3A Care (Solihull) Limited

Willow Grange Care Home

Inspection report

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West Midlands
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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

We carried out this inspection on 14 January 2016. The inspection was unannounced.

The home provides accommodation and personal care for up to 46 people. At the time of our inspection there were 40 people living at the home, one person was receiving temporary respite care.

A requirement of the service's registration is that they have a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was in post and had been for 13 years.

Support was provided that met people's individual needs and there were enough staff to care for people safely. People's health and social care needs were reviewed regularly. Staff referred to other health professionals when needed, so people were supported to maintain their health and wellbeing. Risk assessments were completed and plans minimised risks associated with people's care.

People told us they felt safe living at the service. Staff knew how to safeguard people and what to do if they suspected abuse. People were protected from harm as medicines were stored securely and systems ensured people received their medicines as prescribed. Checks were carried out prior to staff starting work at the service to make sure they were of good character and ensure their suitability for employment.

Staff understood the Mental Capacity Act 2005 (MCA), and Deprivation of Liberty Safeguards (DoLs) had been applied for where applicable. Staff gained consent from people before supporting them with care.

Staff received training to do their jobs effectively in order to meet people's care and support needs. Staff were encouraged to continue to develop their skills in health and social care. Staff told us they felt supported by the management team to carry out their roles effectively.

People's nutritional needs were met, choice was offered and special dietary needs were catered for. People took part in some organised activities and day trips, and told us there was enough for them to do. Social support was provided for people, on an individual basis if they did not wish to join in with group activities, or were not able to.

People told us they liked living at the service and that staff were polite and kind. People were cared for as individuals with their preferences and choices supported. Staff treated people with dignity and respect when supporting them and encouraged people to be independent. Relatives were encouraged to be involved in supporting their family members. People were offered a choice about the care they received.

People were positive about the management team and the running of the service. The registered manager

was responsive to people's feedback in developing the service, and making continued improvements. People knew how to complain if they wished to, and complaints were addressed to people's satisfaction.

Systems and checks made sure the environment was safe and that people received the care and support they needed.

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 told us they felt safe living at the home. Staff were confident in how to safeguard people from abuse and actions to take if they had any concerns. Risk assessments reflected the risks to people's health and wellbeing, and were managed to minimise these. Medicines were stored safely and people received these as prescribed. Staff were available at the times that people needed them and recruitment checks reduced the risk of unsuitable staff being employed at the home.

Is the service effective?

Good

The service was effective.

Staff received training and understood how to meet people's needs. Staff had an understanding of MCA and DoLS and provided suitable support to enable people to make decisions. People enjoyed the meals, and special dietary needs were catered for. Referrals were made to other professionals when required to support people maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were encouraged to be as independent as possible and staff maintained people's dignity and respect when providing care. People told us staff were caring in their approach. People were involved in decisions about the care they received and staff encouraged relatives to be involved in their family member's care. People could personalise their rooms and had a choice in how they wanted to be cared for.

Is the service responsive?

Good

The service was responsive.

People received person centred care and staff knew their individual needs and preferences. People took part in some organised activities and felt there was enough to keep them

occupied. People and their relatives had opportunities to feedback about the running of the home. People knew how to raise complaints, and the registered manager addressed these to people's satisfaction.

Is the service well-led?

Good

The service was well led.

People were positive about the management of the home. People and staff told us the registered manager was approachable and issues raised were addressed. Audits and checks ensured the environment was safe and the care provided was effective. Staff felt supported by the registered manager who was responsive to new ideas to continue to make positive changes at the home. The registered manager networked with other providers to ensure they kept up to date with 'best practice.'

Willow Grange Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 14 January 2016 and was unannounced. The inspection team comprised of one inspector and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from relatives and visitors, we spoke to the local authority commissioning team who made us aware they had also visited in January 2016 and made some recommendations about further training. We reviewed the statutory notifications the registered manager had sent us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

We spoke with 14 people who lived at the home, five relatives and three professionals. We spoke with 11 staff including the registered manager, deputy manager, the administrator, the cook, care staff and the activities co-ordinator. We looked at five care records, three staff files and records of the checks the registered manager made for assurance that the service was good. We observed the way staff worked, and how people at the service were supported.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. Comments from people included, "Of course we feel safe here, the carers are always here," and, "Yes, the main door is always locked." Relatives told us, "We've never had concerns about safety," and, "When you visit they come to the door and escort you out as well."

