Roja Limited

Richmond Care

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 was an unannounced inspection carried out on the 10 October 2016. At the last inspection in June 2013 we found the provider met the regulations we looked at.

Richmond Care is a nursing home with 20 beds that provides care and support for people with enduring mental health problems and/or substance misuse issues. The accommodation is situated over three floors and includes a number of communal areas and a large garden.

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

People told us they felt safe and the service was caring. There were systems in place to manage risk and protect people from abuse. Staff were aware of their responsibilities and knew what actions they needed to take to ensure people were protected.

Overall there were sufficient numbers of appropriately trained staff on duty to care for people. Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting with vulnerable people.

Medicines were safely administered by staff who had received appropriate training, including an annual check of their competence.

Equipment, such as hoists, bathing aids and pressure relieving mattresses were available in the home and these helped promote people's safety and comfort. There were new procedures in place to ensure standards of cleanliness were monitored and maintained.

Our inspection of the building showed it was a safe environment in which to care for vulnerable people with the exception of some damaged floor coverings and a broken window restrictor.

Staff were appropriately trained and skilled and demonstrated a good understanding of their roles and responsibilities. Staff had completed training to ensure the care and support provided to people was safe and effective to meet their needs.

Staff understood the importance of encouraging people to make choices, where they were able to, and always sought consent before undertaking any care. There were policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005. Staff were trained in the principles of the MCA and could describe how people were supported to make decisions; and where people did not have the capacity; decisions were made in their best interests.

Most people we spoke with were happy with the quality and choice of food provided at the home.

People were supported to maintain good health and where needed specialist healthcare professionals, such as dieticians, were involved with their care.

People who used the service were very positive about the care they received. People told us the staff were caring and their dignity and privacy were respected.

Care plans were person centred and were reviewed regularly by the trained nurses. Staff cared safely for people with a variety of complex health problems.

Records showed people were involved in range of activities. However, some people told us they were sometimes bored at the service.

There were systems in place to ensure complaints and concerns were fully investigated.

Quality assurance processes such as audits were in place to ensure that the service delivered high quality care that met people's needs.

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.

There were systems in place to ensure that people received their medicines safely. Risk assessments were in place to ensure people received safe and consistent care.

Staff were confident in recognising safeguarding concerns and potential abuse and were aware of their responsibilities in protecting people.

Staffing levels were sufficient to meet the needs of the people using the service and staff had been recruited following safe recruitment procedures.

Is the service effective?

Good

The service was effective.

People were supported by skilled and knowledgeable staff. Staff had received training in a variety of subjects which enabled them carry out their roles effectively.

Staff had received training in the MCA and Deprivation of Liberty Safeguards (DoLS) authorisations were, where appropriate, in place for people.

People who used the service received the appropriate support from staff to ensure their health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were very positive about the staff and said they were treated with kindness and respect.

Staff showed warmth and friendship to people using the service and they spoke to people in a kind and sensitive manner.

Staff knew people well and were aware of people's preferences for the way their care should be delivered.

Is the service responsive?

Good

The service was responsive.

Care plans and associated care documents were detailed, personalised and reviewed regularly to help make sure the assessed needs and preferences of people using the service were met.

Activities were offered that enabled people to spend time with others and maintain and develop links within the community where they lived. However, some people said they would like to do more.

Systems in place for receiving and responding to concerns and complaints helped to make sure people who used the service would be confident if they had any concerns or complaints these would be appropriately addressed.

Is the service well-led?

Good

The service was well- led.

Staff we spoke with told us the management team were approachable and supportive.

There were effective systems in place to monitor the quality of care provided by staff.

People were provided with opportunities to express an opinion about how the service was managed and the quality of service being delivered.

Richmond Care

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 10 October 2016 and was unannounced.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications sent to us by the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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.

At the time of our inspection there were twenty people using the service. During our visit we spoke with seven people who used the service, three members of staff, the registered manager and the provider. We also spoke with the cook and an administrator. We spent some time looking at documents and records related to people's care and the management of the service.

The inspection was carried out by one adult social care inspector, a specialist advisor in mental health and substance misuse 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.

Good

Is the service safe?

Our findings

People who used the service said they felt safe and well looked after. We saw positive interaction throughout our visit, and people were relaxed and comfortable with the staff and their surroundings.

Staff told us they had received safeguarding training and the records confirmed this. Staff were clear about their responsibilities for reducing the risk of abuse, and were able to describe the common types of abuse. They explained what signs they would look for which may indicate a person was being abused. We asked staff how they would act if they suspected abuse to people. Their answers confirmed they knew how to act which included their ability to make a safeguarding referral. One staff member said, "If I saw any form of abuse I would report it to the manager and I have every confidence it would be dealt with."

