# Runwood Homes Limited

# Tallis House

## Inspection report

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05 April 2018
11 April 2018
13 April 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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 unannounced inspection took place on 05,11 and 13 April 2018. Tallis House 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. A previous inspection, undertaken in June 2016, found the provider was meeting all legal requirements and rated the service as 'Good'. At this inspection, we found some improvements were required.

Tallis House is registered to accommodate up to 101 older people. At the time of the inspection, 96 people were permanently living at the service. The accommodation is spread over three floors.

There was a registered manager in post. 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.

On the day of inspection we saw there was sufficient, suitably recruited staff employed to keep people safe. However, when looking at the provider's falls analysis we identified concerns related to insufficient numbers of staff available to meet people's needs. The provider responded to this shortfall immediately and increased staff. Suitable recruitment procedures and checks were in place, to ensure staff had the right skills. All staff had been subject to a Disclosure and Barring Service check (DBS).

Risks to people were identified and regularly reviewed. Written guidance was provided to staff on how to manage risks to keep people safe. We did note on some occasions additional controls to minimise risk of falls were not always updated in a consistent area within records. Staff had a good knowledge of the risks to people and knew what to do to minimise risk. There was sufficient equipment and measures in place to minimise the risk of infection.

People told us they were safe living at the home and we found safeguarding issues had been referred to the local safeguarding vulnerable adult's team. Systems in place to reduce people being at risk of potential abuse were robust

Medicines were managed safely and the provider had procedures in place so they were stored securely, administered in line with recommended guidance and recorded.

Staff had access to regular training to support them to maintain and develop their skills and knowledge. The registered manager had planned some additional training to ensure all staff had sufficient knowledge to meet people's needs. Staff were supported through supervision, observations and appraisals to help them develop professionally.

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. We have made a recommendation the service find out more about training for staff, based on current best practice, in relation to assessing people's capacity in keeping with the principles of the MCA.

Staff took account of people's individual needs and preferences and people were encouraged to be involved in making decisions about their care. People were complimentary about the way staff interacted with them. Independence, privacy and dignity was promoted and respected.

Food was of a good quality and people had enough to eat and drink. The service supported people to maintain their health and wellbeing and people were supported to access healthcare services.

The provider had systems in place to monitor the quality of the service. The management team were open and transparent throughout the inspection and sought feedback to further improve the service provided.

## 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 safe.

Staffing levels were increased following this inspection when information from the falls analysis identified themes and trends the service had not recognised.

There were systems in place to minimise risks to people and to keep them safe.

Procedures were in place to safeguarded people from the potential risk of abuse.

People were provided with their medicines when they needed them and in a safe manner.

### Is the service effective?

**Good**

The service remained effective.

### Is the service caring?

**Good**

The service remained caring.

### Is the service responsive?

**Good**

The service remained responsive.

### Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

The provider/registered manager had not recognised or acted upon themes and trends within their falls analysis.

The management team was approachable and supportive to staff.

External organisations were positive about how the service

worked together in partnership with them to provide people with good quality care.

# Tallis 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 05, 11 and 13 April 2018 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection; they have specialist knowledge in a certain area. An expert-by-experience is a person who has personal experience of caring for someone who uses health and social care services.

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 other information that we hold about the service such as safeguarding information and notifications. Notifications are the events happening in the service the provider is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

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 12 people, six relatives and friends, five professionals and the registered manager, regional operations director, deputy manager and ten members of staff. We reviewed nine people's care files and six staff recruitment and support records. We also looked at a sample of the service's quality assurance systems, the registered manager's arrangements for managing medication, staff training records, staff duty rotas and complaints records.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection at the service in May 2016, we found there were enough staff to meet people's needs and we rated the service good in this area. During this inspection we found some areas required improvement.

