Springcare (Kings Court) Limited

Kingscourt

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Kingscourt Nursing Home is a purpose built three-storey property on the outskirts of Chester city centre and close to local shops, doctor's surgery and other amenities in Hoole. The home provides care for up to 37 older people, some of whom require nursing care. All of the rooms are single occupancy and some have en-suite facilities. Thirty four people were living there at the time of our visit.

This inspection took place on the 7th and 8th of August 2017 and was unannounced.

Our last visit to the service was held in July 2015. Following that inspection we rated the service as Good. No breaches of regulation were identified during that visit.

The service did not have a registered manager. Our records found that whilst a manager had been in place since our last visit, they had not registered with the Care Quality Commission to become the registered manager. 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. The last manager had left earlier in 2017 and an interim manager was put in place to ensure continuity of the service. A new manager had been identified and their appointment was imminent. The registered provider must ensure that an application for registration is submitted to the Care Quality Commission.

Not all staff received regular supervision and group supervision through staff meetings had not occurred. This meant that individual accountability and progress in their role had not been discussed with all staff. We have made a recommendation about all staff receiving supervision.
Staff received training appropriate to their role.

The service was not providing a structured activities programme. While one had been in place in the past, people told us that there was not much to do in the day and in some cases relied on their own preferences or their families to assist in keeping active. We have made a recommendation in respect of reinstating a regular activities programme.

The interior of the building was in need of redecoration and refurbishment as wear and tear to internal doors and walls were noted. No firm plans were in place for when this would be achieved.

People felt safe living at Kingscourt. This view was echoed by relatives we spoke with. The premises were well maintained and this included items such as fire detection systems, lifting equipment and portable appliances. The premises were hygienic and clean.

A staff rota was in place. Staffing levels were maintained with annual leave and sickness being covered by members of the registered provider's own bank staff pool. It was anticipated that this use of bank staff was

temporary. Dependency levels were assessed by the manager and outlined that dependency levels were increasing within the service. This view was echoed by staff and relatives who were aware that people were becoming more dependent on staff to ensure that their needs were met.

Risk assessments were in place for people who used the service. These related to those risks faced by people in their daily lives such as malnutrition or pressure ulcers. All these had been completed and reviewed on a monthly basis. Where people were at risk from malnutrition for example, people had been referred to dieticians with weight monitoring increased.

Staff had a good understanding of the types of abuse that could occur and the action they would need to take if such incidents occurred. They had received training in this and were aware of how to raise concerns with external agencies.

Medication was safely managed. Medication was stored appropriately and audits in place to ensure that systems continued to be safely managed.

The recruitment of new staff was robust. Appropriate checks had been made on people's suitability for the role.

The registered provider included considerations of the Mental Capacity Act 2005 into the support they provided. The capacity of people to make decisions had been assessed and measures introduced to ensure that the best interests of people could be served.

The nutritional needs of people were met. Choices of food were provided and staff endeavoured to ensure that food provided was in line with people's preferences and nutritional needs. Drinks were provided to people at all times of the day. The health needs of people were taken into account. Any changes in the health of people were responded to immediately to ensure that their wellbeing was maintained.

People told us that they felt cared about. Observations of care practice found that people were supported in a friendly and respectful manner. The privacy of people was maintained during personal care tasks and staff were able to give practice examples of how this privacy was to be maintained.

Care plans were regularly reviewed and reflected the health and social care needs of people. Care plans were personalised.

A complaints procedure was in place informing people of how any concerns could be raised. Complaints records showed that the registered provider was responsive to any concerns raised.

The registered provider had ensured that the quality of support provided at Kingscourt had been assessed. The views of people and their families had been gained and the results put on display. A series of audits had been conducted to ensure that all systems within the home best served the people who lived there. The registered provider always told us of any adverse incidents that affected the wellbeing of people. The registered provider demonstrated a transparent approach to the standard of support within the service by displaying the ratings from our last visit.

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

People felt safe living at Kingscourt.

Staffing levels met the needs of people who used the service although there was awareness from the manager, staff and relatives that current staffing levels would need to be reviewed in light of the increased dependency of people.

The interior decoration of the building was in need of refurbishment. This had been identified by the registered provider.

Staff were aware of the types of abuse that could occur and the action to take if it was identified.

