Amber ARC Limited

Kimberley Care Village

Inspection report

23 London Road
Long Sutton
Spalding
Lincolnshire
PE12 9EA

Tel: 01406364309

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Kimberley Care Village is a residential care home, it is registered to provide personal care for up to 68 older people some of who may be living with dementia. There were 56 people living at at the home at the time of the inspection.

People's experience of using this service:
• People told us they were happy living at the home and that staff were kind and friendly. One person told us, "They are all nice to me and so friendly and they are kind to all of us. This is not just a job to them. They definitely want to support us as best as they can and make it a pleasant environment."
• Relatives were also happy with the care provided. They spoke about how caring the staff were and well led the service was. One relative told us, "I always arrive unannounced. When mum first moved here I thought maybe she should move nearer to us, but the care is so good and I have visited others. I have 100% trust in the care here."
• There were enough staff to meet people's needs and they received the training and support needed to provide safe care to people in line with best practice. Recruitment processes ensured that staff were safe to work with people living at the home.
• Care plans contained all the information staff needed to provide care that was tailored to people's individual needs. Risks to people were identified and care was planned to keep them safe. Where needed equipment was in place to support people's well-being. Medicines were safely managed, and the environment was clean.
• The provider had recently introduced home cooked food into the home and people told us that this had improved the quality of the food. The success of this was reflected in the decrease in people at risk of malnutrition.
• The provider was refurbishing the home to improve the environment for people. Areas of the home which had been completed were of a high standard and supported people's well-being. The dementia unit was planned to be refurbished and the provider was aware of best practice in providing a dementia friendly environment for people.
• Systems in place to monitor the quality of care provided and to drive improvements in care were effective. The registered manager ensured that they stayed up to date with changes in legislation and best practice guidance and worked with other healthcare providers to improve people's experience of care.

Rating at last inspection:
At the last inspection the service was rated as Requires Improvement (report published 07 July 2017). At this inspection we found the provider and registered manager had made the necessary improvements.

Why we inspected:
This was a planned inspection based on the previous rating.

Follow up:

We will continue to monitor intelligence we receive about this service until we return to visit as per our inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Kimberley Care Village

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed on 28 November 2018. The inspection team consisted of two inspectors 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. This included experience of looking after someone with dementia.

Service and service type
Kimberley Care Village is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can accommodate 68 people in one adapted building. It has a secure dementia wing to provide care to people living with dementia.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, and local authorities.
• Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

• We reviewed other information that we held about the service such as notifications. These are events that happen in the service that the registered provider is required to tell us about.
• 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 the registered manager, a deputy manager, the manager brought in to oversee the development of the facilities, a care worker and a member of the domestic staff. We also spoke with an external health care professional from the community nursing team.
• We spoke with six people living at the home and three relatives who visited during the inspection.
• We looked at a range of documents and written records including 10 people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.
• Following the inspection the registered manager sent us information about the training and support offered to staff.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe living at the home. One person told us, "I'm safe. I couldn't be any better anywhere else." Another person said, "I have no worries whatsoever. When I'm in bed, they'll pop their head round the door to check on me."
• Relatives were confident that their loved ones were safe in the home. One relative told us, "I always arrive unannounced. When mum first moved here I thought maybe she should move nearer to us, but the care is so good and I have visited others. I have 100% trust in the care here." Another relative said, "Dad is well looked after here. He's safe, comfortable and warm. We never leave worrying about him."
• Staff had received safeguarding training as part of the mandatory training programme. Staff were confident about raising concerns with their line manager, the registered manager or if they felt it was appropriate with external agencies.
• Details of the provider's safeguarding policy and procedures were displayed on the office wall. Safeguarding alerts had been made to the local authority. The registered manager had ongoing discussions with the local authority safeguarding lead to ensure the policy and procedures were followed correctly.