At this inspection during our visits, we observed there were enough staff on duty to meet people care needs. However, when we reviewed the log of falls we noted certain themes and trends had not been identified by the registered manager or the provider that might indicate a higher volume of falls were occurring in one area during the afternoon and evening. The falls analysis indicated the date and time of the fall, the location and the action taken by the provider to minimise the risk for each individual. We found action had been taken for each individual but other indications had not been identified. In reviewing the information we noted the location was put down as room number and the specific area was not recorded, we also found the time frames recorded did not correlate with the actual shift times at the service. This meant falls that should be recorded as occurring during the night were being recorded as morning falls. We also found the majority of falls were occurring in people's bedrooms. When we looked at staffing in this area during the evening we noticed that it reduced by one compared to the morning shift and only one staff member was allocated to this area during the night.

We discussed these findings with the registered manager and regional manager and they responded immediately by increasing staff both for the afternoon/evening shift and night shift in the area identified where unwitnessed falls had been found to be higher. They also made the deputy manager supernumery so they could be more available to support the registered manager. The registered manager told us they would review the analysis in more detail to ensure all important information was captured more accurately to identify any trends.

People had risk assessments and management plans in place which provided guidance for staff on how to keep people safe in relation to aspects such as the risk of choking and risk of falls. Most of these risk assessments provided staff with appropriate guidance. However, we found not all risks, specific to each individual had been identified and assessed. For example, we observed one person who spent long periods of time seated in a wheelchair. We spoke with the person who advised it was their choice as they preferred not to be transferred to an armchair. Spending a long time seated in a wheelchair can put people at risk of skin breakdown. We found there was no care plan or risk assessment for this person to provide guidance for staff on how to keep the person safe whilst respecting their rights and freedom. We also noted not all the updates required following a person sustaining a fall were clearly recorded in their care plan. We found the falls risk assessment tool did record the person had sustained a fall but added controls like thirty minute checks or sensor alarm mats added were not always recorded in the same place. For example, we found for one person these additions had been recorded in their sleep care plan, for another person the information was recorded in their mobility plan. This meant the information might not always be obvious or clear to all staff.

Nevertheless, staff demonstrated they knew people well and showed a good awareness of risks to people.

We observed staff were quick to pick up when people were at risk and intervene appropriately. For example, we observed a senior member of staff see a person was walking on the hard floor in just their socks. The staff member reminded the person the floor could be slippery and helped them put shoes on to minimise the risk of the person falling.

Staff told us information about risks to people was shared during staff handover meetings. We observed the handover process and found whilst the verbal information given to staff by the senior was quite detailed, the written hand-over sheet lacked sufficient information to provide guidance to staff. Not all staff attended the handover, which meant they relied on other staff or the written sheet to provide them with the relevant information. The registered manager showed us a new handover sheet they would introduce following our feedback.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their health and wellbeing. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk or malnutrition. Where a risk was identified a risk assessment and management plan was implemented to support staff to manage this risk. The MUST assessment was reviewed on a regular basis and people had regular weight checks. We saw people who had been identified at risk had received support and treatment and were putting on weight. One person told us, following an earlier hospital appointment, they were pleased they had put on weight. Their visiting relative told us, "That's a big thing, because [family member] has been losing weight for so long. The hospital were very pleased about that."

Appropriate recruitment checks took place before staff started work. We looked at the recruitment records of four members of staff and found completed application forms included their full employment history, references, health declarations, proof of identification and evidence criminal record checks had been carried out. Staffs eligibility to work in the UK had also been verified.

Staff had received training in safeguarding procedures so knew how to protect people from the risk of abuse. Staff knew the signs to look for which might indicate someone was being abused and were aware of the reporting process. Staff had been given a copy of the provider's whistle-blowing policy and told us they would feel confident to report any concerns. One staff member said, "I would go straight to the manager, or I would call the abuse line."

People told us they felt safe, one person told us, "I feel very safe here, I wouldn't want to go anywhere else you know." Another person told us, "They always give me this alarm, and they remind me that I'm not being awkward if I press it. I don't like to worry them though . . . they say, 'it's what we're here for'."

