Bupa Care Homes (AKW) Limited

Erskine Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This comprehensive inspection took place on 23 and 24 November 2017 and was unannounced.

Erskine Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Erskine Hall Care Home accommodates up to 85 people in one purpose built building. At the time of our inspection there were 46 people living at the service.

At our last inspection in November 2016, the service was rated Requires Improvement.

At this inspection, the service remains rated Requires Improvement.

The service had a registered manager however they were no longer in post. A new manager had been appointed and had been in post for a period of six weeks. 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.

Quality assurance systems had not been consistently implemented to evaluate and monitor the quality of the service. However, since commencing work at the service the manager had completed a range of quality monitoring audits and these were being used to identify where actions needed to be taken to drive improvements in the service. Feedback on the service was encouraged and acted upon.

A potential safeguarding concern had not been referred to local authorities. Staff told us they understood their responsibilities with regards to safeguarding people and they had received training.

People felt safe and secure in the service. There were personalised risk assessments in place that offered guidance to staff on how individual risks to people could be minimised. Medicines were stored appropriately, managed safely and audits completed.

There were consistent numbers of staff on duty to meet people's needs however people told us that they experienced some delays in receiving their care. Robust recruitment processes were in place and the required recruitment checks had been completed to ensure that staff were suitable for the role they had been appointed to prior to commencing work.

Staff received training to ensure they had the skills and knowledge to support the people living in the service. Staff felt supported in their roles and received regular supervision. New members of staff received an induction. Staff were positive about the training they received.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People had been in involved in deciding the way in which they wished to receive care. People's consent was gained before any care was provided.

A varied, balanced diet was offered at the service and people were complimentary about the meals provided to them. People's health care needs were being met and they received support from health and medical professionals, when required.

People and their relatives spoke positively about staff. They told us that staff were caring, kind and respectful. People's privacy and dignity was promoted throughout their care.

People's needs had been assessed prior to their admission to the service. Care plans took account of people's individual needs, preferences and choices and had been regularly reviewed.

People were encouraged and supported to participate in a range of activities and received relevant information regarding the services available to them.

There was an effective complaints system in place. People and staff knew who to raise concerns with and there was clear line of accountability amongst senior staff.

People, relatives and staff spoke positively about the manager. The management team were approachable and were a visible presence in the service.

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 always safe.

A potential safeguarding concern had not been referred to relevant authorities.

People felt safe and secure living at the service.

Detailed risk assessments were in place to help protect and promote people's safety and well-being.

Staffing levels were sufficient to meet people's needs and robust recruitment procedures were in place.

Effective arrangements were in place for the safe management of people's medicines.

Is the service effective?

Good

The service was effective.

Staff training, supervision and support from senior staff equipped staff with the knowledge and skills to provide the care and support people required.

People's consent to the care and support they received was sought.

People were supported to access the services of health care professionals to meet any on-going healthcare needs and to ensure their well-being.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind, caring and respectful. People's privacy and dignity was respected and promoted by staff.

Staff were aware of people's preferences and knew the people to whom they provided care.

People were supported to maintain relationships that were important to them. Visitors were welcomed to the service.

Is the service responsive?

Good

The service was responsive.

People were involved in the assessment and planning of their care. Detailed care plans were in place which reflected individual needs.

People were encouraged and supported to participate in a range of activities, based upon their preferences.

The provider had an effective system to manage complaints. People knew who they could raise concerns with.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had a registered manager but they were no longer in post. Another manager had been appointed.

The system for monitoring the quality of the service had not been consistently implemented or used to drive improvements in the service prior to the manager commencing work at the service.

The service had a positive, open culture amongst the staff team and staff felt management were supportive and approachable.

People were encouraged to give feedback on the service provided.

Erskine Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls from moving and handling equipment. This inspection examined those risks.

This inspection took place on 23 and 24 November 2017 and was unannounced. The inspection was undertaken by a team of one inspector, two experts by experience and a specialist advisor on the first day and one inspector 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. Both experts used for this inspection had experience of a family member using this type of service. The specialist advisor was a registered nurse who had experience in providing and managing the care of people with complex care needs and people living with dementia.