The provider checked staff suitability to work with people who lived at the home prior to them commencing employment. We checked three staff files and saw background checks and references had been sought prior to them being able to start at the home.

Staff understood how to safeguard people they supported, and had received training to support them in knowing what to do if they had concerns a person was being abused. One staff member told us, "Abuse could be refusing to support someone, neglecting them, it could be physical abuse or emotional abuse. I would report it." A whistleblowing policy was available and some staff were aware of this policy and how to raise concerns about people's care to protect people, however some others were not. One staff member told us, "I remember seeing it when I first came here, I know what whistleblowing is." We raised this with the registered manager who told us they would highlight this to policy to staff again now.

Assessments of risks associated with people's care and support needs had been undertaken. Risk assessments were updated by senior staff on a monthly basis or earlier if people's care needs changed before. For example, risk assessments had been carried out for risks which related to moving people with equipment such as hoists, and people at risk of falls. One person had skin damage which was being treated with support from the district nursing team. Staff were completing records to show the person was being checked and turned at two hourly intervals to relieve the pressure on their skin.

Staff were available at the times people needed them, and there were enough staff to support people when they required assistance. People told us that staff came quickly when they pressed their call bells and the home was never 'short – staffed'. One staff member told us, "With five carers working in the day, we have been fine." The registered manager informed us there were two staff vacancies they were recruiting to, but no agency staff were being used to cover the vacancies. The existing staff were able to support people and so they knew the people they supported well.
The registered manager told us staffing levels were decided by assessing people's needs and they also considered the layout of the building. This was because the building design meant staff could not always support people as quickly as they would like. The registered manager and deputy manager were considered 'supernumerary' and were able to support staff with additional 'hands on' care for people when required.

We looked at how people's medicines were managed and found these were administered, stored and disposed of safely and in line with manufacturer's guidelines. Staff who administered medicines wore red tabards which signified to other staff to not disturb them during this time. This meant the potential for mistakes was reduced as staff could concentrate on administering medicines. We observed one staff member signed the medicine record to say they had given the person the medicine, before it was administered to them. They then discovered this person was not in the building. The staff member told us

they recognised this was an error, and correctly returned the medicine as 'not taken'.

People were able self-administer medicines if they were able to and the home provided a lockable cabinet they could keep this in, in their rooms. One person told us, "The care staff only get the medicine out for me, I take it myself."

Only senior staff were able to administer medicines. The registered manager told us, "I check the MARs (medicine administration records) each morning and make sure they are completed as they should be." Medicines were administered from a 'bio-dose' system. This meant the pharmacy had already counted out each person's medicines and put them into a sealed container, which the member of staff unsealed and gave directly to the person. The registered manager told us they did not have many errors with medicine. They told us they now had use of a medication room where medicine could be stored separately and kept more securely, and this had been beneficial to them.

Staff who administered medicines received training to ensure they were safe to do so. Their practice was also checked through competency assessments. One staff member told us, "The manager does 'on the spot' checks of us, observations." Medicines were audited by a pharmacy, who had recently visited the home and checked the medicine administration. There were no concerns raised.
Some people received medicine 'as required'. There were medicine plans in place for staff to know when this might be needed if people were unable to communicate their wishes verbally. We observed staff asked people if they wanted their medicine before giving them medicine to take. One person told us, "About a week ago, I was in pain and asked for pain killer and they brought it."

We asked staff what they would do if a person refused their medicines and they told us they would return later to try to encourage them, then speak with the GP and arrange a medicines review if this continued. One person had 'covert' medicines which is medicine usually hidden in food or drink. This was because the person did not always agree to take their medicine. Staff told us the medicine was offered each day first and there had been a meeting with the GP to agree that this would be in the person's best interests to take this medicine covertly if they refused it, as the risks to their health would be high without it.

