The Orders Of St. John Care Trust

OSJCT Townsend House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 1 and 2 September 2016 and was unannounced. Townsend House provides accommodation for 40 people who require personal care with nursing. There were 29 people were living in the home at the time of our inspection. The home provided personal care and support for people with residential and nursing needs.

Townsend House has a large lounge/dining room area and a variety of lounges and quiet areas to sit in. Most rooms and bedrooms are set on the ground floor with eight bedrooms upstairs which are accessible by a lift or stairs. The home has a hairdresser and offers a day centre service.

A registered manager was in place as required by their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People told us they enjoyed living at Townsend House. Relatives were complimentary about the caring nature of staff. Staff approached people in a kind and caring manner. Staff ensured people received care and support in accordance to their preferences and needs. Their privacy and dignity were respected.

The home was generally clean however we found the cleanliness of some toilets and people's equipment had not been maintained while the housekeeping staff were not on duty. We have made a recommendation about the arrangements to manage the cleanliness of the home.

People's care and support needs were documented. People were supported by staff who respected their human rights and encouraged them to make decisions about their care. However, there were limited recorded assessments of people's mental capacity where people could not make significant decisions about their care or agree to the care being provided. Plans were in place to update people's care records to ensure they reflected their present needs. We have made a recommendation about how the service records and obtains people's consent to their care.

People benefited from staff who understood and were confident about using the whistleblowing procedure. Staff were confident about recognising and reporting suspected allegations of abuse. There were safe systems in place to manage people's medicines. People received their medicines on time by staff who were trained to carry out this role. People's care records showed relevant health and social care professionals were involved with people's care. Peoples nutritional and hydration needs were appropriately assessed and monitored. Specialist diets were catered for. Opportunities to take part in activities were available most days.

Staff told us they felt supported and well trained. Plans were in place to ensure that staff received regular

support and address any shortfalls in their training. Staff felt the staffing levels to support people had improved. The registered manager was actively recruiting new staff. Safe recruitment practices where followed to ensure suitable staff were employed.

Quality monitoring systems were in place to check and address any shortfalls in the service. People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Complaints were taken seriously and acted on.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some parts of the home were not consistently cleaned.

Staff were safely recruited. Staff knew how to recognise and report abuse. People's medicines were managed well. Their risks were suitably identified and monitored.

Is the service effective?

Requires Improvement

The service was not always effective.

People who were able were involved in making decisions about their care and support. However, there was little recorded evidence of the assessments of people who lacked mental capacity to consent to their care or make specific decisions.

Records indicated that people had been referred to the appropriate health and social care professional when needed

People were supported to maintain a balanced diet.

Staff received training and support that helped meet people's needs.

Is the service caring?

Good

The service was caring

People's needs were met by kind and caring staff.

Staff ensured people's dignity, privacy and independence was promoted.

Is the service responsive?

Good

The service was responsive.

People's care records provided detailed information about how people's needs should be met.

People and relatives were confident that any concerns they had would be dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

Systems were in place to monitor and improve the quality of care people received.

The registered manager and senior staff were described as supportive and approachable.

OSJCT Townsend 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.

This inspection took place on 1 and 2 September 2016 and was unannounced. The inspection team consisted of an inspector and an expert by experience. 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 had experience and knowledge of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the home and observing how staff interacted with people. 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 talk with us.

We spoke with nine people and three relatives and visitors. We looked at the care plans and associated records of five people. We also spoke with six care staff, the registered manager and a representative of the provider. After the inspection we spoke to the head cook, the activities coordinator and the head nurse by telephone as they were not available on the days of our inspection. We looked at eight staff files including the recruitment procedures and the training and development of all staff. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires Improvement

Is the service safe?