In the PIR, the registered manager told us, 'We do not use a restraint policy as we feel it impairs the relationships between the staff and resident. We instead use a "low stimulus" environment.' Staff we spoke with confirmed this and said they were trained to manage any behaviours that challenged by the use of de-escalation techniques. They said they felt confident this approach prevented incidents of behaviour that could challenge others.

Risks to people who used the service were appropriately assessed, managed and reviewed. We saw risk plans which identified when a person may be the cause of risks to others. We saw for one person a risk assessed care plan had been put into place which identified staff interventions which were designed to protect others from harm. Of particular note, we saw, where appropriate, interventions had been referenced with current published guidance. For example when social inclusion had been identified as a means of promoting mental health and well-being this was referenced with guidance from the Mental Health Foundation. Risk assessments were highly specific to people's individual needs. For example, we saw one person had a falls risk assessment which indicated a moderate falls risk due to their medication and the potential to have a low mood and anxiety which may lead to lack of concentration. We saw staff had identified interventions to ensure the risks were minimised.

Staff we spoke with said there were enough staff to meet people's needs, and they did not have concerns about staffing levels. Some people who used the service told us the service would benefit from more staff to undertake activities and one person told us their medication had sometimes been given to them later than expected if night staff were busy when incidents occurred.

The registered manager told us there was a nurse and four care staff available through the day, Monday to Friday, and a nurse and three care staff at weekends. They said at night there was one nurse and one carer available. In addition to nursing and care staff there were domestic, maintenance, administration and catering staff. The registered manager told us they kept staffing levels under review to ensure needs were fully met. They told us they had the flexibility to engage more staff if people's health or needs changed. Staff we spoke with confirmed extra staffing was provided if someone's health or behavioural needs determined this was needed. In the PIR, the registered manager stated, 'The registered manager is on-call 24 hours for advice and support and contacts the home every day for a handover of any events which require extra

support. This includes authorising extra staffing for 1 to 1.'

There were effective recruitment and selection processes in place. The registered manager told us people who used the service had been involved in designing the questions used at interview and were asked to participate on the interview panel, but had not wished to do so. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

We observed a member of nursing staff whilst they conducted part of a medication round. We saw the medicines were given safely and people were sensitively helped to take their medicines. People told us they received their medication when they needed it and did not have to wait if they needed pain relief.

Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes also contained medication which had not been dispensed in the monitored dosage system. We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. Medicine fridge temperatures were taken daily and recorded. The treatment room was locked when not in use. Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

We saw people were referred to their doctor when issues in relation to their medication arose. Changes to medicines in care plans and on medication administration records (MAR) sheets were signed by nursing staff. A nurse we spoke with showed us the MAR sheets were complete and contained no gaps in signatures. We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. This showed medicines were administered as prescribed. We examined records of medicines no longer required and found the procedures to be robust and well managed.

We saw one person was recorded as being administered their medicines covertly. Our observations and a discussion with a nurse demonstrated the need to administer the medicines covertly was a rare occurrence, and only used when the person was experiencing periods of mental ill-health. Our discussion with the registered manager indicated they had a good understanding of the requirements to construct the necessary legal framework to administer medicines covertly. However, a review of the continuing need for covert medication had not recently been conducted. The manager assured us a review to comply with the requirements of the National Institute for Health and Care Excellence (NICE) guidance on managing medicines in care homes would be carried out.

A member of the management team carried out audits of medicine administration, storage and disposal. The audits demonstrated medicine irregularities were of a minor nature with no evidence of recurrent themes. Written comments on the audit demonstrated issues were picked up early and used as a learning tool to ensure a climate of continuing quality improvement.

A number of practical steps were in place to address the potential risks of cross infection. For example, anti-bacterial gel dispensers were located throughout the home. We observed all staff washed their hands

appropriately between tasks and had disposable gloves and aprons to support people with their personal care tasks. Staff had undertaken training in infection prevention and control. This meant the staff had the knowledge and information they needed to minimise the risk of the spread of infection which they demonstrated during the day of our inspection as they carried out practical tasks.

The registered manager had introduced new procedures to ensure standards of cleanliness were monitored and maintained. This included the introduction of new, detailed cleaning schedules, increasing the hours of domestic staff and hiring an outside cleaning contractor for deep cleaning tasks such as steam cleaning of floor coverings and furnishings.