Before the inspection, we reviewed the information available to us about the service such as information from the local authority, information received about the service and notifications. A notification is information about important events which the provider is required to send us.

During the inspection we spoke with 12 people who lived at the service and four relatives. We also spoke with four care workers, two nurses, a clinical supervisor, an administrator, the deputy manager and the manager. In addition, we spoke with the regional director from the provider organisation.

We carried out observations of the interactions between staff and the people living at the service. We reviewed the care records and risk assessments of seven people who lived at the service and also checked

medicines administration records to ensure these were reflective of people's current needs.

We looked at four staff records and the training records for all the staff employed at the service to ensure that staff training was up to date. We also reviewed additional information on how the quality of the service was monitored and managed to drive future improvement.

Requires Improvement

Is the service safe?

Our findings

A potential safeguarding incident had not been reported to the local authority or the Care Quality Commission (CQC) by the service. During our inspection, a person raised a concern to a member of the inspection team. We immediately brought this concern to the attention of the manager who followed the appropriate procedures and referred the concern to the relevant safeguarding authorities. However, during the initial 'fact finding' to complete the appropriate reporting forms, it became known to the manager that the person had previously raised the same concern some months before. This was known by the registered manager in post at the time and senior members of the nursing staff. The concern raised by the person was immediately identifiable as a safeguarding concern and neither the manager nor regional director could explain why the appropriate action had not been taken at the time it was initially disclosed. This meant that there was a risk that safeguarding incidents were not identified and reported correctly.

We found that the manager maintained a log of safeguarding concerns referred to the local authority and maintained detailed records in relation to each concern. However, they could not be sure that all relevant safeguarding concerns had been raised prior to them coming into post considering the concern raised during our inspection. The manager confirmed that, although at the time of our inspection they were unable to proceed with any investigations in relation to the concern until instructed to do so by the local authority, they would ensure that reporting of safeguarding concerns would be discussed and highlighted to all members of staff during shift handovers in the coming days.

Staff told us that they knew how to recognise and respond to abuse. One member of staff told us, "I would talk to the senior nurse on duty or the manager." Another member of staff told us, "I wouldn't hesitate to report any concerns I may have." We saw that there was information displayed around the service on how to recognise and report concerns along with the contact details of the local authority safeguarding team.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls from moving and handling equipment. This inspection examined those risks.

There were personalised risk assessments in place for each person who lived in the service. The assessments considered a wide range of daily living activities and included identified hazards people may face and any actions that staff should take to minimise the risk of harm. Examples of risk assessments carried out included support regarding skin integrity and pressure care, nutrition and hydration, personal care and medicines.

In light of the incident where a person sustained a serious injury, we reviewed the risk assessments of people who required support from staff in using moving and handling equipment. We found that all risk assessments were up to date, all having been recently reviewed. Detailed steps that staff should take and

the equipment to use to keep people safe were recorded including the involvement and guidance of physiotherapists and other health professionals, where required. In addition, we found that members of staff had completed refresher training in the use of moving and handling equipment.

The provider organisation had also commissioned a 'root cause analysis' investigation to be completed following the incident. Whilst this investigation had been concluded, the report and subsequent findings had not yet been made available to the manager. It was expected that this would be received in the coming weeks.

Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of ways. These included looking at people's care plans and their risk assessments and by talking about people's needs at staff handovers. One member of staff told us, "We have the risk assessments to read and follow and we talk at handover. We get an update on anyone who may need more support from us." Another member of staff told us, "I always work on this unit so have got to know people well. I know what I need to do to keep them safe and well." We observed the afternoon handover where the nurse informed the staff on duty of any changes in people's needs, any incidents that had occurred and highlighted concerns with regards to people's health and well-being. This meant people received continuity of their care and staff were provided with up to date information.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments, the maintenance and inspection of mobility equipment and the security of the building. People living at the service had Personal Emergency Evacuation Plans (PEEP's). Information and guidance was displayed in the entrance hallway to tell people, visitors and staff how they should evacuate the service if there was a fire.

