Bupa Care Homes (ANS) Limited

Middlesex Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

Our inspection of Middlesex Manor Nursing Centre took place on 27 and 30 September 2016. This was an unannounced inspection.

At our previous inspection of Middlesex Manor in September 2015 we found that the service was not meeting the requirements of the law in relation to the assessment and management of risk for people who lived there. During this inspection we found that the provider had made improvements in order to meet the requirements identified at the previous inspection.

Middlesex Manor Nursing Centre is purpose built and consists of three units of single rooms with ensuite facilities. The home provides nursing care for up to 83 people. At the time of our visit there were 67 people living at the service. Most were older people, some were living with dementia or with other conditions associated with ageing. Other people had significant physical disabilities.

At the time of our inspection there was no 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. However, a new manager had been appointed and had started full time working during the week of our inspection. They had commenced the application process to become registered with CQC.

People who lived at Middlesex Manor told us that they felt safe. Staff members had received training in safeguarding, and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

We observed that people's medicines were stored, managed and given to them appropriately. However we found that the number of stored medicine to be administered as required did not always match the service's records.

People had up to date risk assessments to ensure that they were kept safe from avoidable harm. Risk assessments contained detailed guidance for staff on how to manage identified risk to people. Care plans were also detailed and up to date and included information about how people wished to be supported. We saw that care plans and risk assessments were reviewed regularly and amended where there were any changes in people's needs.

There were enough staff members on duty to meet the physical and other needs of people living at the home. Staff supported people in a caring and respectful way, and responded promptly to needs and requests. People who remained in their rooms for some or part of the day were regularly checked on. People told us that they were happy with the support that they received from staff.

Staff who worked at the service received regular relevant training and were knowledgeable about their roles and responsibilities. Appropriate checks took place as part of the recruitment process to ensure that staff were suitable for the work that they would be undertaking. All staff members received regular supervision from a manager, and those whom we spoke with told us that they felt well supported.

The service was generally meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. Staff had received training undertaken training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions. However records of best interest's decisions did not always meet MCA guidance.

Meals that were provided to people were varied and met individual health and cultural requirements. Alternatives were offered where people did not want what was on the menu. People appeared to enjoy their meals. Drinks and snacks were offered to people throughout the day. People's nutritional needs were recorded in their care plans and risk assessments with guidance for staff. Health professionals were involved where there were concerns about people's weight.

Procedures to reduce the risk of infection were in place and we observed that these were followed by staff members. However, we identified infection control risks in relation to the lack of ongoing maintenance to communal bathrooms. We saw that this had been identified as a concern by the provider and that plans had been made to refurbish the bathrooms,

People told us that staff members were caring and we saw a number of positive interactions between people and their care staff. People told us, and we observed that they were offered choices and that their privacy was respected. However we observed that a small number of staff did not always interact in a positive way with people.

The service provided and group activities for people to participate in throughout the week. However, these were limited and some people chose not to engage with these. We were told that this had been recognised and that changes to the activities programme were planned. People's cultural and religious needs were supported by the service

People and their family members that we spoke with knew how to complain if they had a problem with the service. The records showed that actions to address complaints effectively had been put in place.

Care documentation showed that people's health needs were regularly reviewed. The service liaised with health professionals to ensure that people received the support that they needed.

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. Policies and procedures were up to date and staff members were required to sign that they had read and understood any new or amended ones.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Records of medicines did not always correspond with the number of medicines held at the service.

Communal bathrooms had not been maintained and this meant that there was a risk of infection.

Staff we spoke with understood the principles of safeguarding vulnerable adults, how to recognise the signs of abuse, and what to do if they had any concerns.

Risk assessments were up to date and included guidance on how to manage identified risks.

Is the service effective?

Good

The service was effective. It was meeting the requirements of The Mental Capacity Act 2005. However, the records of some best interests decisions were not always clear.

Staff members received the training and support they required to carry out their duties effectively.

People were supported to maintain good health and to access health services when they needed them.

People chose their meals and were provided with the support they needed to eat and drink.

Is the service caring?

Good

The service was caring. People told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that many interactions between staff members and people who used the service were caring and respectful.

Staff members respected people's privacy and dignity, and

religious, cultural and relationship needs were respected and supported.