Our findings

On the morning of the second day of our inspection we inspected the facilities of the home in more detail. Whilst the home was generally kept clean and odour free, we found four toilet seats soiled with dried faecal matter. Some bathrooms were untidy with storage cupboards being left open, laundry bags on the floor and pieces of equipment were being stored in the bathrooms which could be hazardous to people. We also observed that the tray attached to two people's walking frames were dirty. We revisited the bathrooms several times during the rest of the inspection and found that the toilets had been effectively cleaned and were being maintained. We raised this with the registered manager who told us the home had two housekeeping staff who worked in the mornings and they had just recruited a new housekeeper to help with cleanliness in the home. We were told that care staff also had a responsibility to maintain the cleanliness of the home especially when the housekeepers were not on duty. The registered manager told us this would be immediately raised and reinforced with staff. We revisited the bathrooms several times during the rest of the inspection and found that the toilets had been effectively cleaned and were being maintained.

We recommend that the service seeks guidance from a reputable source to ensure the safe and effective management of and arrangements for preventing and controlling the spread of infection.

Staff wore the appropriate personal protection equipment such as gloves and aprons when they supported people with their personal needs to reduce the risk of cross contamination. People were given hand sanitiser wipes before their lunch to wash their hands. We saw housekeeping staff cleaning communal areas and people's bedrooms and bathrooms. We inspected the kitchen and saw that schedules were in place to ensure the cleanliness of the kitchen was maintained.

The level of staff on duty was determined by the number of people who lived in the home and their individual needs. The registered manager completed a dependency and capability tool each month which informed them of the required staff which were needed to support people with their direct care needs.

Prior to our inspection, we received information of concern about the home's staffing levels and their ability to meet people's needs. On speaking to staff they told us that the staffing levels 'had been an issue a few months ago' due to the high support needs of people and staff sickness. Staff commented that the needs of people being admitted to the home had been high and this had impacted on their work load and they had felt under pressure. One staff member said, "We have needed more staff, a lot of new residents needed two carers to support them. We went through a bad time a couple of months ago." One person shared with us, "The staff are good, they are hardworking but under a lot of pressure at times." However, staff mainly felt that the staffing levels at the time of our inspection were adequate to meet people's needs. One staff member said, "Staffing is a struggle at times, we've been short staffed at times but it has improved now."

The staff rotas of August 2016 showed that there was mostly sufficient staff on duty to meet people's needs. Where there had not been enough staff to meet the desired staffing levels of the home, the registered manager had requested agency staff to fill in any shortfalls. Some agency staff were used regularly as there had been several staff vacancies in the home. People and staff knew them well and they were familiar with

the home's procedures. The registered manager also helped to support people if required. They had recently completed a course in the management of medicines so they could assist with the administration of people's medicines when required.

The registered manager regularly requested and audited the staff response times to people requests for assistance using the call bell system. The monitoring identified if there were any patterns or trends emerging which required investigating or actions. The call bell audits showed the majority of times, staff had responded to people requesting assistance within the timeframes the provider expected. Where the timeframe exceeded the desired response times, the registered manager had investigated into the cause of the delay and taken appropriate action.

During our inspection there were enough staff suitably deployed to meet people's needs. We observed that the general staff approach was caring and kind but most of the interaction from staff was limited to supporting people with their personal needs. Staff chatted to people when supporting them but there was little time to socially interact with people.

The home had several staff vacancies. The registered manager explained that recruitment in the local area was difficult; however they had successfully recruited two new staff members who were in the middle of their induction period at the time of our inspection. Plans were also in place to interview prospective candidates the following week. The registered manager told us they were actively advertising for additional qualified nurses and a new head nurse as the current head nurse was stepping down in their role.

We concluded that whilst there was enough staff to meet people's needs during our inspection, there had been issues regarding the staffing levels due to sickness and unplanned leave in the past as well as an increased number of dependent people being admitted to the home. However the registered manager was aware of the issues around staffing and was actively recruiting and inducting new staff.

People were supported by staff who were deemed to be suitable to carry out their roles and of good character. New applicants were required to apply for employment at the home via the provider's new on-line recruitment system. We were told there had been a few teething problems with the system which were being addressed. The registered manager reviewed all applications and associated recruitment documents on line. Background and criminal checks were completed via the Disclose and Barring Service before new staff worked with people. Any queries regarding their previous employment or irregularities were discussed during their interview.

