Earlybirdcare Ltd

Alexandra Park Home

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

The inspection took place on 21 May 2018 and was unannounced. The service first became registered on 26 April 2017. It was previously registered under another provider. This was the first inspection of the service with the new provider.

Alexandra Park Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Alexandra Park Home provides accommodation and care to up to 13 people. At the time of our inspection, 13 people were living in the home. Care is provided across two floors with a communal area on the ground floor. The service specialises in providing care to older people who
are living with dementia and mental health conditions.

There was a registered manager at this service. 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.

People and their relatives told us they felt safe with staff and there were enough staff to meet their needs. Staff were trained in safeguarding and knew how to safeguard people against harm and abuse. People's risk assessments were completed, regularly reviewed and gave sufficient information to staff on how to provide safe care. Staff kept detailed records of accidents and incidents that took place. Staff wore appropriate protection equipment to prevent the risk of spread of infection. Thorough recruitment checks were completed to assess the suitability of the staff employed. Medicines were stored and administered safely. The home environment was clean.

Staff knew people's individual needs and were provided training to meet those needs. Staff told us they felt supported by the registered manager and receiving regular supervision. People were supported to meet their dietary needs and told us they liked the food. Staff assisted and supported people to access ongoing healthcare services to maintain healthier lives. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. Staff understood people's right to choices and asked their permission before providing care.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is a law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. People who had capacity to consent to their care had indicated their consent by signing consent forms. However, where people lacked capacity to consent to their care the provider had not followed the principles of the Mental Capacity Act (MCA) 2005. We have made a recommendation about following the principles of

the MCA.

People's needs were assessed and met by staff in a personalised manner. Care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Most staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

The service had an end of life policy for people who used the service. However, the service did not explore end of life wishes during the initial needs assessment and care planning. We have made a recommendation about supporting people with end of life wishes.

People who used the service and staff told us the registered manager was caring, knowledgeable and communicated well. The service had various quality assurance and monitoring mechanisms in place.

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. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

Medicines were recorded and administered safely.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. Staff undertook regular training. Staff received regular supervision and appraisals..

The provider did not always meet the requirements of the Mental Capacity Act (2005) to help ensure people's rights were protected. The registered manager and staff had a good understanding of Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink sufficient amounts and eat nutritious meals that met their individual dietary needs.

People's health and support needs were assessed and appropriately reflected in care records. People were supported to maintain good health and to access health care services.

People's cultural and religious needs were respected. Most staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Is the service caring?

Good

The service was caring. People and their relatives told us that they were well treated and the staff were caring. People could

make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities.

People knew how to make a complaint and felt confident their concerns would be dealt with appropriately.

The service had an end of life policy for people who used the service.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place. Staff told us they found the registered manager to be caring, knowledgeable and communicated well.

People and their relatives told us that the service was well run and they received good care.

The service had various quality assurance and monitoring systems in place.

Alexandra Park 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.

Before the inspection, we asked the provider to complete 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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. Before we visited the home, we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placements at the home, and the local borough safeguarding team.

This inspection took place on 21 May 2018 and was unannounced. The inspection team consisted of two inspectors.

During our inspection we observed how the staff interacted with people who used the service and looked at people's bedrooms. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with four people who lived in the service and one relative during the inspection. We also spoke with the nominated individual, the registered manager, one senior care assistant, one care assistant and the chef. We looked at five care files, staff duty roster, four staff files including supervision and training records, a range of audits, minutes for various meetings, four medicines records, accidents and incidents, health and safety folder, and policies and procedures for the service. After the inspection we spoke with a professional from the local clinical commissioning group.

Good

Is the service safe?

Our findings

People felt the service was safe. One person told us, "[Staff] always tell you what things are going to happen like when they mended the roof." Another person said, "The area is nice and not seen any trouble. I feel quite safe." A third person told us, "I feel safe as [home] is locked at night and no one dangerous here." A relative said, "It is comforting when I leave [as] staff are looking after people."

There was a safeguarding policy in place which made it clear the responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission. Staff and the registered manager had undertaken training about safeguarding adults. Staff we spoke with had a good understanding of their responsibilities. One member of staff said, "I would tell the manager. I could call social services if the manager took no action." Another staff member said, "I would report it to the manager immediately." The service had a whistleblowing procedure in place and staff were aware of their rights and responsibilities with regard to whistleblowing.