Is the service responsive?

Good

The service was responsive. People told that their needs were addressed by staff.

Care plans were up to date and person centred and included guidance for staff to support them in meeting people's needs.

People were able to participate in a range of individual activities. The service recognised that these did not always reflect people's interests and were taking action to introduce new activities.

The service had a complaints procedure and people knew how to make a complaint.

Is the service well-led?

Good

The service was well led. There were systems in place to monitor the quality of the service being provided to people.

Staff members told us that they felt well supported by the manager. People who used the service felt that the home was well managed.

There was a good working relationship with health and social care professionals and organisations.

Middlesex Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 30 September 2015, and was unannounced. The inspection team comprised of two inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with eleven people who lived at Middlesex Manor and two family members. We also spoke with four nurses, six care staff, an activities co-ordinator, the manager and deputy manager. We also made telephone contact with the local authority commissioning team and a specialist nurse who visited the service.

We spent time observing care and support being delivered in the main communal areas. We looked at records, which included 13 care records, 10 staff records and records relating to the management of the service.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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 reviewed the information included in the PIR along with other information we held about the home.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe. People knew who to speak to if they had a concern about their welfare. We were told that, "The staff understand safety and they remind me about [how to keep safe]," and, "I feel very safe here."

At our previous inspection of Middlesex Manor we were concerned that risk assessments for some people had not been completed. We saw that improvements had been made. People's care plans included risk assessments that included risks, for example, in relation to mobility, personal care and behavioural management. These assessments identified hazards that people might face and guidance for staff members about the support they needed to minimise the risk of being harmed. These were up to date and reflected information contained within people's care assessments and care plans. The risk assessment for a person who went outside independently showed that a risk management plan was in place and this showed that staff had discussed this with them. The deputy manager told us that staff made frequent checks on the person when they were outside smoking and there was a record of these checks.

People told us that they received their medicines on time. On person told us that, "The staff always remind me when it's time to take my medicines." We saw medicines being given to people in a safe and caring manner. Nurses administering medicines to people offered drinks and gave explanations of what they were doing. Nurses made an accurate record of the administration or the reason medicines were not given on the medication administration record (MAR). We looked at the MAR charts for people in the home and saw that they were clear and contained information such as allergies, preferences, blood tests and protocols to support nurses when giving people their medicines. Separate charts were completed for topical medicines which included body maps to show care workers where creams should be applied. We looked at a record for a person whose medicines were administered covertly. We saw that a best interests decision about giving medicines covertly had included the person's GP and pharmacist.

Medicines were stored securely on each floor, including controlled drugs and medicines which require cold storage. Controlled drugs were stored and recorded effectively. Nurses had received training in safe management of medicines, and there were records showing that their competency was regularly assessed.

Monthly medicines audits were carried out and these included action plans to address any concerns. We saw examples of these and noted that actions had been taken as a result. There were also weekly stock checks of medicines. However we found that, in five cases, the number of PRN (as required) medicines recorded on people's MAR charts did not match the number of medicines stored at the home. For example we saw that the number of pain relief medicines for two people were fewer than recorded. For another person the record of laxido sachets stated 10 but there were only nine in stock. This meant that we could not be sure that PRN medicines were always administered and recorded safely.

We spoke with the manager and deputy manager about this. They showed us copies of weekly stock checks and we saw that a count of medicines against records was due to take place on the day following our inspection. They told us that they would ensure that they would ensure that our concerns were discussed

with nursing staff as a matter of priority.
The service had an infection control policy and we observed staff members using protective clothing such as disposable aprons and gloves when carrying out care and cleaning tasks and when serving food to people. We observed domestic staff cleaning communal areas, bedrooms and bathrooms. There was a rota for 'deep cleaning' people's bedrooms and those that we saw appeared clean and tidy. However a family member told us that they were not satisfied that their relative's room was always cleaned effectively on a daily basis.

When we looked at the communal bathrooms on each floor, however, we noted that they were in need of refurbishment. In four of the bathrooms that we looked at sealant was damaged exposing gaps between the floor and walls around toilets sinks and baths. There was paint peeling from some of the walls, cracked tiles in one bathroom, and the surfaces around the boxing in of pipes were damaged and unable to be cleaned effectively. We noted that there was a build-up of dust behind a specialist bath on one bathroom. The failure to maintain communal bathrooms effectively meant that the service was failing to fully control the risk of infection.

