HC-One Beamish Limited

Fleming Court

Inspection report

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Website: www.hc-one.co.uk

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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 21 November 2017.

This was the first inspection of Fleming Court since it was registered with the Care Quality Commission in November 2016.

Fleming Court is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under a contractual agreement with the local authority, health authority or the individual, if privately funded. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Fleming Court accommodates a maximum of 69 older people, including people who live with dementia or a dementia related condition, in one purpose built building. At the time of inspection 34 people were using the service.

A registered manager was not in post. A relief manager was responsible for the day to day management of the service until a manager was appointed. 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.

The atmosphere was lively and bustling and visitors told us they were made welcome to the service.

There were sufficient staff to provide safe and individual care to people. Staff knew about safeguarding vulnerable adults procedures. Staff were subject to robust recruitment checks. Arrangements for managing people's medicines were safe. Appropriate processes were in place for the administration of medicines.

People told us their privacy, dignity and confidentiality were maintained. Staff understood the needs of people and care plans and associated documentation were clear and person centred. Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. People received a variety of food and drink.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People told us staff were kind and caring and they felt comfortable with all the staff who supported them

Appropriate training was provided and staff were supervised and supported. People were able to make choices about aspects of their daily lives. They were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. Most areas of the building were well-designed to help people who lived with dementia to be aware of their surroundings and to remain involved.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided.

People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. People had access to an advocate if required.

Staff and relatives said communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from possible abuse as systems were in place to protect people from abuse. Staff said they would be able to identify any instances of possible abuse and would report any that occurred.

People received their medicines in a safe and timely manner.

Staffing levels were sufficient to meet people's needs safely. Appropriate checks were carried out before new staff began working with people.

Is the service effective?

Good

The service was effective.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a balanced diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs. People's privacy and dignity were respected.

People were encouraged and supported to be involved in daily decision making. There was a system for people to use if they wanted the support of an advocate.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping to help staff provide person centred care and support. There was a programme of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was not in post as the previous registered manager had left. However, a relief manager was responsible for the day to day management of the service until a new manager was appointed.

Staff and people told us the management team were supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

Fleming Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 6 November 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 12 people who lived at Fleming Court, seven relatives, the relief manager, the operations manager, seven support workers, two activities co-ordinators, two members of catering staff and one liaison officer. We received feedback after the inspection from one visiting health care professional. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the provider had

completed.

Good

Is the service safe?

Our findings

People who used the service and relatives all told us that they and their relatives were safe at the home. One person told us, "I feel safe here, staff are around." Another person commented, "I have never felt unsafe here, quite the opposite." One relative said, "We're quite confident, [Name] is safe and well looked after by staff." Another relative told us, "I do think there are enough staff on duty, buzzers are answered promptly." A staff member told us, "We have adequate time to support people."

Our observations during the inspection showed, at current occupancy levels, there were sufficient numbers of staff available to keep people safe and provide effective care to people in all parts of the home. Staff were not rushed and responded promptly and patiently to people's requests for support. One relative commented, "[Name] had a tumble in the bathroom, they were very happy with the speed that staff arrived and the caring way they helped him. [Name] felt very respected and safe."

There were 34 people living at the home at the time of inspection. Staffing rosters and observations showed there were seven support staff including two senior support staff to support people. Overnight staffing levels were five support workers including senior support workers. These numbers did not include the relief manager who was also available during the day and an on-call system operated overnight if urgent advice and support was needed.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the manager. One staff member told us, "I'd report any concerns to the senior and complete a form." Staff were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. We saw alerts had been made by management to the local authority and the management team investigated all concerns.

Risks to people's safety had been identified and actions taken to reduce or manage hazards. Risk assessments were recorded in people's care records. The documents were individualised and provided staff with a clear description of any identified risk and specific guidance on how people should be supported in relation to the identified risk. For example, from falls or risk of choking. An internal falls team monitored any incidents of falls and where required people were referred to an external falls clinic, for more specialist assessment and advice. Positive risk taking was encouraged and one person's assessment stated, '[Name] can make simple drinks.'

A personal emergency evacuation plan (PEEP) was available for each person, in case the building needed to be evacuated in an emergency. It took into account their mobility and moving and assisting needs and was reviewed monthly to ensure it was up to date.

Staff were aware of the reporting process for any accidents or incidents that occurred. Where an accident or incident did take place these were reviewed by the manager or another senior staff member to ensure that any learning was carried forward.