Is the service effective?

Good

The service was effective.

Not all staff had received one to one supervision to support them in their role. However, staff received the training they needed to perform their role

People who used the service and their families were complimentary of the skills staff had.
The registered provider took the principles of the Mental Capacity Act 2005 into account when assisting people to make choices about their lives.

The nutritional needs of people were met.

Is the service caring?

Good

The service was caring

People told us that they felt cared about and were supported in a respectful manner.

Staff interactions with people were positive and friendly with a focus on helping people make decisions for themselves.

Staff were able to provide us with practical examples of how people's privacy was maintained during support with personal care.

Is the service responsive?

Good

The service was responsive.

No structured activities programme was in place although efforts had been made to provide other activities.

Care plans met the needs of the people who lived at Kingscourt

A robust complaints procedure was in place and people felt confident that concerns would be listened to.

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Is the service well-led?

Requires Improvement

The service was not always well led. This is because the manager is not registered with the Commission and there has not been a registered manager in post since 2015.

People were complimentary of the service they received.

Relatives confirmed that they were always informed by the manager of any issues affecting their relation.

Audits were in place to check on the quality of the service provided.

Kingscourt

Detailed findings

Background to this inspection

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

This inspection took place on 7th and 8th of August 2017 and was unannounced.

The inspection team consisted of one Adult Social Care Inspector.

As part of our inspection, we ask registered providers to complete 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 improvements they plan to make. The PIR was returned to us when we asked.

Before our visit, we reviewed all the information we had in relation to the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service, comments, concerns and safeguarding information. Our visit involved looking at six care plans and other records such as four staff recruitment files, training records, policies and procedures, medication systems and various audits relating to the quality of the service. We also observed care practice within the service.

We spoke to four people who used the service and three relatives. We also spoke to the interim manager and four members of staff. During our inspection we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at information from the last visit made by the Local Authority Commissioning Team. They had not recently visited. We contacted the Cheshire West Healthwatch team. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. The team last visited in August 2016 and had identified some minor points for improvement.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Kingscourt. One person said, "I feel safe" another said, "staff are really good with us". This view was echoed by relatives who felt that the service had supported their family member in a safe manner. People told us that they always received their medication when it was needed and that this was never missed.

We looked at the staff rota. This included nursing staff, care staff and other ancillary staff. The registered provider employed their own bank staff to assist in covering any shortfalls in staffing throughout the organisation. Our visit noted that there was a mix of bank and regular staff on duty to cover sickness and annual leave. The manager had recognised this and had sought to recruit new staff and it was anticipated that there would less need to use bank staff in the near future. An allocation sheet was in place assigning two members of staff to each of the three floors within the building with nursing staff providing support for all. Ancillary staff also were on duty. Care staff levels had been increased in recent months to reflect an increase in the number of people who used the service.

Relatives we spoke with felt that dependency levels within the service were increasing. This was a view echoed by the staff team who focused on the increased assistance people needed with hoisting and the mobility needs of people. The manager was aware of this and had recorded dependency levels of people on a monthly basis. Records showed that there had been an increase in the dependency of many people in respect of their mobility, increased frailty or health issues that had affected people. There was no evidence during this visit that people's needs were not being met.

Our tour of the building noted that the interior decoration of the building was in need of refurbishment. Many corridor areas had paintwork on doors and skirting boards that had experienced wear and tear and as a result the internal decoration was in need of redecoration. This issue had been brought up through the internal auditing process earlier in 2017 and fedback to the registered provider The need for refurbishment had also been raised at the last meeting between the manager, people who used the service and their relatives. It had also been raised as an issue during the last Healthwatch visit in August 2016. Maintenance staff were employed at Kingscourt and were present on the day of our visit. Maintenance records of repairs were available and these indicated that repairs were addressed quickly.

Other records were in place relating to the health and safety of the premises. These included regular checks to fire detection and firefighting equipment as well as other checks to the building such as water temperature monitoring and legionella checks. There was evidence that lifting equipment such as portable and fixed hoists had been serviced every six months. Other items had also received servicing such as the passenger lift and also checks had been made on portable appliances and firefighting equipment. Risk assessments were also in place relating to the needs of people if an urgent evacuation of the building was needed. These included details of people's needs in respect of their mobility, barriers to communicating with people and the number of staff required to assist if people needed to be evacuated from the building in an emergency. All personal emergency plans had been reviewed this year and were available to staff in the foyer for quick reference if needed.