We spoke with the manager and deputy manager about this. They told us that the service was due to refurbished and that the bathrooms had been designated as a priority. We saw records that showed that this was the case. However they did not yet have a date for when the works were due to start.

We looked at staffing rotas and observed the care being provided in each unit of the home. We observed that there was always at least one nurse available on each unit, and that there appeared to be a sufficient number of care staff on duty to meet people's needs. People told us that they did not have to wait long when they required support. Staff members undertook regular checks on the welfare of people who remained in their rooms and we saw that they responded promptly when people used their call bells to seek assistance. A staff member told us that some people could not use the call bells in their room, "so we do extra checks for them."

Staff members told us that they usually worked in the same unit throughout the week. "We know the people well and they know us." One staff member told us that she sometimes worked in another part of the service when there was a need to cover absence. There was an ongoing recruitment process in place and the service had recently recruited a number of new staff.

We looked at the recruitment records for 10 members of staff. We found that application forms had been completed which had included people's employment history, two references obtained and there was a record of formal interviews that had been carried out. Criminal record and barring checks had also been completed to establish that people were suitable to care for people living at the service.

There were systems in place to protect people from abuse and to keep them free from harm. Staff were knowledgeable in recognising signs of abuse and the related reporting procedures. Information about reporting abuse was displayed. Staff told us that they had received
training about safeguarding people and training records confirmed this. The service maintained a record of safeguarding concerns and actions taken to address these. This showed that safeguarding concerns had been immediately reported to the local authority safeguarding team. There were also clear records of any actions taken by the service to reduce any further risk. The deputy manager told us that, "Even if we are not sure that it's safeguarding we report it to social services as we need to ensure that people are protected."

The service managed a small amount of cash for some people in the home. We saw that records including receipts of expenditure were available. Regular checks of the management of people's monies were carried

out by the registered manager and other management staff to reduce the risk of financial abuse.

Staff took appropriate action following accidents and incidents. Incidents and accidents were recorded, investigated, reported to the provider and where appropriate, organisations including the CQC and local authorities were informed. There was evidence that action was taken to make improvements and minimise the risk of them happening again.

Staff knew about emergency procedures and the emergency services they would need to contact, for example, if there was a fire. The provider maintained an out of hours emergency contact rota, and details of this and other emergency numbers were accessibly displayed.

Good

Is the service effective?

Our findings

People that we spoke with were positive about the support that they received from staff. We were told that, "I believe that staff meet my care needs," and, "They do seem to know what they are doing."

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 so that they can 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.

At our previous inspection of Middlesex Manor we recommended that the service sought guidance on the assessment and use of bedrails to ensure that these were always in people's best interests and that they were the least restrictive option to keep people safe from harm. We looked at capacity assessments and best interest decision making records in relation to the use of bedrails and noted that these were up to date and met the guidance related to the MCA. Where people had capacity to make decisions about whether or not they had bedrails in place, this was also recorded.

However, during this inspection we found best interest decision making for people who were unable to make their own decisions about care and support did not always reflect MCA guidance. Although we saw that the records of best interest decision making for some people were clear about the decision and showed that family members and other representatives had been involved, this was not always the case. For example, a best interests decision for one person showed that their GP had been involved but there was no record that family members or other representatives had been included in this. Another person had a best interests decision made that all future decisions have to be made in consultation with a relative. The MCA guidance is clear that each decision should be treated individually and at the time it is required.

We discussed our concerns about the records of best interest decision making with the manager. They told us that the MCA guidance would be discussed with key workers as a matter of priority and that where family members were not involved in decisions the reasons what this was the case would be recorded in future.

The service was otherwise meeting the requirements of the MCA. Applications for DoLS authorisations to the relevant local authority for people who were assessed as lacking capacity to make decisions about their care and wellbeing and these had been re-applied for within appropriate timescales where required.. There was also evidence that a number of these had been authorised and the deputy manager told us that the local authority was in the process of assessing others.

