Express Care Limited

Crystal Court

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

This inspection was unannounced and was carried out on 5 February 2016. At the previous inspection, which took place on 17 June 2014 the provider was meeting regulations. Crystal Court is registered to provide accommodation for persons who require nursing or personal care, treatment of disease disorder or injury and diagnostic and screening for up to 62 people. It is divided into three units; a general nursing unit; a unit for people living with dementia who required residential care and a unit for people living with dementia who require nursing care. There were 46 people living at Crystal Court on the day we inspected, 30 of whom required nursing care.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager had also completed a Provider Information Return (PIR).The PIR 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.

Crystal Court provided good care and support for the people that lived there. People we spoke with said they felt safe and they spoke positively about the care and support they received. Staff recruitment processes included carrying out appropriate checks to reduce the risk of employing unsuitable people.

Staff knew the correct procedures to follow if they considered someone was at risk of harm or abuse. They received appropriate safeguarding training and there were policies and procedures to support them in their role.

The service had systems in place for recording and analysing incidents and accidents so that action could be taken to reduce risk to people's safety. Risk assessments were completed so that risks to people could be minimised whilst still supporting people to remain independent.

The home had safe systems in place to ensure people received their medication as prescribed; this included regular auditing by the home and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was reassessed regularly.

Staff received appropriate training, supervision and support. Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure that people's rights were protected when they were unable to make decisions.

There was a variety of choices available on the menus, snacks were freely available throughout the home and people were supported to have sufficient food and drinks to meet their dietary needs.

People had good access to health care services and the service was committed to working in partnership

with healthcare professionals.

Staff were caring, kind and compassionate and cared for people in a manner that promoted their privacy and dignity. People felt listened to and had their views and choices respected.

People were involved in the decisions about their care and their care plans provided information on how to assist and support them in meeting their needs.

People were involved in activities they liked and these were linked to previous life experience, interests and hobbies. Visitors were made welcome to the home and people were supported to maintain relationships with their friends and relatives.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

The provider actively sought the views of people using and visiting the service. They were asked to complete an annual survey and this enabled the provider to address any shortfalls and improve the service.

The service had a quality assurance system, and records showed that identified problems and opportunities to change things for the better had been addressed promptly. As a result we could see that the quality of the service was continuously improving.

Staff told us they were clear about their roles and responsibilities. Staff had a good understanding of the ethos of the home and the quality assurance systems in place. This helped to ensure that people received a good quality service. They told us the registered manager was supportive and promoted positive team working.

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.

People and their relatives told us that the home was safe. Staff had undertaken training with regard to safeguarding adults and were able to demonstrate what to do if they suspected abuse was happening.

We found there were sufficient staff on duty to attend to people's needs. The way in which staff were recruited reduced the risk of unsuitable staff working at the home.

People's medicines were managed safely and they received them as prescribed.

Is the service effective?

Good

The service was effective.

Staff had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the associated Deprivation of Liberty Safeguards (DoLS).

People were supported to eat sufficient nutritious food and drink. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff.

The service had developed good links with health care professionals which meant people had their health needs met in a timely manner when their needs changed.

The staff had received regular training and supervision to enable them to effectively meet the needs of the people they supported.

Is the service caring?

Good

The service was caring.

The staff respected people's wishes and choices and promoted their privacy and dignity.

We observed positive and respectful interactions between the

staff and people who used the service.

The staff we spoke with demonstrated that they knew the people they supported well and that they understood their needs.

Is the service responsive?

Good

The service was responsive.

People were involved in planning how their care and support was provided. Staff knew people's individual preferences and these were taken account of.

Documentation was completed with up to date, accurate information to support people's needs being met when they transferred between services.

People had an opportunity to participate in group activities and attention was also paid to people's individual interests and hobbies.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Good

The service was well led.

Staff and people using the service, their relatives and representatives expressed confidence in the registered manager's abilities to provide good quality care.

There were effective quality assurance systems in place to monitor the service and drive forward improvements. This included internal audits and provider lead audits which provided positive feedback about the service.

People were encouraged to routinely share their experiences of the service and the provider used this information to further improve on the service.

Staff were well motivated and felt that their views were listened to and respected.

Crystal Court

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 5 February 2016 and was unannounced. The inspection was carried out by one adult social care inspector and a specialist professional advisor who specialised in providing services to people living with dementia.

Prior to the inspection we reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send to the Commission by law. We planned the inspection using this information. We also contacted the local authority contracting team to ask for their views on the service and to ask if they had any concerns.