Other risk assessments were in place relating to the specific needs of people who used the service. These included the susceptibility people had to falls, risks faced by malnutrition, susceptibility to pressure ulcers and risks in manual handling. All risks were evaluated monthly with any changes recorded. The information was retained in care plans and meant that staff were able to promote the wellbeing of people who used the service.

The premises were clean with no offensive odours. The registered provider employed domestic staff within the service and these staff were seen attending to the cleanliness of the building throughout our visit. All areas were clean and hygienic. Domestic staff had access to sufficient personal protective equipment (known as PPE) such as disposable gloves and aprons and in turn these were used by care staff when supporting people with personal care tasks. There were sufficient stocks of PPE available for staff to use.

Staff demonstrated a good understanding of the types of abuse that could occur. In addition to this, staff were able to outline the action they would take if they witnessed or suspected abuse. Nursing staff were aware of the process for reporting any safeguarding issues to the Local Authority. The service reported, when needed, low level safeguarding incidents to the Local Authority. Low level concerns are any safeguarding concerns which put a person at risk of harm that does not meet the threshold of significant harm set down by external agencies. Staff confirmed that they had received training in safeguarding vulnerable adults and this was confirmed through training records. Staff were confident that the management team would report any concerns appropriately if allegations of abuse were raised. Staff were aware of how to report concerns relating to care practice to other external agencies such as CQC. Information was available for staff on how to do this.

Recruitment files indicated that the registered provider sought to ensure that people who used the service were only supported by people who were suitable to perform the role. Files indicated that new staff received a Disclosure and Barring check (known as a DBS). A DBS is a check made to see if people had been convicted of offences which would affect their suitability to work there. References in place as well as information confirming the identity of the individual. Interview notes were in place enabling the registered provider to make a judgement on the skills, values and experience of potential candidates.

Medication was safely managed. All medication was secured in either purpose built cupboards or within portable trolleys. Three portable trolleys were used by nursing staff and when not in use these were securely tethered. Separate lockable storage was in place for controlled medication. These are prescription medicines which are controlled under the Misuse of Drugs Act 1971. A controlled drug register was used to ensure that stocks of these could be accounted for. In addition to this, the register had been signed by two nurses to ensure accountability. We checked the controlled drugs register to ensure that actual stocks of medication held tallied with records. This was found to be the case.

Information was in place for those who required their medications to be managed by the staff team. This was linked to the individual preferences of people or through Mental Capacity Act assessments and best interests meetings. Nobody living at Kingscourt managed any aspects of their medication during our visit. Information was in place for Nursing staff to refer to in respect of how medication should be administered to each person. This included ensuring people understood what medication was to be given, receiving their consent and ensuring that a drink was available to assist people to swallow any tablets.

The temperature of areas where medication was stored was monitored on a regular basis throughout the day. In addition a refrigerator was available for those medications which required to be stored within an ambient temperature to ensure they remain effective.

Audits of medication systems were undertaken every month and stock checks were completed every day. The competency of nurses to undertake safe administration of medication was undertaken annually. A recent audit of medication systems had been undertaken by the pharmacy supplier and was found to be satisfactory.

Good

Is the service effective?

Our findings

People and their families told us that they were happy with the way the staff support offered support. People were positive about the food provided and they told us that they always got a choice. People told us that they were able to make decisions about their lives and with regard to the support that was offered to them. People told us that while they felt in good health; staff always sought to get a Doctor if they were not well.

Records indicated that staff one to one supervision meetings were not consistent. Records showed that while some staff had received one to one supervision, this had not applied to all staff. Some staff told us that they had received recent supervision while others had not. Where supervision had been carried out, this had been recorded. Some newer members of staff had not received supervision and had not had the opportunity to discuss how they had settled into their role. There was no evidence that staff meetings had occurred in 2017. This meant that the training and development needs of staff and their general performance within their role had been not discussed with all. We recommend that the service ensures that all staff receive supervision so that their performance is monitored and appropriate support given to them.