Risks to people had been individually assessed. People's care records contained detailed risk assessments including risks associated with moving and handling and falls. Their records gave staff guidance on how to mitigate the risks. Staff were able to tell us about people's risks and how they were being managed. For example, one person was experiencing frequent falls. We heard staff discussing the possible cause of their falls and the actions they planned to take including seeking advice from their GP and other health care professionals. The registered manager audited and analysed information about falls in the home. They told us actions would be taken if any patterns or trends emerged as a result of the analysis.

Some people had been assessed as being at risk of developing pressure areas. Plans and guidance were in place to help mitigate the risks such as the use of appropriate pressure relieving equipment. For example, repositioning charts were being used and completed where people needed support to be turned to prevent pressure areas. People's weight was monitored and checked monthly. Staff monitored people's food and fluid intake where people had lost a significant amount of weight.

We found the building and environment had been maintained. Maintenance staff carried out regular safety checks around the home. Fire safety equipment and alarms were regularly checked and tested. Each person had a personal emergency evacuation plan. Other safety checks on the home's utilities, water, and lifting equipment had been completed.

People's medicines were managed safely. Systems were in place to order, check in and sign for people's prescriptions. All unused medicines were disposed of appropriately. People's medicines were stored safely. The temperature of storage areas including fridges were checked and monitored daily. People's medicines records showed people had received their medicines correctly and did not contain any gaps. Codes indicated when people had refused their medicines. Protocols were in place for people using 'as and when required' medicines to guide staff when the person might need them.

Staff who were responsible for administrating people's medicines had been trained to do so. They all were required to carry out an online training course and score full marks in a test at the end of the course. Principle Designated Person (PDP) for medicines was in place. This person had advance knowledge in the management of people's medicines. They met with PDP's from the providers other homes to discuss concerns and trends around medicines and discuss better ways of working when managing medicines.

People benefited from a service where staff understood that people should be protected from harm and abuse. Staff understood their responsibilities to report and record any concerns or allegations of abuse. Staff confirmed they received regular training in safeguarding and protecting vulnerable people. They were familiar with the home's safeguarding policies and procedures. The registered manager was aware of their responsibility to report or discuss safeguarding concerns with the local authority and notify CQC. Staff told us they would be confident to whistle blow if they had any concerns. A whistle blower is a person who raises a concern about a wrongdoing or poor practices in their workplace. People told us they felt safe living at Townsend House. One person said, "I feel very comfortable here. They have helped me a lot." Relatives also praised the staff and felt their family members were safe living at the home.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some people had the capacity to consent to the care and support they received and make decisions about their day. However, some people had been identified as not having the mental capacity to make significant decisions or were unable to consent to aspects of their care. We observed staff supporting people to make day to day decisions such as choosing their meals or the clothes they wished to wear. Information about their day to day needs and preferred choices were detailed in their care plans to guide staff when acting in their best interest. However there was limited recorded evidence that people's mental capacity to make specific decisions had been assessed when staff had acted in people's best interest.

Of the care records inspected, two people had consented to having bed rails when they first moved into the home when they had the mental capacity to make this decision. However, whilst records showed the assessment of their need for bed rails had been reviewed, there was no evidence that people's mental capacity had been reassessed to consent to the bed rails being in place. This meant the home had not reviewed if the person could lawfully consent to the continual use of bed rails being in position before a best interest decision was made. There was no evidence that another person had consented to a sensor being placed under their chair cushion or recorded evidence that the cushion was being used in their best interest in accordance with the principles of the MCA.

We raised our concerns with the registered manager who said they were aware of that more work was required to assess people's mental capacity and consent to the care being provided. We were told this would be addressed through the review of people's care plans to ensure there was recorded evidence that people's consent to their care was in line with the principles of the Mental Capacity Act.

We recommend that the service seeks advice and guidance from a reputable source about supporting people to make decisions and recording people's consent to their care lawfully.

Whilst plans were in place to address the record of obtaining people's lawful consent; we require the home to be consistent in their practices over time. We will check this during our next planned comprehensive inspection.

Staff had a good understanding in the importance of respecting people's rights and helping them to make choices about their day and work within the principles of the Mental Capacity Act. They were able to give us examples of how they supported people in line with the principles of the Act. For example, we observed staff supporting and encouraging people to make choices and act in their best interest.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had identified if people were being deprived of their liberty and had applied for authorisation to do this in accordance with the legislation around DoLS. The registered manager had identified a number of people who they believed were being deprived of their liberty while living at Townsend House and had made DoLS applications to the local authority and were waiting for the outcome.