During our inspection we carried out observations of staff interacting with people and completed a structured observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us. We spoke with five people who lived at the service and eight relatives.

During the inspection visit we reviewed eight people's care records, three staff recruitment files, records required for the management of the home such as audits, minutes from meetings, satisfaction surveys, and medication storage and administration records. We also spoke with ten members of staff, including nurses, senior care assistants, care assistants, the activities organiser, the chef, the deputy manager and the operations manager. The registered manager was not present during the inspection as they were taking annual leave.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person told us "I am very happy here, I feel much safer than I did at the previous home." One relative told us, "I sometimes have to go and search for a member of staff but they are usually attending to someone else and come as soon as they can." Another relative said, "There are occasions when it feels a bit busy but this has not affected my relative."

The service had policies and procedures with regard to safeguarding adults and whistleblowing (telling someone). Our records showed that safeguarding concerns, accidents and incidents had been reported to the CQC and the local authority appropriately. When we spoke with staff about their responsibilities for keeping people safe they referred to safeguarding polices and confirmed they had received training about safeguarding adults. Staff were aware of who to report any concerns to and how to escalate their concerns should they need to.

We saw that any risk to people was identified and where possible reduced or eliminated. Risk assessments were personalised and were reviewed monthly or when there was a change in the person's needs. Standard supporting tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments to ensure people's nutritional and pressure sore risks were minimised.
People who were at risk of pressure areas had been identified and appropriate pressure relieving equipment had been put in place. Risk assessments had been carried out on footwear, transfers into and out of bed, the number of falls and skin integrity. We spoke with staff about how risks were managed. They explained that risk assessments for individuals were completed as part of the assessment and care planning process. This meant that risks had been identified and minimised to keep people safe.

Accidents and incidents were analysed for trends and patterns; for example if someone started to fall more frequently. In the event of a person falling additional checks were put in place to monitor for any on going effects.

There were risk assessments in place relating to the safety of the environment and equipment used in the home such as hoisting equipment and the passenger lift. We saw records confirming equipment was serviced and maintained regularly. The service had in place emergency contingency plans in the event of power failure or adverse weather for example. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

We spoke with the regional operations manager about how they determined staffing levels and deployed staff. They told us staffing levels were determined according to the needs of people living at the service and they told us the registered manager had the authority to increase staffing levels if required. On the general nursing unit there were 26 beds. On the day of the inspection 22 were occupied of which 7 of these people did not require nursing care. One person was in hospital leaving 14 people requiring nursing care. On the day of the inspection there was one nurse, one senior care assistant and four care assistants on duty for the general nursing unit. On the first floor, which contained both the 21 bed dementia nursing unit and the 13

bed residential unit, there were 15 people requiring nursing care and 8 people living in the residential dementia unit. There was one nurse and four care assistants on duty and a senior care assistant and a care assistant on duty in the dementia care unit. In addition the deputy manager (a qualified nurse) was working on the dementia nursing unit and there was an activities organiser on duty. The residential care unit was accessed by a key coded entry system. Staff who worked in this unit told us they felt staffing was short, that they sometimes did not have time to take their breaks and on occasions they felt unable to spend time with people other than to provide people with personal care. The operations manager told us there was an expectation that staff from the dementia nursing unit would provide support to the residential dementia unit. We discussed staffing levels with the operations manager who confirmed there were plans to reconfigure the first floor layout in order that staff would be better deployed across both units. These changes formed part of the provider's dementia care strategy, devised by the Alzheimer's society titled 'Tomorrow is another day,' which was soon to be implemented. In the meantime, the operations manager gave assurances that our comments would be addressed and they would discuss staffing levels with the registered manager on their return to the service.

We looked at the recruitment records for three members of staff. There was a robust recruitment process in place to ensure that staff who worked at the home were of good character and were suitable to work with people who needed to be protected from harm or abuse. Staff confirmed that they did not take up employment until the appropriate checks such as, proof of identity, references, satisfactory Disclosure and Barring Service [DBS] certificates had been obtained. This process helped reduce the risk of unsuitable staff being employed. The staff records we looked at showed a clear audit trail of the recruitment processes including interview questions and the checks carried out. We saw the provider had a system to check every month the current status of nurses' professional qualifications with the Nursing and Midwifery Council (NMC).