Accidents and incidents were recorded and were up to date. These were analysed by the registered manager to assess if there were any trends which could prevent further accidents occurring.

Emergency evacuation plans were contained within care records. These contained information about people's care and mobility needs, so they could be supported effectively in an emergency. The maintenance person completed unannounced weekly fire drills and checks.

Checks were carried out to ensure the buildings and equipment were safe for people to use. Fire and moving equipment, such as hoists, had been recently serviced. Restrictors were fitted on windows to reduce the risks of accidents. The maintenance person had a system to ensure all necessary checks such as of water, gas or fire were correctly completed. The registered manager held a health and safety meeting with the maintenance person. The last one was in December 2015 and this was to discuss any issues and maintain regular communication with them.

Good

Is the service effective?

Our findings

People told us that they were supported by staff who had the right knowledge, skills and experience. One relative told us, "They are very efficient, they make a note of what you are saying, they know the procedures. The right people work here." Another relative told us, "They are good at their jobs."

Staff received training relevant to the health and social care needs of the people who lived at the home. One person told us, "They seem to know what they're doing. I think they do get training, they have the right skills." An induction period when staff first started work covered 'essential' training. One staff member told us, "Yes, I had induction, but since then I have had more training." A checklist was completed during induction to ensure staff got to know the people that lived there, other staff, policies and procedures. New staff worked alongside more experience staff in a pair until they felt confident to work independently. A video of induction information supported staff in understanding the expectations of them in their new role, alongside a written job description which was provided.

New staff members completed the 'care certificate'. This sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment

The provider offered other training in areas considered essential to meet people's needs. This included moving people, food safety, and understanding dementia. One staff member told us about the training, "It can be on the computer or face to face. We have someone coming in soon to talk about nutrition." They told us about the moving and handling training, "We practised how to move a person again and again until we felt more confident." During our visit, we observed staff put their training into practice. For example, we saw staff, assist people to move correctly from a chair to wheelchair. We were told some staff were also going to be attending a course to understand how to work with people who had diabetes. A staff member attending this course was to become the 'champion' in this area and support other staff with their knowledge.

A training record meant the registered manager was aware of what training had been completed and when this was next due, to ensure staff knowledge was updated when necessary. The registered manager told us one staff member had recently completed a 'train the trainer' course so they could now carry out some training for other staff, so this could be personalised to them and the people at the home.

Staff received regular management support and 'one to one' meetings were held every six to eight weeks between senior staff and individual staff members. The registered manager told us this frequency would depend on the staff member's needs. The registered manager also observed staff practice as part of their supervision. One staff member told us, "Lately I have had a supervision monthly, any issues I can raise in confidence, it might be how to progress in my training, I find them helpful." Annual appraisals were held where staff could set objectives with their manager.

At the beginning of each shift, staff from the previous shift met to 'handover' information about any changes to people's health or well-being. We attended a handover meeting and saw information was shared well about people. For example, staff were informed that one person had been in pain and their pain relief had

been changed that day.

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.

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 found the rights of people who were unable to make important decisions about their health or wellbeing were protected.

Staff had received training on the MCA as part of their induction, and demonstrated an understanding of the principles of the Act and how this affected their practice. One staff member told us, "If a resident has no family, social services can be involved, in case of someone with dementia, we would follow their care plan and the 'best interests' decisions." Another staff member told us, "We are having more training around mental capacity and DoLS, we have been talking about this," and they felt they would benefit from this training as they felt it was a complex area. We saw capacity assessments were incorporated into the records of people who lived with dementia and information was 'decision specific'. This meant the registered manager did not assume that people did not have capacity to make a decision, and assessed their capacity based on the decision which needed to be made. The deputy manager told us they referred people to the GP or specialist mental health service if they were concerned about people's decision making abilities for formal capacity assessments to be completed.

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). At the time of our visit 10 people had a DoLS authorisation and other applications had been submitted. The registered manager was aware of the circumstances when a DoLS authorisation may be required and other people were waiting for DoLS assessments.

Staff sought consent from people when providing them with care. One person told us, "They always check what I want to do first." Consent forms had been completed on care records for areas such as consent for photographs to be taken.

