audits were completed monthly, such as handwashing, care plans and medicines. Health and safety and infection control audits were alternated quarterly. There was also a quality and compliance team that visited, sometimes unannounced, to conduct quality and compliance or clinical audits. Records of audits showed that actions were followed up if an issue was detected. A full audit by head office staff in October 2014 had identified very little for attention.