We completed a tour of the premises as part of our inspection. We looked at two people's bedrooms, bath and shower rooms, kitchen and various communal living spaces. There were no malodours and all equipment we looked at was clean and fit for use. We saw there were systems in place to make sure equipment was maintained and serviced as required. We saw up to date maintenance certificates were in place.

We saw fire-fighting equipment was available and emergency lighting was in place. All fire escapes were kept clear of obstructions. We saw upstairs windows had tamper-proof opening restrictors in place. However we found a high window on the ground floor had a damaged window restrictor which allowed the window to fully open which could pose a risk to people who used the service. We also saw some floor coverings were in poor condition. For example the vinyl flooring on a stairway was poorly fitted causing a trip hazard. Similarly we saw a vinyl floor with a tear directly outside a person's bedroom, again posing a trip hazard. We brought these to the attention of the registered manager who said they would be addressed.

Good

Is the service effective?

Our findings

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff sought consent to help people with their needs. When people were not able to verbally communicate effectively we saw staff accurately interpreting body language to ensure people's needs were being met. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care. Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions.

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 16 standard authorisations had been submitted to supervisory bodies for people who currently used the service. Of these submissions nine authorisations were still awaited. We saw conditions attached to authorisations had been translated into support plans and enacted. We saw one person was being supported by an appointed Independent Mental Capacity Advocate (IMCA) to legally challenge an authorisation for DoLS. Care plans indicated care home staff were filing and recording all correspondence with regard to the appeal.

We reviewed the care records of a person with a mental illness who had previously been detained in hospital under Section 3 of the Mental Health Act 1983. We saw at the time of admission to the service the person had been discharged from hospital on a Community Treatment Order (s17 (2A)) (CTO). CTO's were introduced to the Mental Health Act 1983 by the Mental Health Act 2007. These orders allowed people to be discharged into a community setting whilst still being subject to mandatory conditions. Our discussion with staff demonstrated they knew of the conditions imposed by the responsible clinician and how they should act to support the person to comply with the conditions. We were told this person had also been assessed as needing a DoLS authorisation. Our discussions demonstrated nursing staff had a good understanding of the need to ensure the DoLS did not conflict with the requirements of the CTO.

We asked staff about the MCA. They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. Staff

we spoke with confirmed they had received training on the MCA.

The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is a screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. Care records showed the service was referring people to a dietician or speech and language therapist if they required support with swallowing or dietary difficulties. We saw the home had devised a robust method of recording the use of thickeners in drinks. The system delegated the authority to add thickeners to drinks to care staff. Care staff told us they had been specifically trained to carry out this task to ensure people, where prescribed, had thickeners added to all drinks to ensure safer swallowing.

People who used the service said their meals were filling and they were happy with portion sizes. The meals were at set times through the day but people told us they could have drinks or snacks anytime they wanted. One person told us they did not like the meals and described them as "sloppy and unhealthy". However, menus were seen to have individual choice options and showed a good variety of foods were on offer. We observed some of the lunch time meal and saw staff provided the assistance people needed.

We spoke with the cook who told us people could have alternatives if they didn't like what was on the menu. They said they found out people's likes and dislikes by speaking with them regularly about the menus and undertaking food surveys twice yearly. They said themed nights and takeaway nights had been introduced in response to this.

People who used the service said they could see a doctor, dentist or any other health professional when they needed. We saw evidence in care records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community nurses, speech and language therapists, dieticians and dentists.

In the PIR, the registered manager told us, 'Our current 12 month relapse prevention audit has just been completed and it has been a fantastic piece of work, with hard evidence of good physical health outcomes for our residents as a result.' We looked at this audit and action plan and could see hospital admissions for people who used the service had been significantly reduced by the introduction of a number of changes to practice. These included registration of all people who used the service with a single GP surgery, a named GP for each person, monthly GP visit and medical review and the delivery of a training package to all nursing staff; focussed on early identification and action on early symptoms of illness. After the inspection, the registered manager told us the results of this audit had been presented to the recent conference of the Royal College of GPs.

Staff told us they received good training and were kept up to date. There was a rolling programme of training available and staff told us they felt they received the training they needed to meet people's needs and fulfil their job role. The training record showed most staff were up to date with their required training. Staff said they received regular one to one supervision and annual appraisal. The registered manager confirmed there were systems in place to ensure this. Staff said they found this useful and a good opportunity to discuss their training and development needs. Records we looked at showed this to be the case.

Good

Is the service caring?

