Care Quality Commission

Swallowcourt Limited

Ponsandane

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Ponsandane on 6 February 2018. Ponsandane is a 'care home' that provides nursing care for a maximum of 58 adults. 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. At the time of the inspection there were 42 people living at the service. The accommodation is spread over four floors. Shared lounges and a large dining room are on the ground floor. There was a working lift in place.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

On the day of the inspection there was a relaxed and friendly atmosphere in the service. People and staff welcomed us into the service and were keen to share their views with us. People told us they were happy with the care they received and believed it was a safe environment. Comments from people and their relatives included; "They never neglect what they need to do", "Yes, 110% safe" and "Yes, I am very happy here; I couldn't have any better; nothing is too much trouble for them." Staff knew how to recognise and report the signs of abuse.

Throughout the day we saw numerous examples of staff and people laughing and chatting together in a light-hearted and friendly way. Staff continually checked on people's well-being and were respectful in their approach.

Improvements were being made to the environment and the dining room was being redecorated at the time of the inspection. Carpets were being replaced in some areas of the building. Bedrooms were personalised to reflect people's individual tastes.

Arrangements for the storing and administration of people's medicines were robust. Medicine Administration Records (MARS) were completed appropriately and there were no gaps in the records.

There was a system of induction, training, one-to-one supervision and appraisals in place. Staff all told us they were very well supported. Throughout the day we heard staff refer to 'team' working and it was clear staff felt part of a supportive and nurturing team. There were sufficient numbers of suitably qualified staff on duty and staffing levels were adjusted to meet people's changing needs and wishes. Staff completed a thorough recruitment process to ensure they had the appropriate skills and knowledge.

Care plans were well organised and contained personalised information about individual's needs and wishes. Care planning was reviewed regularly and whenever people's needs changed. People's care plans gave direction and guidance for staff to follow to help ensure people received their care and support in the

way they wanted. Risks in relation to people's care and support were assessed and planned for to minimise the risk of harm.

People were able to take part in a range of group and individual activities. Two full time activity coordinators were in post who arranged regular events for people. These included gentle exercise sessions, arts and crafts, visits by external entertainers and trips out.

Management and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Staff demonstrated the principles of the MCA in the way they cared for people. Where people did not have the capacity to make certain decisions the service acted in accordance with legal requirements. Applications for DoLS authorisations had been made to the local authority appropriately. Staff assumed people had capacity and were keen to find ways to help ensure people's views were heard. 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.

There was a management structure in the service which provided clear lines of responsibility and accountability. Staff had a positive attitude and the management team provided strong leadership and led by example. Comments from staff included, "The manager is very supportive" and "The best manager I've ever had, she's constantly flitting around."

There were regular meetings for people and their families, which meant they could share their views about the running of the service. People and their families were given information about how to complain. There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

CareQuality Commission

Ponsandane

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 unannounced inspection took place on 6 February 2018. The inspection visit was carried out by two adult social care inspectors, an expert by experience and a specialist nurse advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor had a background in nursing care.

Before the inspection we reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law. We had not requested a Provider Information Return (PIR) recently. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people and two visitors. We also spoke with the manager and deputy manager, the nominated individual, the head of quality compliance and specialist services, the training manager and 18 members of staff including nursing staff, specialist healthcare assistants, care staff, kitchen staff, an administrative worker, an activities co-ordinator and domestic staff.

We looked at three people's care plans, monitoring records for six people, Medicine Administration Records (MAR), four staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Ponsandane. Comments included, "They never neglect what they need to do", "Yes, 110% safe" and "Yes, I am very happy here; I couldn't have any better; nothing is too much trouble for them."

People were protected from the risk of abuse because staff had received training to help them identify possible signs of abuse and understand what action to take. Staff received safeguarding training as part of their initial induction and this was regularly updated. They were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. Staff told us if they had any concerns they would report them to management and believed they would be followed up appropriately. Information about how to report concerns was available to staff and visitors in the foyer and staff room. A staff survey planned for later in the month focused on areas covered in CQC's, 'Is the service safe?' question. For example, it asked if staff felt confident to support people to be safe.

There was an equality and diversity policy in place and staff received training in this area as part of the induction process. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. A member of staff had recently been given the role of 'human rights champion.' This meant they were supported to specialise in this area and share their learning with the rest of the staff tem. The manager told us the member of staff had been chosen due to their approach to care and commitment to protecting people's rights.