Staff members had received training on the MCA and DoLS and we saw that there was an ongoing programme of such training for new staff and those whose training required refreshing.

The service used the MUST (Malnutrition Universal Screening Tool) on a monthly basis to assess risk to people in relation to maintenance of healthy body weight. These charts were well recorded and we saw that there was guidance in people's care files about how these should be completed.
We noted that the care plans of people who had gained or lost a significant amount of weight showed that appropriate action, such as referral to a GP or other health professional had been made. People's care plans included dietary information where appropriate to address such concerns, and we saw that food supplements had been prescribed for people who required these. Guidance on people's nutritional and eating needs (for example soft or pureed diets) was available, and people were seen to eat food that was appropriate for their needs and preferences. Two people who were unable to swallow received nutrition through use of PEG (tube) feeds and we saw that use of these were well managed and recorded.

Risk to people of developing pressure area sores was assessed and monitored using the Waterlow scale. We saw that these records were completed appropriately and that risk management plans were in place where they indicated that the risk was high. Turning charts were in place for people who were not mobile and records showed that people's skin was checked for signs of tissue breakdown. Where there were signs of breakdown we saw that the person's GP and the tissue viability nursing service had been involved.

People told us that they liked the food provided by the service. One person told us, "I love the food here," and another said, "There is plenty of food and plenty of choice." We saw that there was a choice of meals, and people were asked to choose what they wanted to eat on the previous day. However, we observed they were also given choices at mealtimes. We saw that some people had meals that were different from those indicated on the menu. Another person, however, told us that they did not like the food and that relatives brought food to the home for them to eat. We asked the manager about this. They told us that, although the service had provided a range of meal options, this person preferred to eat the food provided by their family. We looked at their care plan and saw that this was recorded.

The care files that we viewed included forms consenting to care. These had been signed by the person or a family member. Where people or family members had no signed the forms the reasons why were recorded. People told us that they knew about their care plan and had been asked about it. We observed that staff members asked people for their consent before providing support and when entering rooms.

Staff training records showed staff had received up to date training in key aspects of their role such as dementia care, moving and handling, health and safety, pressure area care,
end of life care and behaviour that challenges. Nurses had received training in cardio pulmonary resuscitation (CPR) Training was refreshed regularly to ensure that staff remained up to date, and this was recorded and monitored monthly through use of a training needs matrix which indicated clearly for each staff member when training was due.

Staff had regular supervision meetings with senior staff where they had the opportunity to discuss practice issues and concerns in relation to their work. Nurses also received clinical supervision, which was supported by a regular weekly clinical meeting. A programme of annual appraisal was also in place. This showed us that systems were in place to support and develop staff. The staff members that we spoke with were positive about the training and support that they received.

People we spoke with told us they were able to access health care services as and when necessary. Care records detailed information about medical appointments and visits by health professionals. We saw, for

example, that a person with complex needs had received support from a range of health professionals. Their care records described this support and showed that the service had worked in partnership with them to achieve improvements for the person. Another person had been provided with specialist equipment to reduce the likelihood of admission to hospital. The equipment was unfamiliar to the staff team so an urgent request had been made for training. We saw that this had been followed up, and that training had been provided to staff members working with the person.

Good

Is the service caring?

Our findings

People who used the service and their family members told us that staff members were caring. Comments included, "I know and expect the same positive respectful care," and "I really look forward to staff coming." Some people told us about individual staff members and their positive support.

We saw that most staff members interacted with people in a positive, respectful and considerate manner. We heard staff initiate conversations with people and speak with them when providing them with support. We also saw staff members singing along with a person, sitting with people and reading with them and asking people about things that were of interest to them. During one activity session a staff member sat close to a person with a hearing impairment, stroking their hand and encouraging them to participate. However, this was not always the case. For example we saw that during an activity in one unit there was little interaction with people. Some people were sleeping and staff members were speaking to each other. During breakfast on another unit we observed a staff member offering a list of food which the person refused. They were then left alone without further encouragement to eat. We discussed this with the manager and deputy manager, who told us that they would ensure that the importance of positive interaction with people was highlighted with staff as an important part of their responsibilities in relation to ensuring quality of life at the service.