People were supported to eat a well-balanced diet and drink enough fluids. We received mixed comments about the variety of food. The majority of people said the food provided was good and their diets and preferences were catered for, whilst a couple of people told us the selection of meals provided was limited. For example one person said, "The meals are really good" however another person said they enjoyed the meals but told us the menu was very repetitive. We were told that there was a four week rolling menu which changed twice a year which were reviewed quarterly to allow for seasonal variations. Notice boards and menus on the tables provided people with information about the choice of food each day. Kitchen staff were made aware of people's preferences of food, meal choices and special dietary needs. They were kept informed by care staff if people nutritional needs had changed such as requiring additional calories if people had lost weight. One person was offered an alternative to the meals provided on the day of our inspection due to their dietary needs. They were offered a choice of three soups. We observed people were offered a selection of fruit or biscuits with their mid-morning hot drink.

Some people chose to eat in the dining rooms while others preferred to eat in their bedrooms. Throughout our inspection we checked on some people who spent most of the day in their bed due to medical reasons. We observed people had been left with drinks within easy reach of them and were assisted at meal times to eat their meals. A representative of the provider who specialised in supporting people with dementia had recently observed the dining experience of people who ate in the dining room. Overall their feedback to the registered manager was positive.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Communication from health care professionals was recorded and acted on. Staff had good connections with two local surgeries. Qualified nurses were knowledgeable in supporting people who were nearing their end of life. They told us their aim was to ensure that a clear plan of support was recorded to give staff guidance of the measures to be taken and symptom control when people were being supported in the last few days of their life. People who were supported to access specialist health care professionals to ensure they remained comfortable and pain free.

People received care and support from staff who had the skills, knowledge and understanding needed to carry out their role. New staff were required to attend an intensive seven day induction programme, including shadowing experienced staff in the home and understanding the provider's polices and the home's procedures. They were also trained to gain a basic knowledge in skills related to their role such as safeguarding, first aid and moving and handling. There was an expectation that new staff were required to complete the care certificate alongside their induction training within the first 12 weeks of employment where possible.

The registered manager had reviewed the training needs of all staff. Records showed that staff had been booked on training where gaps had been identified in their training. The skills and competency levels of staff to carry out their role was regularly checked and observed. Plans were in place to provide additional training to support the provider's mandatory courses such as end of life. Staff told us they felt supported and trained to carry out their role. One staff member said, "Training is always good here. We get plenty of support." This

view was confirmed by other staff who we spoke with.

We looked at five staff files. The files showed that staff had not always received regular supervisions during a period of time when there was no permanent manager in post. However the new registered manager had reviewed the structure of the supervision process and records showed staff were now having the adequate numbers of supervisions in line with the provider's policy. The provider was reviewing the culture and methodology of staff support. We were told a new process of supporting staff would soon be implemented which will encourage staff engagement and assist them in setting their own objectives. Staff who were responsible for supervising others would be trained in the new approach.

Good

Is the service caring?

Our findings

Townsend House supported people with varying degrees of mental and physical health needs including people who live with dementia. Many people had moved in to the home from the local area. We spoke with several people in the home although some people were not able to express their views and experiences about living in the home. However, people were generally positive about the care they received. We received comments such as, "The staff are very nice to me"; "It's lovely here" and I'm treated very well, they are all so kind." and "The staff look after us very well. They are kind."

Throughout our inspection we heard positive and respectful interactions between people and staff who were supporting them. Staff showed concern for people's well-being in a caring and meaningful way. For example, we heard one person telling staff that their feet were cold when sitting in the dining room. Staff offered to get them a pair of socks and helped them put them on. Another staff member was quick to respond when they saw a person sliding down in their chair. They reassured the person and helped them into a better sitting position.