Care files contained individual risk assessments which identified any risks to the person and gave instructions for staff to help manage the risks. These risk assessments covered areas such as nutrition, pressure sores, falls, choking and breathing difficulties. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe.

There were enough skilled and experienced staff on duty to keep people safe and meet their needs. Nurses were supported by specialist care workers and healthcare assistants. The manager and deputy manager were also available to support people if needed. Neither were included on the rota which meant they could provide cover for unexpected staff absence or additional support in an emergency. In addition to care staff there were two full time activity co-ordinators, kitchen staff, domestic staff and maintenance workers. Staff and people all told us there were enough staff to ensure people's needs were met.

During the inspection we observed call bells were answered quickly. Call bell audits showed average response times were between three and four minutes. The deputy manager carried out daily checks of call bell response rates. Where they found people had waited an unacceptable length of time for staff to respond to call bells they followed this up to try and establish the reason and apologise to the person concerned. People told us staff were quick to respond to requests for assistance. One commented; "I have an alarm, and it's all very cleverly done. I don't need to be concerned because I get help when I need it. They are quite quick to come and attend to me; it's all done in a 'flow' – it's very good." A relative told us; "The alarm is always in his reach besides him and he doesn't have to wait long at all. I have pressed it for him when I am

visiting each day and we don't wait long for them."

Staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required to provide care to meet people's needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

The service had suitable arrangements for the ordering, storage, administration and disposal of medicines. Nurses and specialist healthcare assistants were responsible for the administration of medicines. Specialist healthcare assistants had completed additional training to enable them to support nursing staff in this area. Medicines trollies were kept securely on each floor. Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored. The temperature of the room where medicines were stored was also monitored and was within the acceptable range. Medicines which required stricter controls by law were stored correctly in a separate cupboard and records kept in line with relevant legislation. Medicines which needed to be taken at specific times were administered appropriately.

There were auditing systems in place to carry out weekly and monthly checks of medicines. Medicine Administration Records (MARS) had been completed appropriately and these were neat and easy to decipher. This meant any gaps or errors could be more quickly identified. Any handwritten entries were counter signed by a second member of staff to help prevent information being wrongly recorded. Topical creams were dated on opening and there were clear records of when staff applied creams for people.

Incidents and accidents were recorded in the service. Appropriate action had been taken and where necessary changes made to learn from the events or seek specialist advice from external professionals. Care records were accurate, complete, legible and contained details of people's current needs and wishes. They were stored securely and were accessible to staff and visiting professionals when required.

The environment was clean and there were no unpleasant odours. Housekeeping staff were employed to work every day and had clear routines to follow. The housekeeper was the named infection control lead for the service. This meant they had responsibility for overseeing this area. Staff received suitable training about infection control, and records showed all staff had received this. Hand gel dispensers and personal protective equipment (PPE) such as aprons and gloves were available for staff throughout the building. Some people needed help from staff to move from one place to another, with the use of a hoist and a sling. Each person had been allocated their own individually assessed sling which was suitable for their needs. This meant they could be supported to move safely and reduced the risk of cross infection.

Equipment owned or used by the service, such as specialist chairs, beds, adapted wheelchairs, hoists and stand aids, were suitably maintained. Systems were in place to ensure equipment was regularly serviced and repaired as necessary. All necessary safety checks and tests had been completed by appropriately skilled contractors. There was a system of health and safety risk assessment for the building. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. People had Personal Emergency Evacuation Plans (PEEPs) in place outlining the support they would need if they had to leave the building in an emergency.

Good

Is the service effective?

Our findings

People's need and choices were assessed prior to moving in to the service. This helped ensure people's expectations could be met by the service. Staff were knowledgeable about the people living at the service and had the skills to meet their needs. In our conversations with them it was clear they knew people well. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination in the way they provided care for people.

The 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 had their capacity assessed appropriately and this was well documented in people's care records. Some people had appointed lasting powers of attorney arrangements in place for either finances or health, and this was also recorded. This meant staff would be aware when people were unable to consent and whether anyone had the legal authority to consent to decisions on their behalf.

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. Management had applied for some people to have a DoLS authorisation put in place and were waiting for the outcomes of applications from the Supervisory Body. Records showed the deputy manager communicated regularly with the local DoLS team to ensure people's legal rights were protected. The ethos of the service was to assume people had capacity to make day to day decisions. The deputy manager told us; "Just because they can't speak doesn't mean they can't consent." One person's care plan read; "Staff can interpret her wishes with pictures and her nodding and pointing."