People told us that staff members respected their privacy. We were told that staff members knocked on people's doors and asked permission to enter, and this was confirmed by our observations. Doors were closed when staff supported people with their personal care.

People maintained relationships with family and other people who were important to them. Information about people's key relationships was recorded in their care plans. Family members that we spoke with told us that they felt able to visit relatives at any time.

People who used the service told us they were given choices by staff. We saw that people were provided with choices of food and drink throughout the day. We also saw staff members ask people what they wished to watch on television, and offering to fetch books or other items.

The staff members that we spoke with talked about the people they supported in a positive and respectful way. One care assistant told us, "The residents and families are lovely. We all work together as a team for the good of the residents." Another said, sometimes people aren't sure what they want, but if you stay cheerful and speak with them positively you get there in the end."

The care plans that we viewed identified people's individual needs and preferences.
Care plans included information about people's life histories, interests, religious and cultural needs. Staff we spoke with knew people well and were able to tell us about people's individual needs and their personal and family background and relationships.

We saw that people's personal and cultural needs and preferences were supported by the service. For

example, people were offered meal choices that reflected their individual requirements. Representatives from local faith centres visited the service on a regular basis. On the second day of our inspection we saw that representatives from such a group had attended with children to visit people with a shared cultural background. Staff members told us that when people had visitors they were given privacy to spend time with them as they wished.

Care plans contained a record of people's wishes regarding end of life care and support. These were not complete for everybody and the deputy manager told us that some people did not always wish to discuss this. We saw that this had been recorded where appropriate. The service had ensured that there was support from the community palliative care team when people were coming to the end of life and we saw that nurses and senior care staff had received appropriate training in this area.

Good

Is the service responsive?

Our findings

People's care records showed that assessments were undertaken to identify people's individual care and support needs and care plans included guidance which showed how these needs were met with support from staff. People told us, "They ask me about things," and, "they listen to what I say and do things how I want."

People told us that staff understood their needs and had involved them in decisions about their care. The care plans showed that people's relatives had been involved in reviews of care plans where the person wished or could not give consent. One family member said, "They are very good at keeping us involved."

The care plans and risk assessments that we looked at were well written and up to date. These were reviewed regularly and amended if there was a change in people's needs. For example we saw that the care plan for a person had been reviewed and amended for a person following a hospital stay. Other plans had been updated to reflect support and guidance provided by health professionals such as speech and language therapists and dieticians

There was an activity plan displayed on each unit. The activities shown were based in each unit and included arts and crafts, music and seated exercises. However the activities that we saw on the first day of our inspection were limited. We saw, for example, sessions where people passed balloons to each other, and a film being shown in one unit. Some people slept during these activities or chose not to be involved. One person told us that they liked the activities. However, another person said that they usually stayed in their room as the activities, "are boring." We saw that photographs of people participating in activities were displayed. However these photographs showed occasional seasonal activities and parties rather than regular daily activities. We also saw people engaged in individual activities such as reading and puzzles.

The activities co-ordinator told us that they were trying to identify new activities which were of interest to a wider range of people. She showed us, for example, a record of a tea tasting event to which families were invited. She said that this was successful and that there were plans to do this again. The activities co-ordinator told us that part of their role was to visit people who were unable to leave their rooms for a chat, or any one-to-one activity of their choice. She said that this was particularly important for people who were bed bound as care staff and nurses did not always have time to sit and chat. We noted that these individual visits were recorded in people's care files. However, apart from these visits which took place weekly, there was limited evidence that people who were unable to leave their rooms were offered any activities.

We asked about activities outside the home which appeared to be limited to outings with family members for a small number of people. We were told that three people did go out independently to local shops but that there were currently no planned outings for other people. There had not been any outings since a group shopping trip in December 2015. The deputy manager told us that having evaluated this, the service had decided to plan outings for smaller groups of people with a higher staff ratio, but had been unable to do so because of staff shortages. She said that she hoped that when the current recruitment process for new staff had been completed external outings would recommence.

People had the opportunity to attend quarterly resident and relatives meetings and people spoke positively about these. The manager told us they tried to ensure that these were linked to a social event, as people were more likely to attend. We looked at a record of the most recent meeting which took place on 17 September 2016 and saw that people were consulted about the refurbishment of the service which had not yet taken place, planned social events and staffing changes.