An induction programme for new staff was in place. Staff who were recently recruited to the service thought that this had helped them into their new role. People had commenced the Care Certificate as part of their induction. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

Records outlined the training staff had received. A training matrix was available which showed what training had been done and what was due. Staff told us about the training that they had received. This had included mandatory health and safety topics as well as dementia awareness and safeguarding. Registered Nurses had been provided with training linked to people's clinical needs such as catheter care and tissue viability. In addition, it is a requirement for registered nurses to provide evidence that they maintain their professional knowledge at the point that they re-register as nurses. They confirmed that the registered provider had supported them to do this.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Arrangements were in place to ensure that the registered provider was compliant with the Mental Capacity Act.

Staff confirmed they had received training in the MCA and were able to give a summary of how capacity should be taken into account and how the best interests of people could be determined in their support. There was evidence that when applicable, authorisations seeking restrictions on people in their own best interests had been sought from the local authority and all authorisations were in date.

On this visit, we looked at how the Mental Capacity Act had been incorporated into care practice. Staff told us that they had received training in this and were able to provide a summary of how people could be best assisted to make decisions. The capacity of people to make specific decisions had been included within care plans. Where people were considered to have the capacity to make decisions about their lives, evidence was in place outlining that their consent had been gained. Such consent covered areas such as the support they received and the management of their medication. Other people had been assessed as having limited or little capacity to make decisions relating to their care. Where this was the case, the registered provider had assessed capacity and then proceeded with best interests meetings on aspects of care. This ensured that the rights of people were upheld and that care practice was in their best interests.

The registered provider had applied to the local authority for a deprivation of liberty authorisation (known as a DoLS) for some individuals where appropriate.. Applications had been made and granted. A clear audit of authorisations granted was in place outlining the timescale when such authorisations would expire and trigger a process of re-assessing people's capacity.

The nutritional needs of people were met. The kitchen was a well-equipped and hygienic facility for the preparation of meals. All refrigerators and freezers were well stocked. The temperature of these was monitored on a daily basis to ensure that foodstuffs were stored correctly. A cleaning schedule was in place and records maintained for this. In addition, temperatures of cooked meals were also monitored. The kitchen staff had information on the nutritional needs of people. This included whether people were on diabetic diets, their personal preferences or whether their meals were to be presented to a softer consistency to assist them in eating.

A dining room was available and this was able to accommodate all the people who lived at Kingscourt although some people preferred to have meals in their room. Tables had been set with cutlery and condiments prior to lunchtime. Lunchtime was a relaxed time for people although there was a delay in serving the meal meaning that people had to sit and wait for some time before. The same was the case after lunch with people waiting some time before they could leave the dining room with staff assistance.

People had indicated their choice of lunch in advance although staff were able to remind people of their choices or the availability of alternatives if they had changed their mind. No-one required direct assistance with eating although one relative sat with their family member encouraging them to eat. Staff were on hand to assist with people's requests or in some cases to prompt or encourage people to eat. One person did not appear to be keen with their meal and an alternative was provided to them to their satisfaction. Hot and cold drinks were also made available to people and this provision of drinks extended to the rest of the day.

The nutritional needs of people were reflected within care plans. Personal likes and dislikes were recorded and given to the kitchen staff for their information. Some people had allergies to certain food and again this was highlighted. Risk assessments were in place relating to the risk people faced from malnutrition. All care plans included a malnutrition risk assessment (known as a MUST assessment). This outlined consideration that staff needed to take into account to ensure that nutrition was maintained. All these assessments were updated on a monthly basis. Some records indicated that people may be at more risk. In these cases, weight was monitored on a weekly basis as opposed to a monthly basis in line with the recommendations of the risk assessment as well as the recommendations of dieticians. Where a risk had been noted, a referral had been made to the dietician team to help people gain weight.

One person had a PEG feed. This is a procedure whereby a tube is placed in a person's stomach wall so that nutrients can be given. This is a surgical procedure and is done in situations where a person is at risk from eating orally. Following a review from the Doctor and dietician, it was agreed that this person could have a

trial period of eating some meals normally provided it was limited and was a softer diet. The manager told us that this had been successful although the PEG tube would remain. The inclusion of a PEG tube required attention to be paid to ensuring that the area where the tube was fitted was kept hygienic at all times and that records of nutrition were maintained. Records indicated that this was done on a regular basis.