Records showed there had been no safeguarding incidents since the new provider had taken over the service. The registered manager could describe the actions they would take when an incident occurred which included reporting it to the Care Quality Commission (CQC) and the local authority safeguarding team. The registered manager said, "I would start an investigation but first of all report to CQC and the [local authority]." This meant that the provider would report safeguarding concerns appropriately.

Risks to people were assessed and care plans were implemented to keep people safe. People's records contained assessments of known risks such as pressure sores, falls, mobility, diabetes, medicines, manual handling, travelling in the community and toileting. Where risks were identified, plans were implemented to keep people safe. For example, one person had capacity to leave the home on their own. The risk assessment recorded how to make the person safe in the community. Another person had been assessed at risk of choking. To manage the risk, a referral to a speech and language therapist (SALT) was made and the outcome of the appointment was recorded in the care plan. This included what consistency pureed food this person should eat and the associated risks. This information was also available in the kitchen and the chef was knowledgeable about the risks to this person. During the inspection, we observed staff supporting this person as outlined in their care plan during the lunchtime meal. This meant the risk assessment processes were effective at keeping people safe from avoidable harm.

Equipment checks and servicing were regularly carried out. The service had completed all relevant health and safety checks including fridge/freezer temperature checks, fire system and equipment tests, emergency lighting, gas safety, electrical checks, and water regulations. Fire alarm systems were regularly maintained. Staff knew how to protect people in the event of fire as they had undertaken fire training and took part in practice fire drills.

The service had plans to keep people safe in an emergency. We saw each person had a personal emergency evacuation plan (PEEP), which detailed action to be taken in the event of an emergency and was accessible to staff.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes, and actions taken. However, we found one incident had not been recorded. We noted in a daily communication record a person had a fall. Staff took action to help the person and called emergency services however this incident was not recorded in the accident log. We fed back this information to the registered manager, who advised us they would follow this up.

There were sufficient staff present to meet people's needs. One person said, "I think almost too many [staff]. I would say it's about right." Another person told us, "On the whole enough staff." A third person said, "Seems to be adequate. You can always find somebody." Staff told us that they had enough time to meet people's needs and take time to provide people with engagement and interaction. Throughout the day we observed staff were able to sit with people and talk, play games and provide the levels of supervision required to keep them safe.

The provider carried out recruitment checks to ensure that people were supported by appropriate staff. Staff files contained evidence of robust checks being carried out before staff came to work with people. Checks included references, employment history and a check with the Disclosure & Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. This meant the provider had taken steps to ensure suitable staff were employed.

During the inspection we checked medicines storage, medicines administration record (MAR) charts, and medicine supplies. All prescribed medicines were available at the service and were stored securely in a locked medicine trolley. This assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people using the service.

People received their medicines as prescribed. Medicines administration record sheets (MARS) were appropriately completed and signed by staff when people were given their medicines. Medicines records showed the amount held in stock tallied with the amounts recorded as being in stock. Training records confirmed that all staff who administered or handled medicines for people who lived in the home had received appropriate training. Records showed staff had competency assessments on medicines completed on an annual basis. One staff member told us, "Yes I am trained. [Nominated individual] always checks that we have signed on [the] MAR sheets. I would report an error to [registered manager] or [nominated individual]."

The service had policies in place for people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when needed for specific situations. However, reasons for giving PRN medicines were not documented for two people who used the service. After the inspection the provider sent us PRN protocols which gave specific details on 'when required (PRN) medicines for those people.

Records showed staff had completed training on infection control. Staff had access to policies and guidance on infection control. Throughout the home hand sanitizer gel was available and information was available on hand cleaning. The provider employed a domestic assistant and we observed them cleaning throughout the day. One staff member told us, "We have aprons [and] gloves. Make sure we wash our hands. We are very careful at this." A relative told us, "Staff run to clean the toilet. Gloves go on to pick everything up."

Good

Is the service effective?

Our findings

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, the needs of the person, and ways care had been offered with the least restrictive options explored. The service informed the Care Quality Commission (CQC) of the outcome of the applications.

We found the service had up to date policies and procedures in relation to the MCA so that staff were provided with information on how to apply the principles when providing care to people using the service. Staff had received MCA training and they were aware of how the MCA applied within their day to day practice. The provider had a mental capacity assessment template with the MCA policy. However, they were not using this template. The registered manager told us they were given information about people's capacity from the local authority hen the person was assessed during the DoLS application process. The registered manager told us they would start using the mental capacity assessment as part of the DoLS application process.

We recommend that the service consider current guidance on the Mental Capacity Act 2005 (MCA) and take action to update their practice accordingly.

Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. People told us that staff members asked their consent before helping them. This consent was recorded in people's care files. One person told us, "They [staff] ask my permission before I take my pills." One staff member told us, "We seek permission before we do anything."

People who used the service told us they were supported by staff who had the skills to meet their needs. One person said, "[Staff] are friendly and very protective of us as they love us so much." Another person told us, "[Staff] keep up to date [with] what you can do."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. The assessment looked at communication methods, medicines, personal

care, nutrition, social support and what is important to the person. Records confirmed this. One relative said, "[Registered manager] came to see me [about] the assessment. She was with us for quite a few hours."

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. Records showed the training included safeguarding adults, first aid, fire awareness, manual handling, infection control, medicines, person-centred care, care planning, communication, food hygiene, health and safety, COSHH, whistleblowing, equality and diversity, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff also completed training specific to the needs of the people using the service such as dementia, epilepsy, challenging behaviour, Parkinson's disease, mental health, multiple sclerosis, learning disabilities, wound management, PEG feeding, continence care, and diabetes. Records showed that all of the staff had completed the induction programme, which showed they had received training and support before starting work in the home. One staff member told us, "I did induction for one week and shadowing for two weeks." The registered manager told us they had introduced the Care Certificate for all new staff and records confirmed this. The Care Certificate is a set of standards that social care and health workers use in their daily working life.

Staff told us they received regular formal supervision and we saw records to confirm this. Topics included actions from their last supervision, training, work practice, workloads, emotional impact of their work, professional development, and updates of people who used the service. One staff member said about supervision, "Yes, definitely. It keeps us on our toes. We talk about our work and the residents. Any problems we can say and get help." Annual appraisals were being completed with staff.

The kitchen was clean, food items were stored appropriately and labelled. Food hygiene notices were displayed in the kitchen. Records showed fridge and freezer checks were completed daily. The chef was aware of the people who were on specialised diets and explained the meal preferences for these people which were reflected in the care plans we looked at. The chef told us that people could ask for alternatives to the food choices for that day and people confirmed this. The food menu included a starter, such as soup and at least two hot meal options plus dessert. On the day of the inspection, the main meal on offer was sausages and vegetables or chicken burger and vegetables. The dessert available was cheesecake or yogurt. Staff told us and records confirmed people were asked their food option each morning.

People told us they liked the food. One person told us, "I like the food. I think it's good. We get a choice." Another person said, "I do like the food. On the whole we get what we want." A third person told us, "I don't eat pork so I eat chicken. Food is okay. We suggest about food [choices] in a meeting and the manager does it for us." A relative told us, "The food is lovely. I would eat it."

During the lunch time period we saw people being offered a range of drinks. Meals were attractively presented and there was a relaxed and calm atmosphere. Staff members chatted with people while they waited for their food to be served. People who required assistance with eating were not rushed and staff talked to them in a gentle and encouraging way. However, one person who was at risk of choking had their meal blended all together, which meant it was not presented in an appealing way. It did not allow the person to experience and taste different flavours. We spoke to the registered manager about this and she advised us they would explore different ways to present blended food.

People were supported to maintain good health and to access healthcare services when required. Records showed people attended appointments from a range of healthcare professionals such as GPs, district nurses, dentists, chiropodists, opticians and dieticians. One person told us, "I have an appointment with the GP [today]." Another person said, "[Staff] made an appointment at [hospital] for my hearing." A third person told us, "Sometimes we go see the GP. I go for a check-up. The chiropodist comes here." This showed the

service was meeting people's health care needs.

The premises, décor and furnishings were maintained to a good standard. They provided people with a clean, tidy and comfortable home. The registered manager told us that after the new provider purchased the home, they started a programme of maintenance. This included a new roof, new carpeting and painting. There was a secure accessible garden for people's use. Specialised equipment was available for people such as a stair lift, walk in showers and walking aids. People's bedrooms were personalised. One relative said, "[Staff] said whatever we wanted to bring [to decorate bedroom]."

Good

Is the service caring?

Our findings

People and a relative told us that they were well treated and the staff were caring. One person told us, "[Staff] love us so much. They are caring." Another person said, "Never come across staff that are not caring." One relative told us, "The staff are just so lovely. You ring the doorbell and whoever opens the door is pleased to see you. The staff are calm and relaxed. [Staff] are living angels." A health and social care professional told us, "The residents look happy and looked after."