Staff respected people's dignity. For example, we saw staff helping people to adjust their clothing if they became dishevelled. Staff placed a blanket over a person's lap when they were being hoisted in the lounge to maintain their dignity. Staff knocked on people's doors before they entered and waited to be invited in. We heard staff reminding people of their names and explaining why they were in their bedrooms.

Staff knew people well. We saw staff chatting with people and sharing a joke. Staff reassured people and complimented them. For example, we heard one staff member say to a person "So nice to see you smiling." Another staff member complimented them on their clothes. Staff gave people choices and asked their opinions such as whether they would like the curtains in their bedroom opened or not. People were given a choice whether they wished to be supported by a staff member of the opposite gender.

People and their relatives confirmed they had been consulted about their care. . People said that staff were aware of their individual support needs and how they liked to be supported. Relatives were positive about the care their family members received. They told us staff were friendly and approachable. They were welcomed to visit the home at any time. Some relatives had written to the home expressing their gratitude about the care the home provided.

Staff told us how they promoted people's independence while also ensuring they were available if people needed support. We saw staff observing people from a respectful distance and only intervened when they felt the person needed support such as assistance with standing.

Staff understood people's individual way of communicating. Information about how people communicated was in their care plans. For example, the care plan of one person who had complex health stated they needed to wear their glasses and hearing aid. We found the person sat up in bed wearing their glasses and hearing aid. A call bell had been left on their lap to alert staff if they required assistance.

Some people enjoyed visiting the hairdresser in the home twice a week. Information and notice boards were up to date and provided people and their relatives with details about the home, events in the community and external agencies such as advocacy services.

Good

Is the service responsive?

Our findings

The home had an activities coordinator who supported people with their interests and activities. They were employed to organise and facilitate activities in the home and the community during the week, alternative weekends and occasionally in the evenings. People were provided with opportunities to engage in meaningful activities when the activities coordinator was on duty. We were told that they aimed to plan two group activities per day and tried to see people in their bedrooms at least once a week. The activities coordinator ran several clubs such as a gentlemen's club and tea table chats. They had strong links with the local community such as the local school and church and arranged for groups to visit the home as well as supporting people to attend local groups such as art groups. People sometimes joined in activities which were ran in the home's day centre as choir singing. A notice board provided people with information about activities provided in the home which included external entertainers and visitors of interest, such as fitness instructor, music entertainers. Regular newsletters were produced informing people of photographs and write ups of future and past events.

Documents called 'All about me' had been completed for most people which informed staff of people's backgrounds, hobbies and social interests. The activities coordinator told us they used this information to talk to people and plan activities especially if they working with people on a 1:1 basis. We received mixed views about the level of activities in the home. Most people were happy with the activities provided. One person said, "Yes there is enough going on. I can join in what I want." However a couple of people told us they occasionally became bored. One person told us they sometimes joined in with chores around the home such as folding napkins or pairing socks. The activities coordinator told us they left a selection of simple activities which staff could quickly pick up and do with people if they were not on duty; however records did not always indicate whether staff had socially interacted with people. This meant there was an inconsistent approach in the level of activities provided. However we saw a volunteer facilitating a small group activity on one of the days of our inspection when the activities coordinator was not on duty.

People's needs had been assessed before moving into the home. Information gathered at their initial assessment had informed their care plan. People's care plans informed staff about people's care needs, goals and support requirements in areas such as mobility, eating and drinking and communication. All staff were knowledgeable and up to date with the present needs of people. For example, Staff were aware of the actions being taken to address any changes in people's health and well-being such as losing weight or experiencing a fall. Tools were being used to monitor people's risks such as their weight or eating and drinking intake. People's care plan and risk assessments were reviewed monthly.

However, we found the details and consistency of the quality of information in people's care plans was variable. Whilst people's progress was evaluated monthly, we found on two occasions the person's support needs and risks had improved however their care plans did not reflect their reduced support requirements. One staff member explained that as a result of agency staff being used in the home, people's care plans had not always been updated accurately. They said, "We used a lot more agency staff a couple of months ago and they do their best to update the care plans but they don't always know what the expected level is."

The quality and compliance manager and area manager had carried out an audit of people's care plans and recognised that some care plans required improvement. They had formed an action plan to address the quality of people's care plans and they were now in the process of reviewing and updating everyone's care plans. Plans were in place for senior staff to update two care plans per month and for the registered manager to regularly monitor and audit as sample of care plans each month.