People were supported with their medicines safely. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment room. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

An up-to-date medicines policy was in place. It included written guidance for the use of 'when required' medicines, and when these should be administered to people who showed signs of agitation and distress. 'When required' medicines are those given only when needed such as for pain relief. It also included guidance for staff about the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). It advised staff that for people without mental capacity best interest decision making should adhere to the National Institute for Health and Care Excellence (NICE) guidelines with the best interests decision being made with all the relevant people.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the positive behaviour support team. Staff told us they followed the instructions and guidance of the behavioural team for example, to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. One staff member told us, "We're constantly doing training." Another member of staff commented, "I'm always keen on training." A third staff member said, "We do face to face and e learning training." Another staff member said, "We definitely have opportunities for training."

Staff training records showed and staff told us they received training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people and this included a range of courses such as dementia care, basic life support, nutrition and hydration, care planning, person centred care, dignity awareness, promoting healthy skin, equality and diversity, introduction to falls awareness and mental capacity.

Staff members were able to describe their role and responsibilities. Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This was needed to ensure they had the basic knowledge needed to begin work. We were made aware some new staff had not completed all their training in safe working practices before they began supporting people, although they did not work unsupervised. We discussed this with the relief manager and area managers. They informed us it would be addressed so staff had completed all the required courses before they worked with people.

New staff undertook the Skills for Care 'Care Certificate' to further increase their skills and knowledge in how to support people with their care needs. The Care Certificate was designed to provide a standardised approach to training for new staff working in health and social care.

Support staff commented and records confirmed they received regular supervision from one of the home's management team every two or three months. One staff member commented, "I had supervision last week with the manager." Another staff member told us, "I supervise some of the support workers." A supervision planner was available that showed supervisions that had taken place and those that were planned over the rest of the year.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 13 DoLS applications had been authorised by the relevant local authority. Where people were not subject to DoLS they were able to come and go in the home as they wanted. Mental capacity assessments were in place. Records showed where relatives were lawfully acting on behalf of people using the service. This included where they had a deputy appointed by the Court of Protection to be responsible for decisions with regard to their care and welfare and finances when the person no longer had mental capacity.

People were supported to access community health services to have their healthcare needs met. Their care records showed they had input from a different health professionals. For example, the GP, district nurse and the speech and language therapy team (SALT). One person commented, "Staff called a doctor for me the other day and they're coming back today." A relative commented, "I was so pleased staff noticed straight away [Name] was unwell." People also had access to dental treatment and optical services.

People enjoyed a varied diet. The cook told us menus were prepared by head office and they attended resident and relatives meetings to obtain people's feedback and suggestions for menus. People's special diets and any cultural or vegetarian preferences were respected. People were offered regular drinks and snacks throughout the day in addition to the main meal. We observed that the lunch time meal did not finish until 2:00pm and the evening meal was served at 4:30pm, with the tea time trolley serving food and drink at 3:00pm. This meant although food was served regularly, there was only a small interval in between meals. We discussed with the management team about obtaining people's feedback about the time of meals to check it was suitable for all people. We noticed some people had requested to have their evening meal at a later time. They told us that this would be addressed.

We observed some staff, who worked in other areas of the home accessed the kitchen without wearing protective clothing. We discussed this with the area manager who told us it would be addressed in the interests of food hygiene.

A pastry chef was on duty each day as well as the chef and other kitchen staff. They made fresh bread, pastries and cakes which were served every day. One person told us, "The food is alright." Another person commented, "The food is lovely." A third person said, "There is plenty of choice, we never have a problem with the food." Other peoples' comments included, "The food here is lovely, plenty to choose from", "The meal at lunch time was nice" and "I enjoyed that cake, I didn't think I would eat it but it was lovely." One relative told us, "The food looks good."

People enjoyed a positive dining experience at meal times. We observed the lunch time meals in the dining rooms. The atmosphere was calm and relaxing. Most people were served in the dining room and staff were available to provide support and encouragement or full assistance to people. Food was well presented and looked appetising. A choice of main meal was available at each meal. People sat at tables that were set with tablecloths, linen napkins, condiments and flowers. People were also offered protective aprons. Written menus were available however, pictorial menus or photographs were not available for people who may no longer recognise the written word. We were told by the area manager that this would be addressed. We observed at the evening meal, when the meal was served some people enjoyed a glass of wine with their meal.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with reduced appetites were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. People's

care records included nutrition care plans to ensure these needs were met. Information was also available with regard to people's food likes and dislikes and any support required to help them to eat.

Communication was effective within the home. People's needs were discussed and communicated at staff handover sessions when all staff changed duty, at the beginning and end of each shift. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. This was so staff were aware of risks and the current state of health and well-being of people. One staff member told us, "We're told at handover if there has been any change. Information is in people's care plans and the communication book." Another member of staff commented, "I attend handover in the mornings." A third staff member said, "There's good communication between staff." Relatives were kept informed by the staff about their family member's health and the care they received. One relative told us, "Staff will let me know how [Name] is." Another staff member said, "I'm always kept informed."