People told us that they felt safe and secure living at the service. One person said, "(I am) absolutely safe. It's a nice feeling that you can go to sleep and not worry." Another person told us, "I am very safe here. I have been her for a few years now; I would not feel safe at home. Here, I have good care." A relative told us, "Absolutely, 100 percent. My [Name of relative] feels very safe here."

We received mixed views on staffing levels at the service. One person said, "They are always up and down (the corridor) and if one can do something another jumps in. They come in quickly." Another person told us, "They arrive in a few minutes if I call on them." However another person told us, "Not enough (staff) at times. There aren't people about." A relative told us, "They do need more. They (staff) would like to stop and talk but they don't have the time."

Staff told us that when the service was fully staffed that there was generally enough staff to meet people's needs. One member of staff told us, "For the number of people we have on this floor at the moment there is enough but if we get more people, it would have to increase." Another member of staff told us, "We only have three members of staff on this floor today. Sometimes if the other two staff are busy, it's just me on my own."
We noted that on the day of inspection people received support in a timely fashion and the service was calm. Rotas confirmed that a consistent staffing level was maintained as determined by the dependency tool completed by the manager to establish the staffing level for the service.

Robust recruitment and selection procedures were in place and were followed consistently. We looked at four recruitment files for staff in various posts including one member of staff that had recently started work at the service. Relevant pre-employment checks including obtaining references from previous employers, checking the applicants previous experience, and Disclosure and Barring Service (DBS) reports had been

completed for all staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. This meant that steps had been taken ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

People we spoke with confirmed they received their medicines as prescribed and that staff administered additional medication, including pain relief when they asked for them. One person told us, "I'm happy. It has to be first thing in the morning and last thing at night and always is." Another person told us, "Staff are very good at doing medication. It's the same time every day." There were effective processes in place for the management and administration of people's medicines and a current medicines policy available for staff to refer to should the need arise. We reviewed records relating to how people's medicines were managed and they had been completed properly.

Medicines were stored securely and audits were in place to ensure these were in date and stored according to the manufacturer's guidelines. A nurse on duty explained to us how regular audits of medicines were carried out so that all medicines were accounted for. These processes helped to ensure that medicine errors were minimised, and that people received their medicines safely and at the right time. We saw that all medicines were stored securely with appropriate facilities for controlled drugs and temperature sensitive medicine. We observed a nurse administering medicines for people at lunchtime and they demonstrated safe practices.

Effective infection control procedures were in place. There was an up to date infection control policy and training records confirmed that staff had completed infection control training. Housekeeping staff had access to sufficient equipment and materials required to complete tasks and a schedule was in place to ensure all areas of the service were cleaned regularly. Care staff had access to a good supply of protective equipment for the tasks they were carrying out, for example, disposable gloves and aprons when assisting people with personal care. We observed that they wore these when required and items were disposed of appropriately once used. Records we viewed confirmed that cleaning tasks had been completed in accordance to the schedule in place and we noted the service was clean and free from malodours.

Good

Is the service effective?

Our findings

People told us that they thought that staff were skilled and competent in their roles. One person said, "The staff seem to have the right skills. I feel they know what they're doing." A relative told us, "'I'm confident they know what they're doing because their training is visible."

New staff received a comprehensive induction before starting in the service. This covered key areas such as core training, information about staff roles and responsibilities, the service's expectations and the support they could expect to receive from the organisation. Following this, new staff shadowed more experienced members of staff. One member of staff told us, "It can be daunting for a new member of staff when they start so we make sure that more experienced staff guide them during their first few weeks until they feel more settled and comfortable in their role." Another member of staff told us, "The team were great when I started and really looked out for me in the early days."

We reviewed the training provided and saw that staff had received necessary training and a training matrix was in place which enabled the manager to monitor the training received and when refresher training was due. Topics included moving and handling, safeguarding people from abuse, infection control, medication, dignity and communication, fire safety and food hygiene. We saw that online training was available to staff at all times and face to face training updates were scheduled for the coming months. One member of staff told us, "The training available is comprehensive and helps us learn all aspects of care. We are told when training is available or when we need to refresh."