The home had up to date complaints policies and procedures in place. This was supported by a simple complaints leaflet that was displayed on notice boards and given to people who used the service and their families. Staff had an understanding of the complaints procedure and they told us they would report all complaints to senior staff. There was a comments book displayed in the reception area and we saw that family members had used this to raise concerns, give compliments and make suggestions. The service had recently started to display information about how they had addressed concerns on a notice board in the reception area. People told us that they knew how to complain and that their complaints would be listened to and addressed. However, one family member that we spoke with told us that they had made complaints but that, "It always takes time before things get done." Complaints including actions taken to address these were logged electronically and monitored by the provider, and we saw that responses had been timely and constructive. However, we noted that, where complaints required input from external professionals these took longer to resolve. However the records showed that the service had made efforts to work towards a speedy resolution.

Good

Is the service well-led?

Our findings

The registered manager for the home had left in March 2016 and interim management had been provided by the deputy manager supported by a peripatetic manager who had spent three days each week at the service. At the time of our inspection a new manager had been appointed and this was her first full week with responsibility for the service. She told us that she had already commenced the process of applying for registration with CQC.

People and staff members spoke positively about the management of the home. A staff member told us that the new manager was very approachable and was often on the units talking to staff and residents. They felt confident that if she had any concerns she would be comfortable speaking to the deputy or home manager. Although the new manager had been at the home for less than a week, one person who was receiving care in bed told us, "I know the new manager, she talks to me. She walks around a lot." Another person said, "I have seen her a few times. She's very friendly and listens to what I have to say." People also spoke positively about the deputy manager. One person said, "She's lovely. We see her a lot."

We saw that there was a range of monitoring processes in place. These included quarterly provider reviews carried out by an area manager, the most recent of which took place on 8 September 2016. An audit by the provider's clinical development manager in relation to nursing practice had taken place on 20 September 2016. We were able to see an online copy of the previous review which showed that actions were set and progress against these were monitored. We saw that the completed actions had been recorded. The provider produced a monthly 'metrics' report that contained statistics in relation to reported activities and incidents, for example, in relation to pressure sores, medicines, care plans, hospital admissions, DoLS, safeguarding concerns and complaints.. We looked at a copy of the report for August 2016 and saw that this included a management commentary on any specific concerns and changes that affected this report. The deputy manager told us that these were always followed up by the provider if they were not satisfied with the information provided in the commentary. We saw that the statistics and commentaries reflected the information contained within the service's on-site audits. The quarterly provider reviews also looked at these areas and the records of how they were managed by the service.

In addition, regular management audits took place in relation to care activities at the service, such as medicines, infection control, health and safety and care documentation. We saw that progress in relation to actions arising from the audits was fully recorded, and most had been completed. However medicines audits had not picked up our concerns about the medicines where quantities held in stock could not be reconciled with the records. Additionally, no actions had yet commenced to refurbish the bathrooms at the home which was identified as a concern in a number of previous audits.

We asked about service user satisfaction surveys and saw that there had been no formal survey since 2014. We asked the manager and deputy manager about this. They told us that the provider had been reviewing the system to ensure that future satisfaction surveys fully involved people. We were told that a survey would take place within the next few months.

Regular health and safety monitoring was up to date. We saw that checks of, for example, fire bells, call bells, fridge and freezer temperatures and hot water temperatures had taken place. Up to date certificates were in place in respect of checks of fire equipment, lift and mobility equipment, gas and electrical safety and portable electrical appliance testing.

The records of quarterly team meetings for staff members showed that issues in relation to quality and care practice were discussed along with explorations of ways to improve people's care. Regular meetings had also taken place with domestic and catering staff. The management team, nurses and care staff also participated in daily clinical meetings where immediate issues and concerns were discussed. Minutes of these meetings showed areas of the service such as cleanliness of the environment, incidents and people's health and care needs were discussed and actions were agreed to address these. Staff told us that they felt well supported and were comfortable raising issues and sharing ideas about the service.

Policies and procedures were up to date and reflected current regulatory and good practice guidance. Staff members were required to sign that they had read and understood new or amended policies and procedures.

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meetings and visits with such professionals was recorded in people's care files.