The home was bright, airy and accessible for the benefit of people who lived there. The gardens were secure and well maintained. They were overlooked by many of the bedrooms and lounges. All people's bedrooms were personalised, Wi-Fi internet was available for people and some bedrooms were equipped with Sky Television and telephones at the person's request and cost.

A combined café and bar were situated on the ground floor of the home, which was well used by people. There was a cinema room and hairdressing salon. The reception area and lounges were spacious and comfortable. All areas of the home were well-decorated and bright. The communal areas and hallways had decorations and pictures of interest. Appropriate signage was in place to help maintain people's orientation. For example, lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence. The unoccupied area of the home was well equipped and designed to promote the orientation of people who lived with dementia.

We considered some improvements were required on the occupied section of the middle floor of the home to benefit people who lived with dementia. Memory boxes were not available that contained items about people's previous interests or other features to help them identify their room. Although there were seating areas on corridors there were no themed areas of interest on the corridor and around seating areas for people as they moved around on the occupied middle floor of the home. We discussed this with the area manager and registered manager who told us it would be addressed.

Good

Is the service caring?

Our findings

Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives were overwhelmingly appreciative and spoke well of the care provided by staff. They spoke highly of the caring nature of staff. One person told us, "I am so well cared for here." Another person commented, "The staff are very helpful." A third person said, "It is very nice here, we're well looked after." Other peoples' comments included, "There is an air of freedom here" and "Staff here are very helpful and they help me getting around." One relative told us, "[Name]'s care is excellent. Staff know her." Another relative said, "The staff are caring." A third relative commented, "I'm very pleased with [Name]'s care."

The provider had introduced some initiatives such as 'resident of the day' to help ensure that people received person- centred care. A member of staff was also employed, similar to a hotel concierge, specifically to liaise and attend to any personal requirements a person may request. For example, carrying out personal shopping, taking a person shopping, arranging individual social events and arranging to help make people's individual dreams a reality. For example, one person wished to visit the opera and this had been arranged.

During the inspection there was a friendly, relaxed and pleasant atmosphere in the home. During the lunchtime in the dining rooms the atmosphere was calm and tranquil as people ate or were supported to eat their meal. Staff interacted well with people. They were kind and caring and they spent time engaging with people and not only supervising them. One relative told us, "Staff are very caring, they try to keep people involved by talking to them." As staff passed people on corridors they acknowledged them as they passed by.

People were supported by staff who were warm, kind, caring and respectful. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff asked the person's permission before they carried out any intervention. For example, as they offered people drinks or assisted them to move from their chairs. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, one staff member said, "I'm going to move your feet from the foot plates on your wheelchair now."

Care plans provided information to inform staff how a person communicated. For example, one care plan recorded, 'I am vocal.' Another one stated, '[Name] can communicate verbally and express their wishes to staff' and '[Name] communicates by writing things down and with picture cards.' Staff were aware of how people communicated, when they may no longer be able to express their wishes and needs verbally. For example, how they may show they were in pain if they were unable to tell staff verbally that they were in pain or distressed. One staff member said, "I look at the body language."

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed and what they

might like to do. All people were encouraged to make some choices about their day to day lives. Care plans documented how staff could encourage people to remain involved, make choices and express their views. For example, '[Name] can make simple day to day choices.' Another care plan stated, '[Name] can make their own choices regarding their clothing,'

Care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes and dislikes. For example, 'I enjoy arts and crafts and flower arranging.' Another person's care record stated, 'I like to go to bed at 10:00pm and get up at 8:00am. I dislike feeling alone and getting up too early' and, '[Name] dislikes noise.'

We were told the service used advocates as required and if there was no family involvement. Advocates can represent the views for people who are not able to express their wishes. Information was given to the person before they started to use the service which provided information about advocacy services that were available and how they could be accessed.

In all aspects of people's care they were treated with dignity and respect. Staff knocked before entering people's rooms, including when doors were open. They were discreet when speaking to people about their care and treatment. People looked clean, tidy, hair coiffured and well presented. Many people chose to wear jewellery and makeup. Records were held securely.

Good

Is the service responsive?

Our findings

People and relatives confirmed there was a choice of activities available. People received a daily newsletter that included planned activities, menu and events for the day and future entertainment and events. One person told us, "There is always something happening here and newspapers are delivered every day." Another person said, "We get a daily news sheet, that's very useful as it tells us what's happening each day." One relative commented, "There seems to be a lot of activities and things to stimulate people."