Staff told us that they felt supported by their colleagues and the management team. One staff member told us, "Senior staff are always available to us and I find them very supportive." Another member of staff told us, "I feel supported by all the staff here. We have handover, supervisions, and team meetings and can always ask to speak to senior staff if we need anything." We saw that staff received regular one to one supervision and there were team meetings to share information. In addition, all heads of department met on a daily basis to share information across the service and discuss any concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's capacity to make and understand the implication of decisions about their care was assessed and documented within their care records. Staff had received training on the requirements of the MCA and the associated DoLS and we saw evidence that these were followed in the delivery of care. Where it had been

assessed that people lacked capacity we saw that best interest decisions had been made their behalf following meetings with relatives and health professionals and these were recorded within their care plans.

The manager had applied for DoLS authorisations appropriately. We saw that they kept a log of these and the stage each was at. Where these had been approved, there was a record of when these were due to be renewed. We saw for those that were due, applications had been submitted.

People told us that staff always asked for their consent before assisting them. One person told us, "They're good at that. They will ask first." Members of staff told us that they always asked for people's permission before providing them with care. Our observations confirmed that staff obtained people's consent before assisting them with personal care or supporting them to transfer. Where people refused, we saw that their decisions were respected. We saw evidence in care records that people, or a representative on their behalf where appropriate, had agreed with and given written consent to the content of their care plan.

People were supported to eat and drink sufficient amounts and maintain a healthy diet. There was a variety of food available at mealtimes and people told us that they enjoyed the food. One person told us, "The food is very good, sometimes too much as I can never finish mine. I come to the dining room to eat because it's nice to have a bit of company." Another person told us, "The food is good. I go to the dining room to have mine and sit with my friend. It's nice to have company, if you don't fancy what's on they will make you something else like an omelette, they don't mind." There was a menu programme in place which was displayed on tables in the dining areas and within communal corridors so that people knew the meals on offer.

We observed the lunchtime meals in all of the dining areas and found that the meal time was relaxed with people chatting throughout the meal making it a social occasion. We saw staff encourage people to sit at the dining tables and offer support appropriately. Where people required assistance to eat their meals we saw that this was provided and in a way that enhanced the mealtime for the person. We also observed that people were provided with regular drinks of their choice.

People had been asked for their likes and dislikes in respect of food and drink prior to moving to the service and their preferences recorded. Members of kitchen staff were notified of people's dietary requirements and were informed of any changes via regular notifications from the care staff and at the daily head of department meeting. We saw that the chef maintained records in the kitchen which detailed people's preferences and specific dietary needs such as allergies or consistency requirements for example, a soft or pureed diet to ensure that people's needs were met. Members of care staff were aware of people's dietary needs and this information was documented in the care plans and risk assessments.

People were supported to maintain their health and well-being and were assisted to access healthcare services, if needed. One person told us, "The doctor comes every week but they will call one if it's urgent." Another person told us, "I'm under the eye clinic at the hospital, but I see the GP here. An optician calls and there's a chiropodist who comes regularly as well." Records confirmed that people had been seen by a variety of healthcare professionals including the GP, dentist and chiropodist. Referrals had also been made to other professionals, such as dietitians and tissue viability nurses.

Good

Is the service caring?

Our findings

People and their relatives were consistently positive about the caring approach of staff. One person said, "I think the girls (staff) here have a very caring attitude. They couldn't be more helpful." Another person told us, "I have found the staff to be very thoughtful and caring. I am very independent but I have observed the way that staff are towards other residents, especially those in need of extra care and assistance. They are very loving towards them and from what I have seen they are very caring." A third person told us, "It took me a little time to settle here but the staff have made that easy for me in the way they speak to me and care for me. I am happy here." A relative told us, "They couldn't be better. I'm very pleased."

People appeared relaxed in the company of staff and we observed many positive interactions throughout our inspection. All of the staff demonstrated a good understanding of the needs of the people they were supporting and their approach was personalised. It was clear that staff were knowledgeable about the people they were supporting and knew how best to engage them.