The registered manager had been responsive to people's views and experiences. For example, some people had requested that they wished to eat in a smaller dining area. This request was respected and had been organised.

People and their relatives had opportunities to express their views about the home. They were able to share their views and experiences on-line or by submitting ideas in a suggestion box held in reception. They also had the opportunity to attend the home's resident and relatives meetings.

The home had a complaints policy and procedures. The registered manager told us people's concerns and complaints would be listened to, taken seriously and addressed. Since being in post the registered manager had received two formal complaints from relatives about the quality of care being provided. Records showed that the complaints had been dealt with in line with the provider's policy. The provider had recently sent people a survey to complete to evaluate people's experiences of living in the home. The collation of the results was not yet available to the registered manager, but we were reassured that any good practices and shortfalls in the service would be reviewed and acted on.

Good

Is the service well-led?

Our findings

The registered manager had been in post since September 2015. They told us their main challenges since being in the role of the manager of Townsend House had been staff recruitment and familiarising themselves with the providers and local authority procedures as they had previously worked for another organisation out of county. They had subsequently sought advice from representatives of the provider regarding local systems and the provider's processes and were in the process of recruiting new staff.

The registered manager took an active role within the running of the home and had a good knowledge of people living there. They were flexible and often worked in the evenings which gave them the opportunity to meet relatives and gain a clearer understanding of how the home ran. People also said the registered manager was regularly seen around the home. One person described the registered manager as 'very hands on and approachable'. Most staff also described the registered manager as approachable. One staff member said, "He (the registered manager) is good, you can always talk to him if there is a problem and he is often around about the home." Staff said the registered manager and nurses were always available to discuss any concerns or to give advice and support. One staff member said, "I love my job, I love the residents and we are a great team." From our observations and discussions with staff, they interacted well with their colleagues at all levels and had a good understanding of people who lived in the home.

The provider had recently carried out an employee engagement survey to check the morale and well-being of staff. As a result of the survey an action plan had been developed to address staff concerns and improve the engagement of staff such as increasing the number of staff meetings and to hold informal 'drop-in opportunities' with the registered manager to discuss any issues. We were told the provider's values were reinforced at staff meetings. The registered manager was implementing a new approach as a result of their knowledge of managing other care homes to improve the experiences of people living at Townsend House. Their plan was to engage and consult with staff and people about the home's internal and external environment and activities. The registered manager told us they were trying to change the culture of the home by empowering staff to make suggestions and supporting them to make changes to improve the quality of care being delivered as well as increasing their confidence and skills in their role.

There were good systems in place to ensure the home was running effectively and meeting the needs of people at the time of our inspection. A range of policies and procedures were made available to the staff to give them guidance about expected practices. Quality assurance audits conducted by the registered manager, senior staff and the provider provided an oversight and awareness of the quality of the service being provided such as audits of people medicines, people's care records and reportable incidents such as accidents and safeguarding concerns.

The provider carries out robust quality audits of their homes annually. The last audit of Townsend House was positive. We were told that head of departments used relevant parts of the provider's audit tool to self-assess their own departments. For example, the head of maintenance uses aspects of tool that relate to the safety of the home's environment to identify shortfalls. Representatives from the provider also carried out unannounced spot checks at the home. They shared with us their findings of a recent night visit to the home.

The registered manager had regular support from the provider's area manager and told us they were contactable and approachable. They received regular and continual support. They had assisted the registered manager to carry an audit of people's care plans. The results of the audit had fed into the home's action plan. We were told that aspects of the audit would also be discussed with staff who were responsible for updating and writing people's care plans. The registered manager also worked with external health care professionals as well as attending internal managers meeting to keep updated and ensure staff were following best practices.

Accidents and incident which occurred in the home were recorded and reported in line with provider's policies. The reports were reviewed to identify any patterns or trends. The registered manager said, "There is definitely an open culture of reporting errors in staff practices such as medicines errors." They explained that any accidents and incidents were reviewed and additional measures were put in place to reduce the risk of further incidents.