Assessing risk, safety monitoring and management
• At our last inspection in July 2017 we had concerns about the lack of consistency around people's skin damage risk assessments. During this inspection considerable improvements had been made. Physical health care plans were to a good standard with lots of evidence about referrals and assessments by external health professionals.
• People told us they felt safe while staff were caring for them. One person told us, "They hoist me gently and speak to me all the time they are doing it." A relative told us, "They speak to her the whole time they hoist her, giving her confidence through conversation."
• Risk assessments were comprehensive, fully completed and used nationally recognised assessment tools. All the people had received a pre-admission assessment and a full review of their assessments at least once a year or more frequently if required.
• All the charts for re-positioning, personal care delivery and food and fluid intake were well maintained. Targets were clearly identified, and the managers checked the charts every shift to ensure that the targets had been met and to take action if they had not. People at risk of developing a pressure ulcer had pressure relieving aids in their chairs as well as beds.
• Every assessment included a section highlighting the person's preferences and likes and dislikes on the topic to ensure they remained as independent as possible.
• Any risks identified led to clear care plans on how risks would be mitigated and reduced. In addition, people had additional checks made more frequently to ensure their safety and to reduce identified risks. For example, people had checks on their whereabouts, checks on their food and fluid intake and records were made on any challenging behaviour.

Staffing and recruitment
• At our last inspection in July 2017 we had concerns that at night care became task focused. At this inspection people told us that they were happy with the care provided by the night staff.
• People told us that there were enough staff to meet their needs. However, when staff were busy, people occasionally had to wait a few minutes. One person told us, "I do wait say 10 minutes sometimes because I need two to help me."
• There appeared to be sufficient staff available. People did not have to wait long for assistance. Staff were busy but available.
• Safe recruitment processes were followed. The manager had introduced a checklist to ensure all relevant documents were available. All staff had received DBS checks and clearance prior to starting work at the home.

Using medicines safely
• At our last inspection in July 2017 we had concerns the staff were not fully supported to administer medicines prescribed to be taken 'as required' consistently. At this inspection we saw that the provider had made improvements and there was clear guidance available for medicines prescribed 'as required.'
• People told us they were happy with the support they received with medicines. One person told us, "I get my medication on time."
• Medicines were safely administered. Staff who administered medicines had received training and had been observed to ensure that they were competent.
• Records about medicines were fully completed. Recording followed best practice guidance and provided clear information to staff about when and how medicines should be administered.
• Some medicines were administered covertly. This is when medicine is hidden in food so that people are not aware that they are taking it. We saw that need for covert medicine had been discussed with healthcare professionals and advice taken from pharmacists to ensure that medicine could be taken with food.
• Where people were unable to take tablets, the staff had discussed with the GP the need to have liquid medicines.
• Medicines were safely stored and storage temperatures recorded to ensure that it remained within acceptable limits.

Preventing and controlling infection
• People were happy with the cleanliness of the home. A person living at the home told us, "My room is clean and my laundry gets back to me." A relative said, "It's nice and clean here."
• During the inspection we saw that staff worked within infection control guidelines and regularly washed their hands and changed their protective equipment.
• Cleaning schedules were available for housekeeping staff to follow. Audits were carried out daily and others weekly to ensure the care home was clean. Checks were made to ensure wheelchairs and other mobility aids were clean and in a good state of repair. An infection control audit was carried out weekly.

Learning lessons when things go wrong
• Incidents were recorded and reviewed by the registered manager. Action was taken to reduce the risk of the incident reoccurring. For example, additional resources such as mobility aids were put in place, or the person's needs were reviewed by a healthcare professional.
• Learning from incidents was discussed with staff in handover, monthly team meetings and with people living at the home when appropriate.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they moved into the home. This allowed the registered manager to ensure that staff had all the skills and knowledge needed to deliver care in line with best practice.
• The registered manager had taken action to increase staff awareness of best practice guidelines. They had initiated a learning board and used it to share best practice around the home. Staff had handbooks with best practice guidelines.
• The registered manager monitored staff to ensure they kept up to date when policies were updated. If staff were behind in maintaining their knowledge levels then the registered manager would ensure they had some time put aside for catching up.
• The registered manager worked with healthcare professionals when they implemented the latest good practice guidance. For example, they were working with the GP to review the use of Lorazepam in line with national guidance. Lorazepam is a medicine used to help people manage their emotions when they became distressed.

Staff support: induction, training, skills and experience
• Staff received an induction to the home which provided them with the skills and knowledge needed to provide safe care to people. This included working alongside experienced staff to gain knowledge of people's needs. The management team in the home were trained trainers and delivered a variety of in house training such as manual handling and end of life care.
• Staff were also supported to study for a national recognised qualification in health and social care.
• In addition, staff had annual refresher training to ensure that they remained up to date with any changes in best practice. The registered manager monitored people's training and ensured that they were notified of any training that was needed.
• As well as the refresher training the registered manager provided training in areas which could improve the care provided for people. For example, additional training had been provided in topics such as, living with dementia, mental health, tissue viability, medicines and how to be an effective fire marshal.
• Staff had supervisions every three months or sooner if an issue needed addressing. This allowed them time to raise any concerns with their line manager.