We checked whether people received support with their eating and drinking and if they received a balanced diet. People had a choice of meals and spoke positively about the food. One person told us, "Yes the food here is good." Another person told us, "I like the food, we get a choice." People were given a choice of meals each day. The cook told us people could order an alternative if they preferred. The menu was a four weekly seasonal menu. The cook told us, "I order what we need and I feel supported to get what I want to." The cook knew people's likes and dislikes. For example they told us that one person always liked a sandwich and crisps for lunch. On the day of our visit there were two cooked options for lunch and a hot sponge pudding available.

A supper tray was made up each evening for people and night staff could access the kitchen and prepare other food for people if they were hungry. Drinks and snacks were available for people to help themselves to during the day.

We checked whether the home catered for people with specific dietary needs. We were told at the time of

our visit there were only specific needs in relation to people's health. The cook was able to tell us about these needs and ensured they were catered for. The deputy manager told us if they were concerned around a person's nutritional intake they would contact the GP, dietician or district nurse. They told us, "We would still try to encourage them (to eat)." One person was having their fluid intake monitored. We asked staff how they would know they had had enough to drink as the fluid intake was not being totalled and it was unclear if there was a 'target' amount for them to drink. They told us the person was able to tell them when they had had enough to drink.

The cook ensured all visitors to the kitchen wore hairnets and aprons for hygiene reasons. We saw everyone doing this in the kitchen.

People were supported to access health professionals when required. During our visit we saw three district nurses visiting people. GP visits were recorded on people's care records alongside visits from other professionals such as dieticians and social workers. We observed staff making an appointment for one person to see the GP who had become unwell on the day of our visit.

Good

Is the service caring?

Our findings

People were positive about the staff at Willow Grange and told us they were friendly and polite. One person told us, "The staff are friendly, I get on alright with them." Other comments from relatives were, "I think they're very kind," and, "The carers are polite and reliable."

Staff told us they enjoyed caring for people at the home. One staff member told us, "If they don't have a family or friends, I make more time for them, make sure I am there." The registered told us how one person came to the home twice a year for respite care, and had said they would not go anywhere else, they liked it so much.

People were offered a glass of wine or sherry before lunch. We saw them enjoy this, and the atmosphere in the lounge was friendly, as people chatted over their drinks. We observed when staff spoke with people they talked to them at their height and in a friendly manner.

Relatives were encouraged to be involved in their family member's care and there were no restrictions on visiting times. A relative told us they brought in one person's dog during visiting times and this was really important to them. Themed days and social events such as barbecues were held at the home, to encourage relatives to be involved. Visitors were welcome to have a meal at the home and the cook told us they asked for a voluntary donation for this.

No one at the home currently used the services of an advocate, however, the registered manager told us they had in the past, and this service was available for people if required. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to enable them to make a decision.

Some volunteers came to the home to support people. One person was taken out weekly by a volunteer from a local church. Another person was supported by a volunteer from a local charity who visited and they went out for coffee.

Staff encouraged people to maintain their independence yet supported people when this was required. One person told us, "I can do things for myself and my husband does my medication." One staff member told us, "One person walks with a frame, very slowly, we have the wheelchair ready, but encourage them to do some more steps." Another staff member told us, "One person can wash themselves, so I provide them with a flannel and bowl." People had their own letter boxes outside their bedrooms and staff delivered any mail for them directly into their letter box to maintain their privacy and independence in this area.

People's preferences were catered for where possible and people were able to personalise their rooms if they wished to with their own furniture and belongings. One person told us, "My room is lovely," and they liked that it opened directly onto the garden. The deputy manager told us, "It's their home, they should have what they want in it." People were asked how they wanted their rooms decorated. One room was painted pink for someone who recently moved in as this was their preference, even though it had been freshly

painted in another colour before.

People were given a choice of how they wanted to spend their time. One person told us, "Yes carers listen and offer options." The deputy manager told us, "Residents are given a choice, such as what clothes to wear, if they want a bath or shower." They told us some people had chosen to keep their existing GP when coming into the home and this was arranged if possible.