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 observed throughout the inspection that staff asked for people's consent before assisting them with any care or support. People made their own decisions about how they wanted to live their life and spend their time.

Newly employed staff completed an induction which included training in areas identified as necessary for the service such as fire, infection control, health and safety, mental capacity, safeguarding and equality and diversity. They also spent time familiarising themselves with the service's policies and procedures and shadowing experienced staff so they could understand the needs of the people living at the service. The induction was in line with the Care Certificate, which is an industry recognised induction to give care staff, that are new to working in care, an understanding of good working practice within the care sector.

People received effective care because they were supported by a staff team who received regular training and had a good understanding of people's needs. Staff they told us they were provided with relevant training which gave them the skills and knowledge to support people effectively. There was a training

programme in place to help ensure staff received relevant training and refresher training was kept up to date. Staff training needs were overseen by the organisation's training team who highlighted when any training needed to be updated. The training matrix for Ponsandane showed some staff were due to have refresher training and this had been booked. One member of staff commented; "The organisation is brilliant at training, they let us go on courses and encourage us to develop our knowledge."

Staff told us they felt well supported and received regular one-to-one supervision and annual appraisals. There was a lack of documentation to evidence this had occurred. Effective supervision is important as it can influence productivity, absenteeism rates, workplace culture and impact on the quality of care being delivered.

We recommend the service consider current guidance on the importance of organising and recording formal and informal supervision sessions and take action to update their practice accordingly.

Staff supported people to maintain a balanced diet in line with their dietary needs and preferences. Kitchen staff were aware of any specific needs or likes and dislikes. For example, on the day of the inspection one person was feeling upset. The cook told us they had prepared their favourite meal for them to try and cheer them up. People were offered choices at each meal. One person told us; "You have a choice of meals, they come around with a card and you can choose from three meals and if you don't want any of them, they make something else."

We observed the support people received during the lunchtime period. The atmosphere was warm and friendly with staff talking with people as they ate their meals. People were supported to eat at a pace that suited them. We heard one person apologising for being slow to finish their meal. The member of staff reassured them; "No need, I'm not in any hurry at all."

The deputy manager told us they did a 'lunchtime walk round' at least once a fortnight to ask people if they were enjoying their meal and encourage a social environment. Notes from a recent meeting recorded that it had been observed people in large motorised wheelchairs were unable to sit with other people as their wheelchairs would not fit under the tables. This had been identified as impacting on their ability to socialise and was effectively isolating them. Leg risers had been purchased to raise the level of a table top to enable people to sit together. This showed that reasonable adjustments were made to help ensure everyone had equal access to joining in with this social experience.

People's health conditions were well managed and staff supported people to access healthcare services such as tissue viability nurses, GPs and speech and language therapists (SALT). Care records contained details of multi professionals visits and care plans were updated when advice and guidance was given.

Accommodation was spread over three floors and there was a working passenger lift. There was limited signage in place for people who might benefit from this additional support to help them move around the premises independently. However, at the time of the inspection most people did not require this assistance. Some corridors were cluttered with pieces of furniture, equipment, clinical bins and bedding. We discussed this with the management team who told us there was a lack of storage spaces and it was important staff were able to access equipment quickly to support people as and when required and in a timely manner. They told us they would try and identify ways of keeping equipment available for staff throughout the building while improving the homely feel of the environment. There were plenty of safe and secure outside spaces that people could access independently or with assistance from staff.

Good

Is the service caring?

Our findings

On the day of the inspection there was a relaxed and friendly atmosphere in the service and staff interacted with people in a caring and compassionate manner. People told us they were happy with the care they received and believed it was a safe environment. Comments from people and their relatives included, "The staff here are wonderful, so caring, nothing is too much trouble", "The carers are good, kind, considerate and respectful of me", "The carers always walk in with a smile on their face. They are all very friendly" and "We're cared for ever so well here."

We saw many examples of positive interactions between staff and people during the day. Staff were warm and friendly, frequently enquiring if people were comfortable and had all they needed. They were genuinely concerned for people's well-being. We observed one member of staff entering a shared lounge and approach a person saying; "I've come to see how you are, I hear you've not been too well."

We saw staff engaging with people and spending time with them. For example, on the day of the inspection it was snowing and this had reminded one person of their childhood growing up in another country. They had asked the manager; "Can I sing you a song in my language." They manager stopped and sang with the person which clearly brought both of them pleasure. Later on in the day we saw a person standing in the foyer chatting to the administrative worker, music was playing and the person started to dance. The member of staff joined in with them and they shared a laugh together.