People confirmed they felt involved in planning and making decisions about the care and support they received. One person told us, "They always ask if I am ok and if everything is alright. I know they write things down to make sure everyone knows." We observed that staff listened to people and provided information in a way that was appropriate for each person. We also heard staff taking the time to check that people were happy and comfortable with the support provided, and that they understood what was happening. The service operated a 'Resident of the Day' scheme as part of the provider organisations policy where on one day all information within the care plans was reviewed and updated. People and their relatives confirmed they were aware of the scheme and were asked for their input in the process.

People told us that staff respected their privacy and dignity. One person told us, "I am always treated with dignity and respect and the girls have a laugh and a joke with me." Staff communicated with people with respect, using a gentle tone of voice and offering reassurance when this was needed. We observed that staff knocked on bedroom doors before entering and ensured that privacy was maintained when they assisted people with personal care. We found that discussions around people's health and wellbeing were held in private and that all personal information was stored securely, with access to all staff areas via key code protected doors.

People and their relatives told us that visitors were welcome at any time and they were encouraged to maintain important relationships with family and friends. We saw that there were a number of visitors throughout our inspection. One person said, "My relatives can come whenever they like, there is no restriction here." Another person told us, "My family are always made to feel welcome here, any time of day." We noted that staff knew who relatives were and greeted them upon their arrival, making them feel welcome.

There were a number of information posters displayed around the service which included information about the service and the provider organisation, safeguarding, the complaints procedure, fire safety notices and forthcoming activities and events. This meant that people received information on the services that were

available to them and enabled them to make informed choices about their care.

Good

Is the service responsive?

Our findings

People told us that their needs were met and that they felt involved in deciding what care they were to receive. One person told us, "It is totally up to me, when I get up, when I go to bed, everything. I like my door open and they are aware of that." Another person told us, "I know it's a care home but I don't feel like that here. They encourage me to keep my independence but help me where I need it."

Records showed that people's care needs had been assessed prior to their admission to the service and their likes, dislikes and preferences recorded. Each person's care plan was clear, detailed and individual preferences were reflected. They were personalised to indicate people's needs and included clear instructions for staff on how best to support people. Each care file included plans for areas of the person's life including personal hygiene, mobility, nutrition and hydration, health promotion, pressure care and emotional well-being. We found that the care plans accurately detailed people's needs and had been updated regularly with changes as they occurred. We observed staff providing support to people as described within their records.

People's care records included information about the choices people had made regarding their end of life care, when they had expressed a wish to do so. This included whether people wished to be resuscitated, any religious or cultural wishes and where they wanted to be cared for at the end of their life. One relative told us, "The support provided here to [Name of relative] has been so sensitive and caring." We saw that the service had received many cards expressing thanks when their relative had passed away, complimenting the staff on the care and support they had received.

People were supported to follow their interests and a range of activities were provided. One person told us, "I particularly like the quizzes. [Name of activities coordinator] is very good; she knows that and will always come to collect me to go to the lounge to join in. They do ask me to go out on trips but it's my choice not to go because I am less mobile now." Another person told us, "I always go the lounge and join in. [Activity co-ordinator] is lovely and organises things for us. I like to go on the trips as well."

Activities were provided by activity coordinators. They, and members of staff we spoke with, were able to describe the different activities that people enjoyed, for example, quizzes, music, crafts and day trips out in the local area. One member of staff told us, "There is a range of activities planned each week and there is usually something for everyone to enjoy at one point." Another member of staff told us, "Everyone seems to really enjoy the activities that the team provide. I know they've recently been asking people and their relatives again for more choices so that they can encourage everyone to join in."

There was an activity programme displayed in the communal areas so people and their relatives knew the activities that were on offer or any future events that were planned. During our inspection we saw a number of people join the planned activities.

People and their relatives knew who they could raise concerns with. One person told us, "I don't have any concerns but I would tell a family member or the manager." Another person told us, "I have never had any

concerns but feel confident enough to speak up, if I had to." A relative told us, "I have no complaints but would happily speak to any staff if anything was wrong or I was concerned."

Complaints were investigated and responded to appropriately. We saw that there was a log of complaints and a monthly audit to look for themes, trends or factors that increased complaints. We saw that information was shared with staff to help prevent a reoccurrence and that action was taken in response to complaints received. There was an up to date complaints policy in place and information on how to make complaints displayed around the service.