Staff treated people with dignity and respect. One person told us, "There is no time when staff ever rush me." Another person told us, "They care for me with respect and dignity." One staff member told us, "Doors are kept closed, there are signs on the doors, we draw curtains, some residents are shy, we are as nice as possible to support them to feel comfortable and keep things as normal as possible (if assisting with personal care)." Signs were on each bedroom door which could be used to ensure no one entered when any care support was being provided. One staff member had been designated as the 'dignity champion' so they could advise other staff of the best ways to support people. A hairdressing service ran twice a week and the deputy manager told us this was important for many people as they liked to feel well presented.

Good

Is the service responsive?

Our findings

People we spoke with had positive views about how their care and support needs were met. One person told us, "They know where and when I need support." One staff member told us, "The home is pretty good, people get to go out a lot."

Prior to admission to the home, people were assessed based on their level of independence and care needs. The registered manager told us they were 'person centred' in their approach and tried to find out about people's history, likes, dislikes and routines. We saw one person's routine was documented on their care records and said, 'I prefer to go to bed at 9pm and get up at 7.30am.' People were able to request staff of a specific gender to support them if they preferred.

Care plans detailed people's support needs in areas such as mental health, oral care and nutrition. One staff member told us, "We use the resident's care plans," and this was to tell them how care should be provided for a person. One person was receiving end of life care and there was a care plan in place for this, which documented their wishes and needs to ensure they received the care and support they wanted at this time. Care plans were reviewed monthly by staff and managers or when people's needs changed. We saw these had been recently reviewed and were up to date.

Staff knew the people they cared for well and how to support them. People told us they were supported by staff they were familiar with. A keyworker system ensured people were supported by a named worker and this provided consistency for them. One staff member told us, "We match people up with someone (staff) they get on well with." The keyworker was responsible for completing additional checks, such as in people's rooms, to ensure people had the personal items they required. One senior staff member told us there was a plan to develop this role further so the keyworker would be more involved in review meetings with families.

People had memory boxes outside their rooms where they could put important information, photos or mementoes about their lives and history, so staff could get to know them better and to help some people recognise their rooms. Some boxes were empty and the deputy manager explained some people were deciding what they would like to put in the boxes or had decided not to use them.

Relatives were involved in care planning and reviews. Senior staff contacted relatives if they had any concerns or if people's needs changed. One relative told us, "Yes I have been phoned by the person in charge about my relative," and they told us they appreciated this.

Staff planned activities for people, who told us there was enough for them to do. One person told us, "We have various activities," and, "They have something going on here, they try their best." The registered manager told us the activities coordinator had developed a good rapport with people.

The activities co-ordinator had been in post for five months and focused on doing activities based on people's interests, as well as encouraging more trips out of the home. Trips were planned to a sea life attraction, a local museum and for pub lunches. The activities co-ordinator told us, "I know who does and

does not join in, and know people's likes and dislikes." They talked to people and their families about what people wanted to do. This meant they could support people with activities they preferred. The activities co-ordinator told us, "I record involvement and who is or is not taking part." This enabled them to know who liked specific activities and find other ways of involving people who did not like what was available. For example, one person could become upset about other people at the home who were sometimes confused, and so the activities co-ordinator had arranged for a separate group of people to meet for their own coffee morning. They explained, "The person will come down for that."

A daily morning exercise class took place and we saw people joining in with this. There was a 'movie of the day' which people chose themselves. The activities co-ordinator worked weekdays and care staff ran other activities on the weekend. They told us, "I am focussing on getting people out, they tend to love music more that TV, we might look at song re-makes old and new, many people like the new songs more, we try to be creative." Some people attended mass and a visiting priest came to the home. A bible reading class took place on a Sunday and the registered manager told us, "People enjoy this, it seems to go down well."

We asked the activities co-ordinator how people were supported who were cared for in their rooms. They told us, "This can be harder, I talk with them on an individual basis, they give me ideas of what they would like to do."

A meeting involving people who lived at the home and their relatives, was held every three months. One person told us, "Yes they ask us to resident's meetings." People told us they were able to express their opinions and were listened to at the meetings. The registered manager told us the meetings used to be more often, however people had said they did not want them so frequently. The last meeting was in December 2015 when they discussed meals and the Christmas fayre.