Supporting people to eat and drink enough to maintain a balanced diet
• During our last inspection in July 2017 we had concerns around inconsistency with nutritional risk assessments, risk of choking assessments and inconsistent recording of food and fluid intake charts.
• During this inspection considerable improvements had been made. We looked at care plans for six people at risk of malnutrition. The plans were clear in guiding staff to ensure that fortified and high calorie/protein foods and drinks were made available, such as full fat milk, cheese, butter and cream. In addition, people

had supplementary food and fluids prescribed.
• For example, one person had a detailed care plan for managing diabetes. The person had lost weight and had been declining meals. A dietician had been consulted and advised on a care plan which included maintaining food and fluid charts and encouraging the person to eat small and frequent meals and snacks which they particularly enjoyed. The person's weight was monitored weekly and should the person's nutritional risk assessment deteriorate the GP and dietician should be consulted again.
• The registered manager told us how they had stopped using a food supplier and had started to cook everything fresh in the home. They had employed a professional chef to oversee the transition, support the kitchen staff and help to plan a well-balanced menu which supported people's wellbeing. For example, planning meals which supported people living with diabetes and dementia.
• The registered manager told us that since introducing the new food people were eating better and some had been able to be removed from the list of at risk of malnutrition.
• People told us they were happy with the food offered to them. One person said, "Yes I have noticed the food getting better lately. I like what they give me and there's vegetarian alternatives they will give me."
• People did comment that they were not getting offered a choice of food at mealtimes and we raised this with the registered manager. They explained that choice had been removed while staff got used to preparing the meals but that it was planned to be reintroduced shortly. In the meantime, if people did not like the food offered an alternative would be provided.
• We saw that people had access to cold drink throughout the day and hot drinks were regularly offered to people. One person told us, "I have a drink by my side."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The registered manager had developed a good working relationship with the healthcare professionals who supported people living at the home. They worked closely with the two district nurses who supported the home and a weekly round was completed by a healthcare professional from the local GP practice.
• A visiting healthcare professional was highly complementary about the quality of service delivery and responsiveness of staff.
• The staff and local GP practice had developed a post fall observation checklist to ensure people were monitored carefully after a fall to ensure any deterioration in their health was picked up quickly.
• Staff told us that they would support people to attend healthcare appointments to ensure correct information was shared and to support people with communication needs.
• Records had evidence of external health care professionals involvement in advising on and providing care. This included tissue viability nurses, diabetes specialist nurses, podiatry and speech and language therapists.
• Staff had put a "Red bag scheme" in place which held vital information about each person which could accompany them to a healthcare appointment.

Adapting service, design, decoration to meet people's needs
• The provider was in the process of refurbishing the home. They had brought in an extra manager to oversee the project so that the registered manager could focus on the care provided. They explained that they were splitting the project into four parts so that it minimised the disruption in the home.
• We saw that one area of the home which included a dining and seating area had already been completed. We saw it was finished to a high standard. In addition, they had included a beauty salon so that people were able to have the experience of a visit to the salon to have their hair or nails done.
• The manager responsible for the development was able to tell us how they were going to develop the dementia unit in such a way to improve the experience of people living with dementia. They were up to date with best practice in dementia care.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Ensuring consent to care and treatment in line with law and guidance
• Staff had received training in the MCA. They told us how they needed to give people a choice and respect their wishes. This included providing information in a way to support the person's understanding and increase their ability to make decision.
• Capacity assessments had been carried out for people who may not be able to make decisions for themselves. Care plans recorded the decisions people had the capacity to make and an emphasis was put on people giving their consent before interventions were made. For example, one person was able to make simple decisions relating to food and drink. However, they would need support to make decisions about finances or medicines.
• Applications had been made to the local authority for authorised DoLS. Any restrictions on people, for example, bed rails were carefully considered and if the person was unable to make a decision a decision was made in their best interest.
• Where people were unable to make decisions about taking their medicines but were refusing their medicines, a decision was made in their best interest. Records showed that all options had been considered. For example, the GP was contacted with to see if all medicines were necessary of if they could be provided in a liquid form.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• People told us that the staff knew them and their needs. One person told us, "The staff know me well and know how I am as I've been here some time. Lots of them have been here a long time too."
• People had built trusting relationships with the staff. One person told us, "They are all nice to me and so friendly and they are kind to all of us. This is not just a job to them. They definitely want to support us as best as they can and make it a pleasant environment." Another person commented, "The carers are loving and respectful. They treat you with dignity and respect I had one visit from a carer who's working elsewhere in the home now. That was so lovely of her. I felt really elated the fact she took the time to see me."
• People commented about how the staff using their names made them feel wanted. One person said, "The call me by name and they make me feel content. They are really decent people here."
• Relatives also gave positive feedback on the home and how welcoming staff were. One relative said, "Everyone here is so polite. I ring up, speak to reception and they'll take the phone up to dad as he can't use one himself. That is kind. They speak nicely to dad, they are very good." Another one commented, "They ask me how I am. The atmosphere continues to improve. They go an extra mile. They talk to mum like she's a friend, not as if it's a job. They speak in French to her just for fun which makes her respond and smile. There's good banter and the use of nicknames. It relaxes mum. The carers never fuss, nothing is too much trouble."