Staff encouraged people with shared interests to spend time together which helped people forge friendships. For example, two people were sitting together knitting by a large window. They chatted to each other about the general goings on in the building and let other people know as relatives arrived. It was clear they knew each other and other people and their families well and had built up a social network within the service.

Staff were patient and discreet when providing care for people. One person could be resistant to personal care and this was recorded in their care plan. Guidance for staff stated; "Persevere and approach quietly and calmly, maybe later in the day when she is more relaxed." We observed staff supporting this person who was very frail and rarely spoke. Staff sat quietly with them and were gentle and kind in their approach. One person told us; "They do so [provide personal care] in a way that it seems like it's a natural happening almost and they always ask me first. The human aspect is very important with personal care."

Staff took the time to speak with people as they supported them and we observed many positive interactions that supported people's wellbeing. For example, we observed a care worker supporting one person to eat a sandwich. The worker was completely focused on the person they were helping, sitting down to establish eye contact and gently questioning them to determine the level of support they wanted and needed.

Staff clearly enjoyed their work and were motivated to provide as good a service as possible for people. Comments from staff included; "I enjoy my job" and "I love working here, it's like a big family" The manager

told us; "The name is in the badge, a carer cares."

Staff had access to information about people's life histories and backgrounds. They knew what was important to people and used this knowledge to help them engage meaningfully with people. For example, one person's communication care plan read; "[Person's name] was a yoga teacher and her eyes 'light up' when you mention this to her." Some people had 'This is me' books in their rooms which gave further details about people's backgrounds, interests, likes and preferences. If people had any religious beliefs this was clearly recorded in their care plan.

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering.

Some people preferred to spend their time in their bedrooms and staff respected their choice. However, the deputy manager told us they recognised this meant people were at risk of becoming socially isolated. Care plans guided staff on the action they should take to minimise this risk. For example; "Likes the door left open" and "Go in at least three times a day."

Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

People and their families had the opportunity to be involved in decisions about their care and the running of the service. There were regular meetings for people and their families, which meant they could share their views about the service.

Good

Is the service responsive?

Our findings

People had care plans in place covering a range of areas such as communication, nutrition and hydration and personal care. Care plans gave direction and guidance for staff to follow to help ensure people received their care and support in the way they wanted. Staff were aware of each individual's care plans, and told us care plans were informative and gave them the individual guidance they needed to care for people. All care plans were regularly reviewed to help ensure the information was up to date.

Some people had difficulty accessing information due to their health needs. Care plans recorded when people might need additional support and what form that support might take. For example, some people were hard of hearing or had restricted vision. Care plans stated if they required hearing aids or glasses. Other people had limited communication skills and there was guidance for staff on how to support people. For example, one person had aphasia, a communication disorder often diagnosed in people who have had a stroke. There was information for staff about the disorder generally as well as specific information on how to support communication with the individual. People who had capacity had agreed to information in care plans being shared with other professionals if necessary. This demonstrated the service was identifying, recording, highlighting and sharing information about people's information and communication needs in line with legislation laid down in the Accessible Information Standard.

Some people's health needs meant they were at increased risk and charts were used to record the care they had received in specific areas. For example, some people were at risk of losing weight or becoming dehydrated. Food and fluid charts were in place so staff would be aware if people were not eating or drinking enough to maintain their well-being. The need for these charts was clearly recorded in people's care plans. We checked monitoring charts in people's rooms and saw these were consistently completed. Night staff had responsibility for totalling the amounts people had eaten or drunk during the day. This information was reviewed on a daily basis by a member of the management team. This meant any areas of concern would be quickly identified.

Some people required specialist equipment to protect them from the risk of developing pressure damage to their skin. Relevant equipment was provided and records showed staff monitored this equipment to ensure it was set according to people's individual needs.

A system of daily handovers and meetings provided staff with clear information about people's needs and kept staff informed as people's needs changed. 'Flash' meetings were held each day with the manager and representatives from the various staff groups to get an overview of what was planned for the day and any specific issues or concerns. Nursing staff and specialist healthcare assistants had handovers at the start of any shift to help ensure they were up to date with any changes in people's needs. Staff wrote daily records detailing the care and support provided each day and how people had spent their time.

When needed the service provided end of life care for people. People's wishes regarding this were documented appropriately. Nursing staff attended training to enable them to support people at this stage of their lives.