Other records indicated the amount of food and fluid people were receiving day to day so that risks of dehydration could be eliminated. These records were up to date and were evaluated.

Records were maintained to monitor the health of individuals. When health issues arose, people were referred to the appropriate medical agencies such as doctors, hospitals, dieticians or opticians. Registered Nurses within the service routinely monitored the general health and people through making observations relating to blood pressure, heart rate and blood sugar levels. Risk assessments were in place to monitor people's risk of developing pressure sores. Those at risk were provided with pressure mattresses and other aids to prevent pressure sores from occurring. One person had acquired a pressure sore following an admission from hospital. Steps were taken to ensure that their care plan outlined how this was to be treated and monitored.

Good

Is the service caring?

Our findings

People who used the service told us that, "[Staff] are great" and "I feel cared about". Relatives we spoke with considered that they staff team did their best to look after their relations in a caring and positive manner. Relatives felt included in the care that was offered to their relations and told us that they could visit at any time and were always made to feel welcome. One person who had come to live at Kingscourt in recent weeks felt that the staff team had made them feel welcome and as a result they had settled into life there "very well".

Observations of care practice found that staff interacted with people who used the service in a supportive, patient and caring manner. People were always provided with choice about how they wished to be supported. People were assisted in an unhurried manner with staff taking time to provide information to people about their support and how this support was to be provided. Staff communicated with people in a way which took their communication needs into account. For some people who had difficulty in hearing, for example, staff took the time to sit down next to them and speak clearly so that they could be understood.

Staff care practice promoted the privacy of individuals. Staff knocked on bedroom doors before entering and always ensured that doors were closed when supporting people with personal care. Staff at all times asked people how their health was and what they wanted to do.

Staff were able to give us practical examples of how they would promote people's privacy during support with personal care. This included practical matters such as ensuring that doors were closed at all times, that staff knocked on doors before entering and asking people what clothes they wished to wear. One member of staff raised the issue of the preference in respect of the gender of staff in intimate personal care tasks. The preferences of people in respect of the gender of people supporting them were outlined clearly in care plans.

Staff sought to ensure that people were as independent as possible. Some people were able to mobilise independently or with the assistance of mobility aids such as zimmer frames or motorised wheelchairs. This independence extended to eating at mealtimes with staff only intervening if they felt people would benefit from some assistance without taking their independence away. The independence of people in daily tasks was outlined in care plans. This provided information that staff should be mindful of encouraging people to assist in those tasks that they may be able to do themselves without support.

Information was provided to people either in written form or through verbal communication. This included assisting people to make choices in respect of where they wanted to sit at lunch, what they wanted to eat or what drink they wanted. The opportunity to make decisions for themselves was seen in staff interactions and staff were patient in waiting for a response.

Rooms were personalised in line with the tastes and wishes of each individual. People were able to include personal items such as photographs and ornaments in order to make them feel at home

Good

Is the service responsive?

Our findings

People and their families told us that they were happy with the care they received. They told us that they were aware of how staff were to support them with their needs and for relatives. They confirmed that important information or changes to their relations' health was always passed onto them. People had not had to make a complaint but were aware of who to speak to and felt confident that their concerns would be addressed.

The registered provider had employed an activities co-ordinator but they had not been available for a few months. As a result no structured activities programme was in place during our visit. The manager had sought to arrange some activities yet acknowledged that this had been an ad hoc arrangement which had meant that some key activities, including a summer fayre, had been cancelled. People who used the service told us that there was not much to do in the day although some were able to pursue their own activities. Past activities had occurred and were displayed in photographs in the main hallway. Records and care plans highlighted the social needs and interests of people yet current circumstances meant that these needs were not always being met. It was also acknowledged that the increasing dependency levels of people meant that care staff had to concentrate on this support role and were unable to arrange activities. We recommend that the service makes arrangements to ensure that regular activities continue.

Assessment information was in place prior to a person coming to live at Kingscourt. This included information form the agency that referred the person to the service such as a hospital or a local authority. This information enabled the staff team to conduct their own assessment on the main health and social needs of individuals. These assessments contained relevant information about all aspects of a person's daily lives as well as the degree of support they would need.