Medicine was administered by senior staff who were trained to do so, and had their competency checked on a regular basis. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. We observed staff administer medicines and saw that when people were offered their medicines staff explained what it was for and gave each person time to take it at their own pace. The staff member took care to record as people took their medicine, and we saw that there were no gaps in the medication administration record (MAR). A review of records showed that when medicine was refused, clear and detailed records were kept on the MAR chart. If a person continued to refuse their medicine, their GP was contacted so the person's health could be assessed and monitored.

Anticipatory medication for pain relief was available for those people who were at the end of their life. This was recorded on the MAR sheet so that this information was readily available to those responsible for administering it.

We saw drugs liable to misuse called controlled drugs were stored in a suitable locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record. We noted that where people were prescribed PRN (as required) medicines, information was recorded about the circumstances under which the medicine could be administered.

Regular audits were carried out to determine how well the service managed medicines. We saw evidence that where concerns or discrepancies had been highlighted appropriate action had been taken straightaway in order to address those concerns and further improve the way medicines were managed within the home.

Good

Is the service effective?

Our findings

People we spoke said they thought staff had the skills and experience to carry out their role. One relative told us, "Staff seem to do a lot of training and when we talk to them they appear to be confident."

We asked the operations manager about staff training arrangements. They told us newly appointed staff completed a twelve week induction based on the new care certificate. The care certificate is a recognised qualification which aims to provide new workers with the introductory skills, knowledge and behaviours they need to provide compassionate, safe and high quality care. Staff also completed a period of shadowing. Shadowing is where new care staff are partnered with an experienced member of care staff as they perform their job. This allows new care staff to see what is expected of them. One member of staff who had recently completed their induction said they hadn't worked in this kind of role before and the induction had "really helped them."

Staff completed training which included mandatory health and safety training such as moving and handling, first aid and safeguarding adults. The operations manager explained that the provider had a programme of training called OWL (Orchard world of training). Staff completed a 'blended' form of training which included e-learning; face to face classroom based learning and completion of work books. Training was designed according to role, for example trained nurses would complete additional training to ensure they were clinically competent.

Staff we spoke with told us training was good and relevant to their role, but they sometimes found it hard to fit e learning in to their rota.

We did talk to the operations manager about the level of dementia care training staff received given they were a specialist service. The operations manager explained that staff completed basic dementia awareness but that the provider was due to implement its dementia care strategy which included more specialist training designed by the Alzheimer's Society.

Staff told us they received regular supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. Staff also completed an annual appraisal. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. Staff told us and records confirmed supervisions occurred every two to three months. This process was in place so that care staff received the most relevant and current knowledge and support to enable them to conduct their role effectively. Nursing staff received clinical supervision from the provider's regional clinical lead nurse, who was also available as a source of advice to nursing staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met

We saw in people's care plans that MCA assessments had been undertaken of people's capacity to make particular decisions. For some MCA assessments tick boxes had been completed but there was little supportive commentary recorded which would demonstrate a more robust assessment. We discussed this with the operations manager who agreed to follow this up with the registered manager. We saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

We noted that where a person lacked capacity and this amounted to a deprivation of the person's liberty the registered manager was sending DoLS applications to the local authority to authorise in line with legislation. This meant legal safeguards to protect the rights of people who may lack mental capacity to make some decisions around their care and welfare were being protected.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Care staff assisted people to make decisions and sought their consent before supporting them. We observed people were asked their permission before being moved or assisted with their mobility. Explanations were provided by staff about what action they were going to take, for example, when administering medication. Staff took the time to explain what was happening allowing the person to respond and ensure they were happy with what action was going to be taken.

We saw that people enjoyed their food and that there was a variety of food available to them. Staff created a relaxed atmosphere through lunch and we saw people smile and chat with each other making lunch an enjoyable experience. Tables were set appropriately, with table cloths, cutlery and crockery. Staff offered people a choice of meal and drink and showed people sample plates of food which helped people to make an informed choice. People were discreetly offered clothes protectors. Everyone was given the choice, of eating in the dining room, or if they preferred having their meal in their bedroom. We saw that people were assisted to eat at their own pace and in a manner that promoted their dignity.

The provider used a Malnutrition Universal Screening Tool (MUST) to regularly monitor if people were at risk of not eating or drinking enough. Records showed that where people were deemed to be at risk of not eating and drinking enough, the service monitored how much they ate and drank on a daily basis, and their weight was checked regularly. Where necessary, appropriate referrals had been made to speech and language therapists and dieticians and we saw care plans were in place so that people received the care necessary for them to maintain good health and wellbeing.