There were activities on offer within the service and in the community although the numbers of people who could take part in trips out were limited due to a lack of transport. We discussed this with the management team who told us they were exploring ways of addressing this issue. Two full time activity coordinators were employed who arranged regular activities for people. A volunteer visited the service once a week to lead a Gentleman's Club when male residents, who were often reluctant to take part in group activities, met to have a glass of whiskey and a 'chat'. Comments from people and relatives included; "I play dominoes and the bingo", "I like the trips out. There are opportunities here", "They had a party at Christmas, and the food was amazing", "Mum enjoys the trips out to the coastline and they end up at Marazion for ice-cream", "Mum loves the singer that comes in, the choirs and the entertainers; she loves the Sinatra Tribute Act. There are lots of things that Mum can do."

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. When concerns had been raised these had been dealt with in a timely manner and plans had been put in place to make any necessary improvements. Records clearly showed when complaints had been received, acknowledged, investigated and any action taken.

Good

Is the service well-led?

Our findings

There was a robust system in place to assess and monitor the quality of the service provided. Regular audits were carried out across a wide range of areas including falls, DoLS, medicines and care planning. For example, an audit of capacity assessments and DoLS applications and authorisations had recently been completed. This allowed oversight of which people had been assessed as lacking capacity in any area and who had DoLS applications in process. On the day of the inspection we accompanied a nurse as they carried out an audit of pressure mattress settings. This involved ensuring mattresses were set in line with people's weight and making any adjustments when people lost or gained weight. Action was taken following any issues highlighted in audits. For example, we saw a nutrition audit had been completed and, where people had been identified as losing weight over a period of time, the GP had been contacted for advice.

There was a hierarchy within the organisation which provided clear lines of responsibility and accountability. The nominated individual had oversight of all Swallowcourt services. They were supported by two newly appointed members of the management team, a head of quality compliance and specialist services, and a clinical quality manager. A training team was responsible for induction and delivering and organising training.

The service requires a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager in post who was in the process of applying to be registered.

The manager was supported by a deputy manager. Both had clear areas of responsibility. For example, the manager organised staff rotas and the deputy carried out regular audits of most areas. Nurses were supported by specialist healthcare assistants who had received additional training. Individual members of staff had been identified as 'champions' in various areas. For example, there were nominated champions for infection control, human rights, tissue viability and continence. Managers and deputy managers across Swallowcourt were on the on call rota. This meant staff were always able to speak to a manager for advice at any time of day or night.

The management team provided strong leadership and led by example. Staff told us both the manager and deputy manager were visible and approachable. One commented; "Every morning [manager's name] comes in and says hello to everyone, staff and residents and makes sure everyone is fine." Staff repeatedly referred to 'team' and we identified this as a common theme throughout the day. Comments from staff included, "The team has a good ethos here", "We are not divided in our departments, we are the same team." Staff told us they had not experienced any discrimination and were treated fairly.

Regular staff meetings were held for all staff teams. These were an opportunity to share any news about the organisation and update on changes in the care sector. Staff told us there was an open culture at the service and they had opportunities to discuss any concerns. An Employee Forum was being set up to facilitate a link

between staff and senior management.

People and relatives all described the management of the home as open and approachable. One person commented; "They [the manager] are a splendid person; they have a chat with me sometimes'. There were regular meetings for people and their families, which meant they could share their views about the running of the service. Not everyone we spoke with was aware of the meetings. Those that were spoke about them positively. Comments included; "Occasionally we have discussions and can make suggestions of how to improve our 'amusement' and different things at the home; they are quite helpful" and "We always have a gathering and we can say what we would like; and what could be better; and what could be added, situations change so much." A suggestion box was in the foyer to allow people and visitors an opportunity to raise any concerns or ideas at any time and anonymously if they wished.

People's care records were kept securely and confidentially, in line with the legal requirements. Services are required to notify CQC of various events and incidents to allow us to monitor the service. The registered manager had ensured that notifications of such events had been submitted to CQC appropriately. The ratings of the last inspection were displayed in the service and on the provider's website.

We met with the head of quality compliance and specialist services for Swallowcourt who outlined plans to drive improvement across the organisation. They told us they were working to develop a more consistent delivery of care across the group. This would involve sharing best practice and standardizing systems and processes. Managers were required to complete weekly reports which the senior management team analysed to identify any trends or areas for concern. Monthly governance meetings were scheduled to examine any areas of concern or examples of what was working well. Areas looked at included residents, premises, staffing and recruitment, incidents and accidents, complaints and compliments and audit analyses. The nominated individual told us they were keen to invest in technology to further improve the delivery and recording of care.