Once assessment information had been completed, the information was then translated into a plan of care. Care plans covered all aspects of people's lives. Some care plans related to needs that people would have for some time while others were short term care plans. These short term care plans covered temporary health issues such as infection or the acquiring of pressure ulcers and contained detailed information on what staff needed to do to assist in people's recovery. Some care plans had been re-written to ensure that the information was accurate and that people needs could be fully identified.

Care plans were person centred and included information on what people could do for themselves independently with prompts. This information was available for the staff team to ensure that people's independence could be maintained. Consideration was given to ensuring that people's privacy was maintained. Care plans had been reviewed monthly with any changes resulting in a change to the care plan. In addition to this, where possible, the contents of the care plans were agreed with the person themselves. Care plan audits were conducted to ensure that all relevant information was in place. Daily records supplemented care plans. These indicated the progress of each person for each day.

A complaints record was available. This was on display and outlined information people needed to make a complaint, who to speak with and the timescale for investigation. Complaints records were available

indicating the nature of the complaint and the action to address each concern to the satisfaction of the complainant. Our records indicated that one complaint had been received by the CQC relating to the service. This had been passed on to the registered provider and action was taken using the complaints procedure as a result.

Requires Improvement

Is the service well-led?

Our findings

People told us that they were happy with the service provided and considered that the service was well run. Relatives told us that the management team had always sought to communicate with them and provide information to them about the support provided to their relative.

Kingscourt did not have a registered manager. An interim manager had been put into place following the last manager leaving the service earlier in 2017. Our records identified that the last manager had not been registered with CQC and that no application had been forwarded to us. This meant that the service had not had a person managing it who was accountable and who could seek to ensure that the regulatory responsibilities of the service were maintained. A new manager had been identified to manage Kingscourt by the registered provider and their appointment was imminent. The service must ensure that the manager applies for registration with CQC.
Staff told us that the manager was approachable and supportive and the manager was very thorough in their approach in ensuring that the quality of support met people's needs.

We found that the decoration of the interior of the building needed to be refurbished. Internal paintwork had been damaged and work was needed to the front of the building in respect of loose paving stones on the driveway. The latter point had been reported by Healthwatch during their visit in 2016. The interim manager stated that they were aware of the need for refurbishment yet there was no clear evidence of timescales for this to be completed. This had also been identified in the registered provider's internal audits.

The service had an activities programme with an activities co-ordinator employed to carry this out. The activities co-ordinator was not available and had not been for some time through sickness. While some activities had been arranged on an ad hoc basis; no temporary arrangements had been made to cover this absence and to ensure that people who used the service received appropriate activities.

The registered provider had a number of measures in place to assess the quality of the service provided. Surveys had been issued to relatives, people who used the service and staff earlier in 2017. These had been reviewed by the manager and the results of these had been put on display for people to refer to. Other checks included evidence of visits by a representative of the registered provider. A report had been issued following these visits outlining areas of positive practice as well as those areas for improvement. The manager was required to complete a monthly report on any issues within the service.

Other audits were in place in relation to falls, accidents, dependency levels and medication. Where an accident had occurred, a risk assessment had been completed outlining the seriousness of the issue and whether remedial steps were needed to be taken. Statistics were available enabling the manager and registered provider to analyse whether there were any trends or patterns with incidents and steps that could be taken to prevent future accidents. Dependency levels were monitored on a monthly basis. These provided the manager and registered provider with the information they needed to assess whether staffing levels needed to be adjusted therefore enabling the needs of people to be met.

Other audits included health and safety audits, audits in respect of the hygiene standards in the building and medication. Medication audits were conducted monthly with an on-going stock check of medication being conducted daily. Staff meetings had taken place in the past but these had not occurred for some time. The last residents/relatives meeting had occurred in April 2017. Relatives told us that these had been very beneficial and felt that meetings needed to be more frequent. A schedule of care plan audits was in place. As well as care plan evaluations, the care plan audits enabled the manager to identify whether these documents continued to meet people's needs.

Our records showed that the registered provider always informed us of any significant incidents that adversely affected the wellbeing of people who used the service. Included within the service's audit process was reference made to whether an incident or event was reportable to CQC.

We last visited the service in July 2015. At that time we rated the service as good. In line with requirements, the registered provider had ensured that this rating had been put on prominent display for people to refer to.