There were safe systems in place for storing, administering medicines and for monitoring controlled drugs. Medicines were stored securely in a locked room. Where medicines required refrigeration we saw they were stored in a medicines fridge. Staff responsible for administering medicines checked the room and fridge temperatures daily and we saw temperatures were in the correct range for all medicines to remain effective. We carried out a random check of the medication system and observed part of a medication round. We found the medication checked was correct and the Medication Administration Record forms (MAR) had been completed properly.

The environment was regularly audited and risks assessed to ensure it was safe for people to use. Water temperatures, call bells and fire safety equipment were checked and personal electrical appliance (PAT) testing had been carried out to ensure electronic equipment was in safe working order. Each person had an individual personal emergency evacuation plan (PEEP) in place so staff knew what support they needed in

times of emergency.

Staff had been trained in infection control procedures and were provided with personal protective equipment (PPE). An infection control policy was in place, which provided staff with information relating to infection control. This included PPE, hand washing and information on infectious diseases. We observed the home to be clean and there were suitable infection control systems in place which were audited monthly.

Good

# Is the service effective?

## Our findings

People's physical, mental health and social needs were assessed initially and then on a monthly basis in line with legislation, evidence based guidance and other expert professional bodies. People told us they were able to make choices about their care and support needs and staff listened to their preferences. However, during the inspection we observed three staff supporting people to stand using unsafe manual handling practices. We also saw one staff member try to support a person to stand who was unable to complete the task, the staff member then found another member of staff to assist them. We checked the person's care plan which stated the person required two members of staff to support them with all transfers. We discussed our concerns with the registered manager who later confirmed refresher training in moving and positioning people had been organised immediately to reinforce good practice. On the second day of inspection the registered manager told us the manual handling trainer had already delivered some workshops to staff.

Staff confirmed they had received training in a range of topics to support them to be competent in their role, such as health and safety, manual handling, fire training and first aid. However, we found there were gaps in training which meant staff did not always have the knowledge and skills to meet the specific health needs of some people living at the service. For example, people with diabetes. Care plans were in place but staff were not always familiar with the information recorded. We looked at one person's care plan which listed the signs and symptoms that would alert staff a person was having issues with their blood sugar levels. Some staff told us they had not received training in diabetes and were unaware of the signs and symptoms that might tell them a person was becoming unwell as a result of their condition. In addition, some people living at the service had catheters. Some staff also told us they had not received training in catheter care though had been shown how to empty catheter bags. The deputy manager organised additional training for staff during the inspection and showed us evidence this had been booked.

We did note senior staff were supported to follow areas of professional interest and were given a list of courses they could enrol in to help them develop professionally. The senior staff advised they had received training in catheter care and diabetes and they were trained in how to check people's blood sugar. This meant they could identify any problems quickly and seek appropriate health advice and treatment for people.. A healthcare professional told us, "Staff are picking up signs and symptoms and will bring this to our attention. We visit frequently to support them." Another healthcare professional said, "I think they are on the ball, they ask me to check anyone they are concerned about or ask for advice if they are unsure."

People were provided with sufficient amounts of food and drink to meet their needs. People's care plans included assessments of their nutritional needs, food likes and dislikes and allergies and the support they needed with eating and drinking. We saw care plans contained advice from speech and language therapist's and dieticians to support people with eating and drinking. We observed lunch being served in the two dining rooms. In both rooms, there was a social, friendly atmosphere, with staff spending time with people to make sure their dining experience was as pleasurable as possible. Choices of drinks were readily available, with 'top-ups' being offered. People were given ample time to make their choices from the menu, and staff brought the two dinners on offer to some people so they could make a more informed choice. Gravy was brought to each person in turn, and they were asked if they would like more, and where they would like it

poured. Condiments were also offered to people.

People's comments about food were mainly positive and included. "I have to have a very soft diet, they know that and always bring me something I can eat", "If I don't like the food on offer they'll do me a salad or an omelette, but it has to be ordered earlier in the morning", "I do get a bit fed up with mince and sausages, I'd like more fish and some spicy foods sometimes." A person told us they had been to a hospital appointment, so had missed the lunchtime period. They said, "As soon as I got back they brought me my lunch, they'd saved it for me, and it was very nice."

