Dukeries Healthcare Limited

Kirkstall Court

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

Kirkstall Court 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.

Kirkstall Court is a purpose built residential home on the main bus route into Leeds City Centre. It provides a specialist service for people with Korsakoff's syndrome which is a brain injury resulting from alcohol misuse. At the time of our inspection there were 36 people living at the home.

This comprehensive inspection took place on 7 and 11 November 2017. The first day of the inspection was unannounced and the second day was announced beforehand. At our previous inspection in August 2015 we rated the service as 'Good' overall but it 'Required improvement' to be safe. This was because medicines practice needed to be improved. At this inspection we found the required improvements had been made.

There was a registered manager in place. 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 told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. Risks to people had been assessed and plans put in place to keep risks to a minimum. Lessons were learnt from complaints, safeguarding and incidents to prevent reoccurrence in the future.

There were appropriate systems in place to make sure that people were supported to take medicines safely and as prescribed.

There were sufficient numbers of skilled staff on duty to make sure people's needs were met. Recruitment procedures ensured that staff were of suitable character and background to work with vulnerable people.

Staff were supported by a comprehensive training programme and supervisions to help them carry out their roles effectively. Staff were led by an open and accessible management team.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People 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.

Where people required support with eating or drinking, this was appropriately provided, taking into account people's likes and dislikes.

People told us that staff were caring and that their privacy and dignity were respected. People were encouraged to become more independent to support them to return to live in the community.

Care plans provided comprehensive information and showed that individual preferences were taken into account. People's needs were regularly reviewed and where appropriate, changes were made to the support they received.

People were supported to maintain their health and had access to health services if needed. The service worked well with other professionals to support people's rehabilitation.

People received good care at the end of their lives. Staff had received training in end of life care and were sensitive to the needs of people, their friends and relatives.

There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified. People had opportunities to make comments about the service and how it could be improved.

The registered manager had good oversight of the service and there was a caring culture. The registered manager had made improvements at the service since they started in post.

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 received their medicines safely as prescribed.

Staff followed safeguarding procedures in order to protect people from avoidable harm. Accidents and incidents were monitored and action taken where lessons were learnt.

Risks to people had been assessed and associated support plans helped staff provide safe care.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background to work with vulnerable people.

The environment was clean and well maintained.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005. Relevant legislative requirements were followed where people's freedom of movement was restricted.

People were supported to maintain good health and could access other healthcare professionals as needed.

People were supported to eat healthily and drinks were available throughout the day.

Is the service caring?

Good

The service was caring.

People told us that they were looked after by caring staff.

People were treated with dignity and respect whilst being

supported with personal care.

People, and their relatives if necessary, were involved in making decisions about their care and treatment.

Is the service responsive?

Good

The service was responsive.

People received care which was responsive to their needs. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People were supported to work towards achieving goals which promoted their independence.

People at their end of life were provided with good support which was sensitive to their needs and those of their loved ones.

People knew how to make a complaint or compliment about the service.

Is the service well-led?

Good

The service was well-led.

The registered manager had a clear vision for the service. They were committed to improving the lives of people and achieving good outcomes.

There was a positive, enthusiastic and caring culture at the service.

There were robust systems in place to look at the quality of the service and action was taken where shortfalls were identified.

There were opportunities for people to feed back their views about the service.

Kirkstall 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 14 November 2017 and was unannounced on the first day. The inspection was carried out by one adult social care inspector, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of supporting people with alcohol dependency.

Before the inspection we sought feedback from Leeds City Council and Healthwatch. We reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is legally required to send us as part of their registration with the CQC.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we looked around the premises, spent time with people in their rooms, with their permission, and in communal areas. We looked at records which related to people's individual care. We looked at four people's care planning documentation, seven medicines records and other records associated with running a care service. This included four recruitment records, the staff rota, notifications and records of meetings.

We spoke with seven people who received a service and three relatives. We met with the registered manager, area manager and spoke with seven care staff.

Good

Is the service safe?

Our findings

At our last inspection in August 2015 we rated the service as 'Requires Improvement' for Safe. This was because medicines practice needed to be improved. At this inspection we found the required improvements had been made and the service was now safe.