People were supported to maintain good health and could access health care services when needed.

Records showed that when required additional healthcare support was requested by staff. We saw that people were referred to their dental surgery and opticians when required. The service was linked to two local general practitioner surgeries. They held a surgery in the home every week and responded to emergency visits if required. There was evidence of referrals to the community mental health services when required and collaborative working with healthcare professionals, families, and people and care staff. Staff reported a good relationship with district nurses and the community mental health team, along with other health professionals.

When we looked around the service and saw distinct contrasts between the areas where nursing care was provided and the areas where people living with dementia lived. We could see that consideration had been given to research associated with supportive environments for people living with dementia. For example we saw contrasting colours used for rails along the corridors. There were pictures on the walls from the 50's and 60's which seemed relevant to the age of people. There was a board telling people what day, date and season it was and what the weather was like outside. The operations manager told us in preparation for the implementation of the dementia strategy an audit of the environment had taken place. They went on to say that there was an action plan to improve and enhance the environment to ensure it meets with current guidance.

We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms. There was ramped access to the garden areas which had seating areas for people to rest and enjoy the garden.

Good

Is the service caring?

Our findings

All the people we spoke with told us that the staff treated them with dignity and respect. One person told us, "The staff are wonderful, they are kind and respectful. The way they do things for me is respectful." Another person told us, "Staff are brilliant, they knock on my door before they come in and they know what I want and leave me to it, I prefer to stay in my room." A relative said, "They're [staff] lovely" and commented on open visiting which meant they can see their relative when it was convenient.

We spent time in the lounge areas of the home and observed staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. There was a positive atmosphere throughout our visit and people's requests were responded to promptly. It was clear from our observations that the staff knew people well and were able to communicate with them and meet their needs in a way the person preferred. We observed a member of staff chatting with a person, they demonstrated good background knowledge of the person as they were discussing the person's life experiences.

We noted that people were not rushed and staff supported people with patience; people were not hurried by staff and were supported to go at their own pace. We saw staff joking and laughing with people and involving them in conversations. We also saw staff addressing people in the manner they preferred.

One person required assistance using a hoist and we observed staff give verbal and physical reassurance; talking to them about what was about to happen in a patient and reassuring manner. We saw people were offered blankets or were assisted to ensure their clothing protected their dignity. During lunch people were offered protective clothing before being assisted.

Some people living at the service with dementia were unable to tell us about their experiences in the home so we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff. We observed staff treating people with kindness and compassion.

Staff told us they completed training which addressed privacy and dignity and confidentiality as part of their induction training. They told us these areas were revisited through on-going training, staff meetings and individual supervisions with their managers.

We noted that the local mental health team had provided advice and support for staff in how they responded to a person living at the home who experienced distress in a particularly aggressive manner. Staff told us the support they had received included exploring the person's previous life experiences and provided a context to their distress. Staff told us, and we could see, it reflected in a change in the style of record keeping that staff had much more empathy for what the person was experiencing. They understood their distress was not personal and directed at them. In turn the person has now begun to experience less distress and there was mutually a more positive and trusting relationship between them. Learning from this was that the service was placing more emphasis and value on completing people's life histories and having these

readily available.

During our inspection, people chose where they wished to spend their time. The staff respected people's own personal space by knocking on doors and allowing individuals time alone if they requested it. People's confidential information was kept private and secure and their records were stored appropriately.

We saw in the care records we looked at that some information was recorded in relation to people's end of life wishes and that this had been discussed with them or their families as appropriate. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place and there was evidence of advance decisions to refuse treatment. There was also anticipatory prescribed medication in place for people approaching end of life. This meant that health and emotional care information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

We were told people had access to an external advocacy service if required and the operations manager told us they promoted an open door policy for people who lived at the service and their relatives. During the day we saw visitors popping in during our inspection and saw that they made themselves at home and were greeted warmly by staff.

Good

Is the service responsive?

Our findings

People who lived at the service told us they were consulted about their needs and preferences. One person said, "They ask me what I want and how I like things done. They are very good." A relative told us, "They [staff] are very good at communicating with us, [our relative] has poor appetite and we are working together to monitor and provide alternative foods."

The operations manager explained that prior to moving into the service the registered manager or deputy would complete a pre admission assessment. This helped the service establish if they could meet the person's needs and would reduce the risk that the person may need to move to an alternative service in the future. It also provided staff with information to support the person during the first few days whilst the person settled in. We were told information was gathered from the person's relatives if they were unable to contribute themselves and from other professionals involved such as the GP or community mental health teams. Once the person had settled in care plans were developed detailing the care needs and support required to ensure personalised care was provided for everyone.