Supporting people to express their views and be involved in making decisions about their care
• People told us that they were able to make choices and staff respected them. One person said, "They accepted I just didn't want lunch which is showing me respect. I will eat this evening." In addition, staff asked people's permission before providing care. One relative said, "They use dad's first name and ask permission before they do things."
• Care plans had evidence that people were encouraged to express their views throughout the care records and in every care plan. Each care plan had a section for people's views, for example, "I am able to make decisions about my day to day needs and I am able to express my wishes" and "I can make personal choices and I can communicate effectively".

Respecting and promoting people's privacy, dignity and independence
• Staff told us how they supported people's privacy and dignity. They explained that they would ensure that doors and curtains were shut while providing care and how they would encourage people to do as much as possible for themselves.
• Relatives told us that staff respected their privacy. One relative told us, "They'll ask me if I want to find somewhere private if I have anything to discuss."
• Information about people was kept secure. Al the care plans were on the computer and access was with

individual passwords. This meant that only people who needed to see the records were able to access them.

• Furthermore, the registered manager recognised the importance of appropriately supporting people if they identified as gay, lesbian, bisexual and transgender.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People told us that they were asked for their input in developing their care plans one person told us, "Before I started here, they asked me about myself and what I liked doing which is a nice touch." A relative told us, "[The registered manager] and [a care worker visited us before dad came here. They were very kind and helped us through it all."
• There was evidence in the care records of personalised assessments and care plans. Where able to, people had given details about their preferences, likes and dislikes. For example, "Please show me things to help me make choices such as food and clothing." This is good practice advocated by the Alzheimer's Society and the care records included bibliographies, previous employment, key family history, preferences and advanced directives should the person's health deteriorate. We also saw evidence of relatives contributing to identifying their relative's needs and ensuring care was personalised and responsive.
• The care plans, charts, daily progress notes and monthly evaluations were of a good standard and covered all aspects of physical, mental health and social needs. The care records were electronic. Each person had a full care plan review annually and people and their relatives were invited to participate.
• The care plans were highly individualised, personalised, holistic and thoughtful. They contained examples of how care could be tailored to people's individual needs, for example 'Please be patient with me and talk to me slowly and softly. This will allow me to be able to think things through and make decisions for myself' and 'I like to advocate for myself."
• There were good examples of mental well-being care plans and if a person should become distressed or anxious, guidance was given to staff about how they should respond and what interventions they could use. Care plans detailed positive behaviour plans and how a person's independence could be supported safely.
• People told us they would like more activities provided. However, in conversations they told us about events that happened. One person said, "They do line dancing once a month. I come alive when that's on. I am one of the best because I've still got my balance. Some just sit and wave their arms which is fine. If there's something good, I'll do it but not a lot goes on."
• Another person said, "There are few trips out. I'd enjoy more of those. I don't get out of my room so yes a visit from someone like the (activities) co-ordinator, even a few minutes once a week would be nice." Relatives explained that at times people did not want to join in activities. One relative said, "If they warn mum in advance that an activity will be going on, she won't do it. She's seen videos in the lounge with other residents. She doesn't do much, only reading. I'm not sure much goes on. On her birthday they took her out to a restaurant and there was cake and a little party."
• Records showed that a variety of activities had been provided including trips out, entertainment coming into the home. Over the summer people took it upon themselves to choose plants and herbs to go into the garden. They had also attended a local cinema which had showings especially for people living with dementia. Individual activities also took place such as one to ones for people in their bedrooms, providing for example, hand and foot massages.