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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and senior staff demonstrated a good understanding of the MCA and DoLS. Where there were concerns regarding a person's ability to make specific decisions we saw mental capacity assessments had been completed but these were not always decision specific or detailed in regards to who was consulted as part of this assessment.

We recommend the service find out more about training for staff, based on current best practice, in relation to assessing people's capacity in keeping with the principles of the MCA.

Where an application to deprive the person of their liberty for their own safety had been authorised by the local authority we saw all of the appropriate documents were in place and kept under review and staff were following the conditions of the authorisation.

We observed staff offering people choices. Where people struggled to understand and communicate their decisions, staff showed people items and encouraged them to indicate their choice by pointing.

People had access to health care support and the service received considerable support from the visiting GP and the community nursing team. The registered manager met regularly with other representatives from health services which demonstrated a commitment to work pro-actively with other organisations. Staff monitored people's mental and physical health and when there were concerns people were referred to appropriate healthcare professionals for advice and support. We saw people's care files included records of their appointments with healthcare professionals. One person told us, "They'd notice if I wasn't myself – I had toothache recently, and they arranged for me to have two teeth taken out at the dentist. Another person said that recently they felt dizzy whilst walking and said, "People noticed immediately, and they got the doctor in the next day. It's my blood pressure going too low, so now they check it twice every day." A healthcare professional told us, "It is a good service, with good examples of quality care." Another healthcare professional said, "There are some good staff here and always available to help me if needed."

The building was suited to the needs of people. All of the bedrooms had ensuite bathroom facilities and lounge areas were comfortable and sociable. The service had appropriate signage and adaptions to aid orientation and understanding for people living with dementia. Smaller themed seating areas supported

people to have quiet places to sit.

Good

# Is the service caring?

## Our findings

People told us staff were caring or very caring. One person said, " Staff were 'marvellous', and always show great patience and understanding." Another person said, "Staff are always very kind and friendly to me." A third person added, "The staff are alright to me, they'll do anything for you. I'd say they're friendly and chatty, I happened to mention this morning that my bedclothes needed changing, and it was done when I came back from breakfast. At night-time, if I'm thirsty they'll happily bring me a drink of water, or make me a cup of tea. They don't moan." A relative told us, "The staff here are excellent, I can't fault them. I ring up every day to check on [family member] and they never seem to mind." Another relative said, "It is absolutely fantastic, the best year of [family members] life and a godsend to us. They are caring, attentive, informative and level of care is fantastic."

Our observations supported this. During lunch, a person took offence at another person's behaviour at the table, and asked to be moved. Staff handled this in a quiet, unobtrusive manner trying hard not to embarrass the other person in question. This they did whilst assisting the person to move to another table where they could eat their lunch more happily. We saw numerous positive interactions between staff and people that use the service during our visits.

Staff were appointed as keyworkers for people. This meant they had special responsibilities to that person such as, keeping their room tidy, ensuring they had sufficient toiletries and being the point of contact for the person and their family. Staff demonstrated they knew people well who they were keyworker for. One staff member told us, "[Named person] likes to sit in a particular spot, they don't like to go out and they don't eat salad; they like apple juice and they don't drink coffee."

We saw people or their representatives had signed their care plan which demonstrated people were involved in their care and support planning and had given their consent. A café at the service was available for family members to use. Several of the relatives told us how much they appreciated the café/kitchen facilities, saying they can make themselves drinks whenever they visit. One relative said, "I've just helped myself, made drinks for us both, it makes it more homely." Another relative said, "I come at different times and see consistency, they do care and it is like an extended family."

Staff had received training on quality and diversity and understood how to support people with diverse needs. People's care plans included information on their religious and cultural needs. A church service was held at the service monthly.