Our findings

People who used the service spoke highly of their experience. They said they enjoyed living at the home and were complimentary of the staff. Comments we received included; "I am very happy and content being here at this service, the staff go above and beyond their duties to make us happy", "Staff are really nice and helpful when I need them", "I find the staff very caring and compassionate" and "I describe my care as excellent and the staff are always there when you want a chat."

During our visit we spent some time in the communal areas of the home and observed the care provided to people and their interaction with staff. We observed staff were respectful, patient and spoke with people kindly. People were supported to be independent. For example we saw people were supported to mobilise independently with equipment such as walking frames. People were supported to maintain their independence where possible. We saw people moved freely around the home and had access to an outdoor space. We saw people who smoked were able to access an outdoor designated smoking area. People's rooms had been personalised and displayed items that were of sentimental value or of interest to them.

Staff were friendly and enthusiastic in their interactions with people who used the service. It was clear they had built good relationships and rapport with people and they knew them well. People enjoyed the relaxed, friendly communication from staff. In the PIR, the registered manager said, 'The staff know the residents very well, we have a low staff turnover and our staff have worked with our residents for in between 12 months and 15 years. They understand their preferences and abilities and what their needs are and how to meet them.' We spoke with care staff to gauge their knowledge on how to meet people's care needs. We found the descriptions of people's needs given to us by care staff was well matched to that described in care plans.

Staff we spoke with were confident they provided good care and gave examples of how they ensured people's privacy and dignity were respected. Staff were clear about how to respect people's privacy and dignity, and understood how to put this into practice. We saw staff were respectful when they were supporting people with personal care needs. They were sensitive and discreet. They responded quickly to any requests for assistance and support.

People who used the service said there were no restrictions on visiting and they could have visitors whenever they wanted. The registered manager told us some people had friends and visitors who regularly came for a meal with them at the home. In the PIR, the registered manager stated, 'No resident is discriminated against and based on age, gender, preferences and we have residents with mixed age, gender, sexual preferences and cultures.' They also told us they were sensitive to people's cultural and religious needs and made sure a person's bed was positioned in a specific way and dietary observations were made to respect a person's religious needs.

Staff told us they contacted advocacy services for people if they thought it may be beneficial. Staff were able to give examples of where both lay advocates and IMCA's had visited and assisted people.

Good

Is the service responsive?

Our findings

Prior to living at the home, people's health care and support needs were assessed, planned and evaluated to agree their personalised plan of health care and support. Care plans were informed from a range of health and social care professionals which ensured care staff had all the information they needed to construct a meaningful plan. We saw nursing and care interventions were referenced to show the source of current guidance and good practice. For example we saw a care plan required staff to be mindful of the need to monitor the side effects of some antipsychotic medication. The requirement referenced NICE guidance on the subject. Care plans included people's likes and dislikes and what was important to that person. They also provided details about people's personal care needs, their mobility, the support they needed with eating and drinking and managing continence. The care plans we looked at were clear, appropriately detailed and filed in a logical order. Care plans evidenced the person and where possible their families or advocates were involved in the process, and they were looked after in the way they liked.

We saw care plans were centred on helping people to lead a meaningful and fulfilled life and not just focusing on treating symptoms of mental illness. We saw social inclusion was being used to help in this element of care delivery. Many people who were receiving care had a long history of mental ill-health and had received care from hospital services immediately prior to admission to the home. We saw some people had their care needs assessed regularly by a multi-disciplinary team which included psychiatrists, social workers, specialist nurses and staff from the care home. These meetings contributed to the care planning review process at the home.

In the PIR, the registered manager stated, 'We deliver high quality evidence based care based on the principles of assessing, planning, implementing and evaluating our care. We use the NICE guidelines as our barometer for what we should include and then modify it to the context of our clients with their agreement.' Our findings supported this statement.

Our observations showed staff had a good understanding of people's support needs. Staff told us the care and support plans gave them good guidance on how to meet people's needs as individuals. A person we spoke with said their care was person centred as everyone's care was different and staff helped them in all ways possible. People told us their care needs were reviewed regularly with them.

We saw people were encouraged and supported to develop and maintain interests in the community. For example we saw some people had been supported to attend concerts and go on trips to places of interest. We saw care plans made specific reference to ensure people maintained an interest in matters which gave them pleasure. For example, a care plan recorded, "Ensure [name] engages in activities that they enjoy such as playing dominoes and going out for walks". We saw care plans identified the benefits of engaging in social activities when staff identified people were low in mood and lacking volition.

People told us they were encouraged to maintain family contacts and friendships. Staff and the registered manager told us visitors were always made welcome and some people invited friends to have a meal with them. Some people who used the service told us they were bored at times in the home. Our observations on

the day of inspection showed some people had no planned activity and spent their time mainly watching television.