Staff knew the people they were caring for and supporting. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member told us, "I've been here 25 years. I know the residents really well. I sit and chat to people. I make it my business to get to know them." Staff communication with all residents was warm and friendly, and staff showed compassion when talking about people who lived at the home. Throughout the day we saw staff sitting with people and rubbing their back as they talked to them to make them feel comfortable.

People's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. Staff we spoke with gave examples of how they respect people's privacy. One staff member told us, "We help them do personal care. We close the door and windows for their privacy." Another staff member said, "Be respectful and know what [people] require. Give them privacy when needed. Treat them well. They're entitled to privacy. I would leave them alone if they want to be alone." One person said, "[Staff] knock on my door. They ask me when I want my bedding changed." Another person told us, "[Staff] always ask to come into my bedroom."

People were involved in their care. Staff ensured people were given opportunities to make day to day decisions about their care. We observed staff offering people choices when providing them with meals and drinks during the inspection. One person told us, "You get to choose your food. You can choose if you want to go out. Go to bed when you want." Another person said, "You get choice with meals and all sorts of things." A third person told us, "I go to bed about 10 but that's my choice. You can go before." A relative said, "If [people] don't want to participate [in activities] they don't have too."

People's independence was encouraged. Staff gave examples how they involved people with doing certain aspects of their personal care and going out into the community to help become more independent. This was reflected in the care plans for people. For example, one care plan stated, "[Person] likes to go out after lunch for a walk on his own." During the inspection we saw this person go for a walk in the community. This person told us, "I have a lot of freedom and I go out a lot." Another person said, "[Staff] wash my back but I do the rest by myself." One staff member told us, "We don't do everything for them. Some people can dress themselves or shower themselves. We ask them first. We can observe them and support them if needed."

Good

Is the service responsive?

Our findings

People told us they enjoyed living at the home and the care they received was responsive to their needs. A relative told us, "As soon as my [relative] needs help [staff] are there. They are on the ball."

Care plans contained information and guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet their needs. They included guidance for personal care, activities, mobility, nutrition and hydration, medicines, night care, mental health and diabetes. The care plans were reviewed monthly and as and when people's needs changed. Records confirmed this. The service also carried out an annual review of the people's care needs with the person, relatives and their social worker. Records confirmed this.

One person showed us their care plan. A copy of the care plan was kept in the person's room. This person said, "In my care plan is when I see the dentist and how I want my shower." The care plans also included a section called "What is important to me." This section included information about family and important relationships, routines, religious and cultural needs, activities and previous living arrangements. Each person had an hospital passport which gave information about the person's health and social care needs including likes and dislikes. Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People had access to planned activities. The service did not employ a full-time activities co-ordinator however the care staff lead on activities. Also, the service had external professionals visit at regular times to provide activities such as music and Tai Chi. Activities on offer included ball games, quiz, bingo, singing and dancing, arts and craft, movies and dominoes. One person said, "We have enough activities. We have games and newspaper reading. We have someone come in once a week to do music and dancing. We also do Tai Chi Tuesday mornings." Another person told us, "I don't have time to get bored. I do crossword puzzles." A relative person said, "They have an aerobics lady come in. They do dominoes, bingo and [ball game]. [Staff] really encourage [people]."

During our inspection we saw group activities with people. We observed in the morning people reading the newspaper, playing dominoes and colouring in. In the afternoon we saw people having a singalong with the care staff. Activities we observed were tailored to people who used the service and were carried out with care and attention. The activities were managed with kindness and sensitivity, involving everyone who wanted to participate.

People's cultural and religious needs were respected when planning and delivering care. Records showed people had discussions of their spiritual faith during the care planning process. Most staff showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "Everybody is welcome. We have an open-door policy." Another staff member told us, "Not right to discriminate. I know this and would challenge it. [People] are here to be cared for and looked after, it doesn't matter who they are or where they come from. It is not acceptable for staff to be like this and not respect their wishes. Those bad days have

gone now, I hope." However, one staff member we spoke with told us, "Not sure I can allow gays and lesbians onto the facility." We spoke to the registered manager about this staff member as we wanted to make sure if LGBT people were to use the service they would not be discriminated against. The registered manager told us they would speak to the staff member and organise further equality and diversity training for that staff member.

There was a complaints process available and this was on display in the communal area so people and their relatives were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

People and a relative we spoke with knew how to make a complaint and that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions taken as a result and the response to the complainant. Records showed there had been one formal complaint during the last 12 months. We found the complaint was investigated appropriately and the service aimed to provide a resolution in a timely manner. One person said, "I would complain to the [deputy manager] and [registered manager]." Another person told us, "I would go to [registered manager]." A relative told us, "I would speak to [deputy manager] and [registered manager]. Just hard pushed what I would complain about."