Two activities co-ordinators were employed who were enthusiastic and showed a good understanding of providing person-centred activities. One of them told us, "We plan ahead, but are flexible to the needs of people. We don't tell them what to do, we ask them what they want to do." Garden areas and different seating areas within the home were available for people to enjoy some quiet time or to come together and take part in group activities. One person told us, "We enjoy the peace and quiet of the lounge, but there are other people to talk to." A café and bar were situated on the ground floor, the bar advertised 'Happy Hour' drinks in the early evening. People used the bar as a place to meet and socialise. We observed some people met up in the bar before meals to enjoy a glass of wine before lunch or an evening drink.

Activities that were advertised included, reading newspapers and current affairs discussions, arts and crafts, chair badminton and armchair exercises, individual pamper sessions, music sessions and film afternoons. Entertainment and concerts also took place and on the day of inspection a party with people and relatives was taking place to celebrate the first anniversary of the service opening. It was well attended and people enjoyed a 1920's themed party with food, drink and entertainment. Meeting minutes showed future entertainment and resources that were to be arranged as a result of people's requests. For example, trips to the cinema, visiting birds of prey and accessing a mobile library.

The manager told us there were good links with the local community. The home was situated in close proximity to a church, a nursery school and two secondary schools. People benefited from visiting children and youth volunteers and also some people had visited the nursery school for an event. We were told some people went out independently into the local community. The home was situated in a residential area near to cafes and shops. There were opportunities to go out on trips and these included visits to Durham, North Shields and to coastal areas. The hairdresser visited weekly and a local member of the clergy visited regularly.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of people's needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of people's care and support needs took place with relevant people. One relative told us, "I'm fully involved in [Name]'s care plans."

Care plans were in place that provided some details for staff about how the person's care needs were to be met. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition. Information was available in people's care records to help staff provide care and support. Care plans were personalised and provided information for staff about how people liked to be supported.

Other information was available in people's care records to help staff provide care and support. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure people's daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

People knew how to complain. People we spoke with said they had no complaints. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. We saw compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

A registered manager was not in place. The previous registered manager had left in August 2017 and a new manager had been appointed but they had recently left the service. A relief manager was in place to oversee the daily management of the service until a new manager was appointed.

Relative meeting minutes showed there had been some anxiety at changes in management and staffing due to staff leaving. However, a relief manager had just been appointed and had started working at the home the previous day. They were to be a daily presence in the home and provide some continuity and leadership until a new manager was in post.

The relief manager was aware of ensuring that the Care Quality Commission (CQC) was notified of any events which affected the service.

The relief manager, area manager and administrator assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. They were open to working with us in a co-operative and transparent way.

The atmosphere in the home was lively and friendly. People told us the atmosphere was warm and relatives said they were always made welcome. One response to a recent survey stated, 'Run like a first class hotel, with care.'

People and their relatives were kept involved and consulted about the running of the service. A monthly meeting took place with people who used the service and their relatives. One relative told us, "The meetings are useful, they keep us informed of what is going on." Recent meeting minutes showed staffing levels, management changes, entertainment, housekeeping and plans for youth volunteering to the service had been discussed. Minutes were available of meetings for people who were unable to attend. A separate relatives meeting also took place that was facilitated by relatives and with no staff involvement.

Staff told us regular staff meetings took place and these included daily 'flash' (head of department meetings) and monthly general staff meetings. Staff meetings kept staff updated with any changes in the home and informed them of any issues and developments.

Auditing and governance processes took place within the service to check the quality of care provided and to keep people safe. A monthly risk monitoring report that included areas of care such as people's weight loss, pressure area care and serious changes in people's health status was completed by the manager and submitted to head office for analysis. Regular monthly analysis of incidents and accidents took place. The relief manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re- occurrence.

The provider had created a quality compliance team within the organisation to monitor the care provided by all its services. Records showed audits were carried out regularly and updated as required in order to

monitor the service provided by the home.

Audits included checks on medicines management, care documentation, training, kitchen audits, accidents and incidents, infection control and nutrition. Other audits were carried out for falls and health and safety. Visits were carried out by the provider's representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The provider promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. A variety of information with regard to the running of the service was displayed to keep people informed and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out to staff and people who used the service. The service listened and acted on people's views and suggestions. We noted people had been less positive, earlier in the year, in a provider survey about the menus and quality of food. Improvements had been made including changing a food supplier. Arrangements had been made for a person to meet with the local butcher to discuss the meat provision and to ensure peoples' comments were addressed. Other comments about the service included, 'Friendly and professional staff', 'Staff are very obliging' and 'High standard of care.'