The registered manager told us and activity audit had been completed as part of a study completed in the service on prompting choice. We looked at this audit/study and saw this had identified where people had refused activity and the activity participated in. The registered manager; while acknowledging the difficulties of engagement for some people who used the service had identified activity levels could be improved upon. In response to this, a new system of delivering activity and occupation had been introduced. This was based on more one to one support and centred around people's expressed interests. The registered manager said it was too early to see if participation had increased for people, however, early indications were favourable and a full audit would be completed to look at how the new system was working.

Some people who used the service said they did not know how to complain about the service but stated this was because they had never needed to do so. One person told us they would approach any member of staff if they had any concerns.

We saw there were systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. We looked at records of complaints and it was clear people had their concerns, complaints and comments listened to and acted upon. We saw the complaints procedure was on display in the home.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a clinical head nurse and a team of nurses and support staff. The registered manager worked one or two night shifts per week in the home and maintained daily contact with the service by telephone, e mail and attendance at the home on a flexible basis as and when required. Management tasks were delegated between the clinical lead and nursing staff with the registered manager having oversight of this.

Staff spoke highly of the registered manager and management team. One staff member said, "[Name of registered manager] is brilliant. She is approachable, takes a leading role but plays to our strengths, she does a really good job and comes in whenever you need her." Other comments included; "[Name of registered manager] has built a great team; all the staff are supportive and so genuine with the residents which is so important; [name of registered manager and clinical lead] really care about the people here." In the PIR, the registered manager stated, 'The day to day culture in the service is one of care and compassion.'

The provider [also known as the director] of the service was available most days in the home and spent time meeting with people who used the service and staff and observing how the service was run. The provider told us they had daily communication with the registered manager so they were aware of important issues that affected the service. In the PIR, the registered manager said, 'The service has a registered manager, head nurse and director who are all actively involved in improving standards and maintaining the quality of care at the home.'

Staff told us they really enjoyed their jobs and found the home a very rewarding place to work. They said they felt listened to and could contribute ideas or raise concerns if they had any. They told us they felt valued by the management team and provider which motivated them to do a 'good job'. We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the home and receive feedback on issues such as safeguarding, staff practice and complaints. One staff member told us, "We have staff meetings where the manager will listen to what we say." In the PIR, the registered manager said, 'We try to involve all the staff in the developments of the service.'

People who used the service, their relatives and other health or social care professionals were provided with an opportunity to comment on the service through an annual survey. We looked at the results of surveys undertaken between 2014 and 2016 and these showed a high degree of satisfaction with the service. Where suggestions for changes had been made we were told these had been actioned. For example, one person had asked for healthier food options and time had been taken to discuss this with them. Another person had asked for more takeaway food and regular 'chippy' teas and a Caribbean takeaway option had been introduced. Results from the surveys had been displayed in the entrance to the home so people could see the action taken.

The registered manager said any suggestions made through the use of surveys would always be followed up to try and ensure the service was continually improving and responding to what people wanted. We saw where health professionals had made suggestions or asked for meetings to discuss people's care needs

these had been addressed.

There was a programme of audit in place. These included audits on medication, the premises and maintenance, care records, cleanliness, mattresses, choice and activity. We saw documentary evidence these took place at regular intervals and any actions identified were addressed. We saw evidence of audits being carried out with the inclusion of other healthcare professionals. We saw the outcomes of these audits were being shared with a wider health care community. This demonstrated transparency and the desire to share learning with others for the greater good of people who used services.

The home engaged with educational establishments to provide training placements for medical and nursing students. In the PIR, the registered manager said, 'We are very proud and unique in that our collaborations with the medical and nursing school mean our residents get the benefit of cutting edge knowledge and techniques and our staff are able to learn from these.' We saw evidence of partnership working with health and social care professionals. Our discussion with the manager demonstrated they took the lead in care delivery but they sought advice and guidance from a wide range of other health and social care staff. We also saw the manager had a keen interest in making reference to written guidance from a range of sources including NICE.

There were systems and procedures in place to ensure review of incidents and accidents to make sure risks to people were minimised and notifications of incidents occurring at the home had been made to the CQC appropriately and in line with their registration requirements. We saw any learning for incidents was translated into revised policies or areas of practice. In the PIR, the registered manager said, 'Serious and untoward incidents are reviewed by the trained nurses as part of an audit and discussed with the manager who may request further action or training as a result of the incident. It is discussed as part of a review and then monitored to ensure it is developed.'