At the time of our inspection the service did not have any people receiving end of life care. The service had an end of life policy which was appropriate for people who used the service. One staff member said, "We have no one here on end of life but we get support from district nurses." The registered manager told us, "If someone wanted to die here, I would include it in the care plan. I would discuss it with the GP. We have palliative care nurses in the community." However, care records showed end of life wishes were not always explored with people during the initial assessment and care planning stages. This meant there was a risk people did not have a chance to explore their end of life wishes and where they would like to spend the last stages of their life.

We recommend that the service seek advice and guidance from a reputable source, about the end of life care for people.

Good

Is the service well-led?

Our findings

People who used the service and a relative spoke positively about the registered manager and deputy manager. One person told us, "[Registered manager] is loving and caring like a mother." Another person said, "[Registered manager] is lovely and very good. She gave me a pen to do my crosswords. Very cheerful and happy go lucky." A third person said, "I like [registered manager] a lot. She does a lot of good things and changes. It's all changed since [previous provider]. She has modernised the building." A relative told us, "I watch [registered manager] cuddling residents. Such genuine love here. She puts her arm around [person] and his face lights up."

People and a relative were also very positive about the service. One person told us, "It is such a family friendly atmosphere." Another person said, "I enjoy [living at the service]. I like the garden." A relative told us, "[The service] is like a pocket of heaven. Seems to be happiness here. It moves me. It doesn't feel like an institution, it's really a home."

Staff told us that they felt supported by the registered manager and deputy manager and that they were supportive. One staff member said, "She's a good manager. She helps in a lot of things. She has time to talk to us. Every day she teaches us new things." Another staff member told us, "Yes, [registered manager] very good. Very up to date on things. She has improved us a lot."

The registered manager described in detail the support provided to people, and knew them, their preferences and needs well. They had built up a strong relationship with people who used the service and their relatives. The registered manager said about her role, "I'm an open person, hardworking and enthusiastic. I am passionate about elderly people." The registered manager had a strong focus on continuous learning for the service. This included the registered managers' own learning and development. The registered manager told us, "I've done QCF level 5 in management. I'm also an assessor in health and social care level 7 and I did train the trainer in medicines administration." Records confirmed this.

The registered manager told us since starting in the role she had improved the service in various ways. This included increasing staffing levels during the day, implementing a building improvement programme and increasing care staff learning. This was reflected from feedback from people who used the service and staff we spoke with. The registered manager also told us she had bought two electronic tablets for people to use if they did not want to participate in activities. We saw during the inspection one person playing a game on the electronic tablet. The service had also invested in two laptops for staff to use for care information recording and online training.

The service held regular staff meetings where staff could receive up to date information and share feedback and ideas. Topics included in staff meetings were building improvements, new care plans, staff training, use of the staff room, team working, medicines, and communication. One staff member told us, "We talk about every aspect of our day, timekeeping, the residents, everything." Another staff member said, "[Staff meetings] about the residents, infection control and how to talk to the residents."

Residents meetings were held every two to three months to provide and seek feedback on the service. Topics recorded for the meetings included home improvements, the call bell system, outdoor and indoor activities. Records showed people were free to discuss their opinions and feedback on the service. One person told us, "We have a meeting every two months. We discuss the food and the entertainment, and games."

The provider had a number of quality monitoring systems in place. These were used to continually review and improve the service. The registered manager told us the nominated individual conducted regular audits of the service. The last audit conducted was 3 May 2018. The audit looked at medicines, activities, communications, welfare of people, appointments, infection control, staffing and records to ensure service was safe. Recommendations for improvement included having a staff register at reception, referring people to advocacy services and coaching staff to write daily progress reports. Records showed these were listed as actioned. The audits were detailed and included all findings and areas for improvement.

The quality of the service was also monitored through the use of annual surveys to get the views of people who used the service and their relatives. Annual surveys were still in the process of being collated, however those returned were positive. Comments included, "Caring, clean and promotes a positive culture. Staff are friendly and accommodating" and "Staff are attentive and responsive to residents."

The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us she attended the local authority care home forum every quarter to share information. Also, the home worked with a local authority contracts team, social services, district nurses and the local clinical commissioning team. A health and social care professional told us, "We had a quality assurance audit last year and we made suggestions. [Registered manager] made the changes."