Requires Improvement

Is the service well-led?

Our findings

When we inspected Erskine Hall Care Home in November 2016, we found the service was meeting all the legal requirements in the areas that we looked at. However, we rated the service Requires Improvement within the domains of Safe, Responsive and Well-led. This led to an overall rating of Requires Improvement.

At this inspection we found that there had been some improvements in the service; however the service remains overall rated Requires Improvement.

There was a registered manager however they were no longer in post at the service. A new manager had been appointed and had been in post for a period of six weeks at the time of our inspection. The manager was registered at another service within the provider group and was intending on completing their registration at Erskine Hall Care Home.

People and relatives were positive about the manager. One person told us, "He's nice. He came and introduced himself to me the other day." Another person told us, "I know we have a new manager, he came to introduce himself. Seems to be a very organised man." A relative told us, "The new manager seems very professional and approachable. He has been like a breath of fresh air."

Staff told us there was positive leadership in place from the manager. One member of staff told us, "[Name of manager] has had a really positive influence in such a short time. I'm so pleased that we have his experience and skills to manage the service." Another member of staff said, "[Name of manager] seems very approachable and interested in our opinions." A third member of staff told us, "It's great to have [Name of manager] on board. I'm positive that Erskine Hall can now develop into the service that it has the potential to be with his direction and support."

We noted that there was a positive, welcoming atmosphere within the service. During our inspection we saw that the manager spoke with people and staff to find out how they were and was actively involved in the running of the service. We saw that the manager was regularly approached by senior staff regarding the support and wellbeing of people living in the service and the experiences of staff on duty and they responded in a positive, supportive manner.

There was a robust quality assurance system put in place by the provider organisation to monitor the quality of the service however we found that it has not been consistently implemented. There was a lack of evidence to demonstrate how processes in place had been used effectively to assess and monitor the quality of the service and ensure that any action identified as required was taken. However, since starting work at the service, the manager had conducted comprehensive audits covering a range of areas, including health and safety, incidents and accidents, infection control, medicines and care plans. In addition, they had completed observations of staff practice and had sought feedback from people, their relatives and staff about the care provided. However, they had not identified that a safeguarding issue had not been responded to or reported appropriately.

Following these audits, and in accordance with the provider's policies and procedures, the manager had compiled a 'home improvement plan'. The 'home improvement plan' was an internal service improvement plan and was a collated schedule of actions required from internal audits, inspection feedback, provider visits and other sources of quality assurance and feedback such as internal surveys. The plan was to be reviewed on a monthly basis by the manager to ensure actions identified as required were being undertaken. This continual cycle of evaluation demonstrates how the service plans to use a variety of sources of feedback to drive improvements at the service.

Also in accordance with the provider's policies and procedures, a member of the senior management conducted a daily 'walkaround' round the service and held a daily meeting with all heads of department. In addition, there were also 'spot checks' by the management team to ensure the expected standards were adhered to throughout the day and night and the deputy manager also spent time completing observations whilst on shift. These checks and daily procedures ensured consistent information sharing amongst key staff and ensured that any shortfalls were addressed and guidance offered when identified as needed.

Satisfaction surveys were distributed annually to people who lived at the service, their relatives and relevant professionals. A survey had been recently been commenced and responses had not been received at the time of our inspection. The manager explained that once the completed survey and results were received from the provider the findings would be shared with people, relatives and the staff team and any actions resulting from the survey would be added to the 'home improvement plan'. This meant that the views of people and their relatives were included in the evaluation of the service provided and used to identify, and address, any concerns highlighted.

Staff were encouraged to attend team meetings at which they could discuss ways in which the service could be improved and raise any concerns directly with management. Recent staff discussions had included record keeping, training, complaint feedback, lessons learnt following incidents, organisational changes and staffing. Members of staff we spoke with confirmed that they were given the opportunity to request topics for discussion. Meetings for all staff were held on a regular basis and within the respective departments in which they worked or position held. This included heads of department, care staff, catering staff and housekeeping.