• People were encouraged to feedback their views on any activities they took part in so that staff could see if it had been successful or if changes were needed.
• The staff identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals. For example, was saw that people with limited or no sight had their communication needs recorded.

End of life care and support
• Staff worked proactively with other health and social care professionals to ensure people had a pain-free, dignified death.
• All staff had been trained in end of life care and protocols had been developed to ensure residents were involved in agreeing advanced directives including their preferences and wishes.

Improving care quality in response to complaints or concerns
• People told us they knew how to complain and were happy that issues that they had raised had been dealt with. A relative told us, "I have met [registered manager] and she is welcoming with everyone. Dad's alarm wasn't working and after I told her it was sorted straight away."
• We looked at the complaints since our last inspection. They had been dealt with within 28 days as per provider policy.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• There was a registered manager for the home.
• There was a clear vision to provide high quality care and support for people living at the home. The registered manager undertook daily walk arounds and spoke with everybody each day to enquire about their welfare.
• Protocols were in place to guide staff about providing high quality care. Staff were confident in their role and people were complimentary about the care and support they received.
• The registered manager attended a monthly meeting with other care home managers, facilitated by the local authority lead for quality and training. The registered manager had been awarded a local authority 'Care leadership award.'

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• At our inspection in February 2017 we found that audits had not always effectively identified concerns around the care provided.
• At this inspection we found the governance framework was clear and strong. The registered manager and duty managers had a series of audits to ensure people were receiving the right care and support and that they were fully involved in deciding what support they required.
• Audits included those related to the care provided, management of staff and the environment. For example, environmental audits included those on safe water temperatures, appliance testing, hoist and mobility aids testing and fire risk assessments.
• The staff spoke positively about the registered manager and all commented on how supported they felt. One member of staff told us, "I can go to the manager if I have any concerns, she will spend time with you and you can talk to her. I also get on well with the deputy managers."
• The provider and registered manager had taken action to comply with the regulatory requirements. They had made the improvements needed after out last inspection to improve the rating of the home. They had ensured that their rating was displayed in the home and had notified us about events which happened in the home.
• However, they had not told us about when people's Deprivation of Liberty Safeguards (DoLS) had been reauthorised. We discussed this with the registered manager who explained that they had notified us when a new DoLS had been authorised but had not realised they had to tell us about reauthorisations. They told us they would ensure appropriate notifications were submitted going forwards.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• People and their relatives were all positive about the registered manager and told us that they would often see them around the home. One person said, "[Registered manager] is very friendly and visits my room from time to time." A relative commented, "[Registered manager] is very friendly and says hello and calls in on mum now and again. The place runs well."

• People and their relatives had the opportunity to input into the running of the home through regular meetings and surveys. One relative told us, "There have been relatives' meetings, but I've not made it." The surveys had been developed using information about people's communication needs and so this improved the ability of people to voice their opinions.

• We saw that continuous feedback was being gathered about people's views on the changes to the catering. This was being used to develop the menu for the home. The registered manager communicated the changes to people and their relatives using a 'You said and we did' feedback board.

• Staff told us they received regular support through team meetings and individual supervision sessions. In addition, staff told us that they could raise any concerns with the management team and were confident that action would be taken. One member of staff told us, "They are very responsive and help us out as much as possible. We are quite good we all try to work with each other. We are a brilliant team, all of us."

Continuous learning and improving care

• The registered manager kept up to date with changes in best practice and legislation. They attended regular meetings with the provider's other registered managers, regularly updated their knowledge with training and reviewed the industry publication. For example, we saw that they had recently attended a meeting about advanced directives in end of life care (ReSPECT).

• The registered manager and provider had been open and honest about incidents that had occurred in the home. They had identified where things could have been done better and used the information to improve the quality of care provided.

Working in partnership with others

• The registered manager had created strong links within the local community. For example, voluntary agencies were invited to hold their meetings in the care home meeting rooms.

• The registered manager was a qualified 'care ambassador' with a local college and regularly gave training to students on social care. Two work placements were available and supported by staff for students studying health and social care at home in addition to an apprenticeship scheme.

• The provider also supported the staff to improve the links between organisations. For example, the registered manager was working with a GP to review the use of a medicine in the home in line with the latest guidance. They had also worked with the local hospital to improve the assessment processes in place. This was so that they could be more confident that referrals from the hospital would be more appropriate and would reduce the impact on staff and people living at the home of unsafe discharges from hospital.