Staff adapted their communication to support people to be involved in decisions about their care and support. One staff member told us, "[Named person] doesn't speak English, we use non-verbal communication like showing them things; we are also learning words and phrases in their language." The staff member was able to tell me how they said 'Thank you' to the person in their native tongue.

People's privacy and dignity was respected and staff understood the importance of promoting people's independence. A staff member told us, "Its small things like helping people to wash but don't take over to

support their dignity. A relative we spoke with told us their family member was often tearful, she told us, "Staff understand they have always been busy, they can't stand not doing anything and like jobs to do, so they give them things to do, for example, they go around and collect the washing for them, it makes them feel useful.

Good

# Is the service responsive?

## Our findings

Care plans included a section called 'My day', which provided information about each person's routines and preferences. This information helped staff to provide person-centred care, which means care tailored to meet the specific needs of each individual. We asked staff how they provided person-centred care to people. One staff member told us, "It's about knowing people and what they like, for example, [named person] at night, they like a specific blanket in certain temperatures; I know what they like now." Another staff member said, "One person has a bird in their room and they look after the bird but we help out and talk to them about it." However, people told us sometimes they did not like to ask for extra baths or showers as staff were busy. One person said, "Yesterday I had a lovely bath, what a treat . . . yes, I'd like more showers or baths if I'm honest, but I know they're busy." Another person said, "I just have a wash down, but I'd like more baths or showers. I don't think there are enough girls for that though." We saw from records people were receiving regular baths and showers, we discussed this with the registered manager who said they would re visit people's preferences in this area to check they were still current.

Family trees were completed with people or their relatives, which allowed staff to understand people's life history. This information helped staff to support people to maintain relationships that were important to them.

People's care plans included information about activities people enjoyed. We saw one person's care plan which instructed staff, "[person] likes to be informed of all activities." We observed staff sharing information on activities with the person and supporting them to attend. We also saw another example where it had been recorded the person enjoyed bingo. Bingo had been organised whilst we were inspecting and we observed staff supporting the person to enjoy the session.

A full programme of varied activities was advertised on notice boards around the home. These included quizzes, card games, jigsaws, arts & crafts and discussion groups, together with a visiting entertainer each Friday afternoon. When visiting a lounge in the afternoon we observed a member of staff sharing a memory box with people. They took out familiar household objects from the past for example, a laundry 'blue bag', sticky fly-paper and liquorice wood sticks, and asked people if they could remember what they were, and how they were used. This generated much discussion, and story-telling about peoples' memories. It was clear people thoroughly enjoyed this activity. During the day, we also noticed people completing jigsaw puzzles, reading books or newspapers, and in the afternoon we saw the activities coordinator visiting peoples' rooms and offering them printed word searches.

We spoke to the activity co-ordinators who told us they provide activities seven days a week and provided a mixture of group activities and one to one activities. They told us they tried to use people's previous hobbies and interests when organising activities for people. For example, they knew one person had an interest in bird watching so they involved them in making bird feeders for the garden to attract more birds. They started a knitting group with people and now have people making 'twiddlemuffs' for people living with dementia. Twiddlemuffs can help to provide comfort and keep people living with dementia hands and minds occupied. Activities included trips out to places like the local pub, garden centres and the seaside.

They told us of a recent initiative called 'bridging the gap' where local school children came into the home to read to people or join in arts and crafts with people. The service had also introduced an electronic tablet people were using to complete favourite activities such as crosswords or card games, the use of this tablet was being recorded and monitored by the service to enable them to review its effectiveness. The maintenance person had recently won an 'unsung hero' award due to their considerable efforts in fund raising. The registered manager told us that their ability to get great raffle prizes including a trip to turkey meant additional funds were raised to support the activity and event programme. This fund raising had meant the service had purchased a billiards table and recently taken delivery of a telephone box.

However, we did see that guidance from health professionals regarding supporting people to follow their interests was not always followed. For example, In January 2018 one person had been seen by an occupational therapist to complete an assessment of their interests. The OT had fed back to the service that the person liked music by Chopin and a request had been made to source a CD. At the time of our inspection in April 2018, this request had not yet been actioned. We discussed this with the registered manager who agreed to action this immediately.