We looked at the care records for eight people and found they included information relating to people's personal care, mobility, nutrition, daily and social preferences and health conditions. We saw care plans were detailed with corresponding risk assessments in place. They were all up-to-date and had been reviewed monthly and on a more regularly if a person's needs had changed. We looked at people's daily notes and saw the information provided a picture of how the person had spent their day. The detail in these records meant people's needs could be monitored and any changing needs picked up at an early stage.

Examination of care plans showed they were person-centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what is important to the person. This was helpful to ensure that care and support was delivered in the way the person wanted. From our discussions with staff it was evident they knew the individual care and support needs of people. Staff told us they had a handover meeting at every shift change where any changes to people's needs were made known so they were able to provide appropriate care.

We saw a range of activities were on offer and the service employed an activities organiser who was responsible for this. During the morning of the inspection the activities organiser was leading a reminiscence group session. One particular person told us they really enjoyed these sessions, they said, "When the carer brought me my cup of tea this morning they told me it was on today and would come and remind me when it was time." We saw there were items available to occupy people located around the building, for example books, magazines and jigsaws. We also saw 'rummage' boxes and memorabilia located around the home to stimulate people's interest and provide something for them do. Chairs were strategically placed around the home to accommodate those people who liked to walk, but needed to rest at regular intervals.

For those people who did not like to join in group activities, this choice was respected by staff, who maintained regular visits to these individuals during the day to stop them feeling isolated.

There was a complaints system in place and the details on how to make a complaint was available in communal areas of the home. We saw the registered manager kept a record of complaints made and that these were investigated and responded to. People we spoke with knew how they could make a complaint if they were unhappy and said that they had confidence that any complaints would be responded to.

Good

Is the service well-led?

Our findings

People who lived at the home and their relatives told us they knew who the registered manager and deputy manager were and saw them regularly around the service; they confirmed they were approachable and responded to concerns and queries.

At the time of our inspection the registered manager was on leave and the deputy manager was in charge. The home was well managed and there was visible support from senior managers within the organisation.

There was a management structure in place to support staff. Staff said that the structure worked well and they knew their role and responsibilities within it. Staff told us that the registered manager was visible and promoted a personalised culture within the service by leading by example. Staff confirmed that morale had been low when there had been a lack of permanent staff and higher than usual use of agency staff but more recently this was much improved. They reported morale was much better and the support they received was good.

Staff meetings had been held at regular intervals, which had given staff the opportunity to share their views and to receive information about the service. Staff told us that they felt able to voice their opinions, share their views and felt the registered manager and deputy manager were fair and would listen to them about any issues they were having. We saw this reflected in the meeting minutes we looked at. They told us that on a day to day basis the needs and wishes of the people living at the service were central to how the service was managed.

There were systems in place to capture and act on people's views on their individual care and the general running of the service. Surveys were undertaken with people who used the service, their relatives and visiting health care professionals to ascertain their views about how the service was run. The surveys identified various topics for people to comment on and these views were collated and analysed with action plans set to address any short falls. The registered manager also undertook to meet with people who used the service and their relatives to gain their views about how the service was run and to pass on information about the service. We saw a record of these meetings. The registered manager collated the views gathered via the surveys and meetings and set action plans and goals to address any issues raised. The people we spoke with told us that the registered manager was easy to talk to and they had confidence in them to address any matters.

The outcome of all accidents and incidents and any actions taken as result of an accident were recorded. The registered manager analysed these to identify any patterns or trends so these could be looked at in detail to establish if any learning could be gained or changes made to working practises to keep people safe. Any learning from either the accidents or incidents was shared with staff through individual one to one supervision or staff meetings.

The provider had a formal quality monitoring system in place. This was used to drive improvements in the care of people. As part of this system the registered manager had a range of audits which they were

expected to undertake on a regular basis. This included audits of staff training, staffing levels, people's care plans, the environment and the décor of the building. These audits were checked by the registered provider who also undertook audits themselves and identified areas of improvement. If any areas of improvement were identified the provider brought this to the registered manager's attention in the form of a report and time scales were set to make sure these were addressed. For example, a recent audit undertaken by the provider had identified a need to improve the outside garden area and the completion of people's life histories.

Documentation to support the running of the service was up to date and well maintained. Policies and procedures were in place and staff were familiar with these.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty team and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.