People were aware of how to make a complaint if they wished to. Comments from people included, "They look after me, I have got no complaints," and, "If I have a complaint, I can speak to the carer or whoever is around." One relative told us, "I know how to complain, but I have never had a reason to." There had been recent complaint in 2016 about an issue between staff and one in 2015. Responses were recorded and the complaint in 2015 had been addressed, and the recent one was currently being addressed. The registered manager told us they recorded all complaints, but did not have many. A policy was available in each room explaining how to complain. People had the opportunity to raise any concerns, and the registered manager addressed these in a timely way.

Good

Is the service well-led?

Our findings

People and staff told us about the management team and the running of the home. One person told us, "It's marvellous." Other comments included, "It's run in harmony," and "I can't fault it." One relative told us, "The manager is [name]. They all want to do their best here, including the people further up (referring to the management)."

Staff told us they liked working at the home and that senior staff and the management team were approachable and they felt supported. One staff member told us the registered manager's philosophy was, "If in doubt, 'shout', (meaning you must go to them and check if you are not sure about something)." They went on to say, "It's very rare we have to do that."

Staff felt supported with staff meetings. One staff member told us, "The manager organises staff meeting so we can contribute to the way things are run." The last meeting had been held in January 2016 and we saw issues discussed were around infection control practices and moving people, discussing any issues they had alongside good practice. A senior staff meeting was held weekly and we saw minutes of the meeting in January 2016 where the use of mobile phones was discussed and medicine audits.

An 'employee of the month' scheme operated. Staff were nominated by other staff and received a gift if they were identified as the 'employee of the month'. The staff member nominated this month, was nominated because they y were always willing and available to help everyone. One senior staff member told us staff had recently recognised that they only met socially at Christmas and so were arranging some staff events such as a shared breakfast. They hoped this would encourage stronger relationships, which would mean staff worked even better as a team.

The management team consisted of the registered manager, a deputy manager and seven senior staff. The registered manager told us they were most proud of, "The care of the residents, staff are here for the right reasons. We welcome visits here, and professionals, we think it is a lovely home." They told us, "They are a happy group of resident's."

Some fundraising events had been held in 2015 such as a Halloween and Bonfire party, and a Christmas Fayre recently. Previous fundraising had enabled a summer house to be built in the garden for people to use. This had been used as a grotto at Christmas. The activities co-ordinator told us that any money raised was matched by the provider and they thought this was, "Really good."

The registered manager encouraged feedback from people and relatives. A manager's surgery was held each week when relatives could come and speak with the registered manager directly. We saw this advertised on a notice board in a communal area. A survey was conducted every February and we saw the response from the last survey where comments included 'I would like more activities,' 'I enjoy my trips outs', 'I am well cared for' and 'I feel safe.'

The registered manager told us they felt supported in their own role. A change in the provider two years ago

meant they had been given some more independence when making decisions and they had found this had been positive for them. They told us, "It's fantastic in a way, I have been able to utilise my management skills, have more control."

Plans were underway to refurbish and improve some areas of the home and new bathrooms had been added. Feature walls had been created in some rooms.

The management team networked with other local providers to share ideas and 'best practice'. They had attended a 'steering group' and had met with other managers recently, learning more about DoLS. This was an external event hosted by the local authority and enabled providers to get together to share their knowledge and new initiatives. The registered manager told us they had requested some further training around managing diabetes and this was had now been arranged in response to this by the local health care trust in February 2016.

The registered manager told us the local authority commissioning team had visited in January 2016 and this had been a positive visit. They had identified that staff could do some further training around MCA and this was now being arranged.

Manager's audits had been undertaken and were up to date. We saw audits included monthly checks of people's care records, medicines, the environment and equipment. Any action taken was documented.

The registered manager was able to tell us which notifications they were required to send to us so we were able to monitor any changes or issues with the home. They understood the importance of us receiving these promptly and of being able to monitor the information about the home. They were unaware they were required to inform us of DoLS authorisations and they told us they would ensure this was now done.