There was a complaints procedure in place which explained how people could raise a complaint. People and relatives we spoke with knew how to raise a complaint and who they should speak to. One person said, "I would complain if there were any problems, but there aren't. . . . I'm sure they'd listen to me." Another person told us, "I'd ask to see someone from the office if I had a complaint." A relative said, "I feel I can raise any issue with the manager or seniors . . . I'm never made to feel like I'm being a nuisance. If they can change anything to help us, they will sort it." They also added, "The Relatives' Meetings are always booked for 4pm which is never a good time for me so I can't go, I'd like them to be staggered at different times, and I know this would help others too." We reviewed complaints records and saw three complaints had been received in 2018, two had been resolved and responded to appropriately. One complaint was still on going.

People's wishes for their end of life care had been explored and documented if this was their choice. Information recorded included people's religious beliefs and any preferences they may have at the end of their life. The service kept important information, which included preferred priorities for care documents. Where appropriate a do not attempt cardiopulmonary resuscitation (DNACPR). A DNACPR is a way of recording the decision a person, or others on their behalf had made that they were not to be resuscitated in the event of a sudden cardiac collapse.

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection in May 2016 the service was rated good. During this inspection we found some areas required improvement.

We found while action had been taken regarding people's individual falls the registered manager and provider had not identified themes and trends within the falls analysis that potentially indicated more staff might be required to further mitigate risks associated with people falling. Although the provider responded immediately to our findings and increased staffing in one high risk area this had only been identified by inspectors during the inspection. This meant the information collated by the provider was not being analysed in sufficient detail to highlight these trends prior to our visit.

It was noted while information related to controls put into place to mitigate the risk for individual people was found on the falls analysis, we found senior staff did not always take a consistent approach when updating care plans and written handover information was not always captured in detail. This meant the registered manager could not always be assured changes and updates to people's risk assessments were communicated effectively to staff. The registered manager and deputy manager responded to these findings immediately by updating the handover sheet and communicating to senior staff what information they would expect to be written on the handover.

People, relatives and professionals we spoke with said the service was very well-led. Two deputy managers supported the registered manager and all were a visible presence in the service. One person told us, "I think they do a good job of picking the right people to work here, they know who would fit in and do the right thing." Another person said, "I know who the manager is, and they are very approachable. I'd talk to them if I had any problems. I think they would sort it." A third person said, "I'd totally recommend it here to anyone, they all work together well to look after us." A relative said, "I really like [named registered manager] they put the hours in and they give me confidence, and the staff really care for people." Another relative said, "We talk to [named deputy] and get updates, all our questions are answered, it has exceeded our expectations."

Staff were positive about the culture and the management style at the service. One staff member told us, "It's a nice place to work, challenging but I enjoy it." Another said, "Good manager, very supportive." Staff told us the deputy managers worked alternate weekends which gave them support and guidance from senior staff throughout the week.

There were a range of audits and checks in place to monitor safety and quality of care within the service. Audits included health and safety, infection control, medicines and care document checks. The regional operations director carried out a monthly visit and all actions recorded were followed up by the service. An external company also completed twice yearly checks on the service with return visits to check and sign off any action points.

A customer satisfaction survey was carried out yearly with the last survey sent in 2017. Results were analysed and an action plan was in place for any shortfalls. We noted the response rate for this questionnaire was

very low with only 13 responses returned from 80 sent out. However, all results returned were positive.

The service had good links with a host of health and social care professionals and there were good working relationships with local primary care providers and attended neighbourhood meetings with GP's and local clinical commissioning groups. The feedback we received was positive and one professional told us, "It is a lovely home." Another professional said, "If I go to the manager about something, they will find a solution and staff are kind."

Records showed the Care Quality Commission (CQC) had been informed of incidents when the provider was legally obliged to do so. This showed us the registered manager was aware of their responsibilities in reporting events to CQC when required.