People told us that they received their medicines on time. One person said, "Because I am able to, I take my own medicine. They (care staff) bring it to me daily". A relative told us, "Yes, [Name] gets it every day on time".

We checked the systems in place to ensure people received their medicines safely. The service used a monitored dosage system (MDS) with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the person's doctor.

Each person's medication administration record (MAR) had a photograph of the person and details of any allergies they had. We sampled these records and saw that medicines had been administered as prescribed. However, we identified occasional gaps in the recording of one person's cream and another person's fortified drink. This was raised with the staff member responsible for administration and we were satisfied that there had been minimal impact. The temperatures in the medication room and refrigerator, used for the storage of medication, were recorded daily to ensure medicines were kept at the correct temperature to remain safe for use.

We checked the systems in place for the safe storage of drugs liable to misuse (controlled drugs) and saw they were stored in an approved wall mounted, metal cupboard and a controlled drugs register was in place. We completed a random check of stock against the register and found the record to be accurate.

We asked people about pain relief medicine and if it was given when needed. One person told us, "If I need medication because I am in pain it's usually paracetamol". We asked if they got it promptly and they said, "Yes straight away". A relative commented, "[Name] gets it. I have all the confidence in the world with the staff here".

We observed the lunch time medicine round in one area of the service. A 'do not disturb' tabard was available for the nurse in charge although they did not wear this. The tabard would make it clear that the nurse should not be interrupted, which would reduce the potential for errors. Medicines were given as required and people were informed about what was happening. The nurse gave people time to take their medicines at their own pace.

People who used the service told us that they felt safe living there. One person said, "Yes, I feel safe. I have a buzzer. I can't get out of bed by myself, so I use my buzzer. I get help". Another person said, "Yes. I feel surrounded with people who look after me. I am a nervous person and I feel relaxed here".

The friends and relatives we spoke with all thought that people were safe. A friend of a one person told us, "[Name] has an alarm and the staff are very attentive. He is not mobile and relies on staff for everything. Yes, he is safe". A visiting relative added, "Because of the staffing, there are plenty of nurses here. [Name] wasn't safe at the last home. Here there is a buzzer and pressure pad (to alert staff if the person gets out of bed)." Another relative told us, "Everyone who comes into the home has to pass reception and have to sign in and out. Staff know who is in the home".

Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being. Staff confirmed they had access to safeguarding and whistleblowing guidance. There were up to date safeguarding policies and procedures in place which detailed the action to be taken where abuse or harm was suspected.

There were up to date risk assessments in people's care plans. These detailed any risks to the person's well-being and gave guidance on how to minimise them. For example, some people were at risk of falls or skin breakdown. Each person had a Personal Emergency Evacuation Plan (PEEP) in their care plan which explained how to support them in the event of an emergency, such as a fire.

Records showed that any incidents or accidents were logged and appropriate action taken. Accident reports went to the manager to review and assess if further action needed to be taken. Any serious incidents or concerns had been reported to other authorities as required. Two safeguarding concerns had been reported in the last year and records showed there had been thorough investigation with actions noted to prevent future incidents. The provider had signed up to the 'Herbert protocol' with the local police. This meant that people who were at risk of leaving the home unattended were registered with the police in the event of a disappearance.

We asked people if they thought there was enough staff to meet their needs. One person told us, "Yes I can't speak highly enough of them". Another person felt, "They (staff) are run off their feet and are worn out". Relative comments included, "I think there are times when they are very busy but I have never found them too busy to speak or to see to mum", "Definitely enough staff" and "I do think there is enough staff".

Throughout the inspection we observed there were sufficient members of staff to attend to people, keep them safe and meet their needs. The registered provider was not using agency staff which meant there was a consistent and familiar team of staff to support people. The provider used a dependency tool to assess staffing levels. This was reviewed every two weeks to make sure staffing levels were sufficient.

Recruitment records showed that staff completed an application form which was discussed at interview. Interview notes were recorded and showed why applicants were deemed suitable for a position. References were sought prior to employment and checks were carried out on each applicant's suitability. A criminal background check was provided by the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

The registered manager took steps to make sure the environment was safe. The service had generalised risk assessments associated with ensuring the health and safety of people using the service, staff and visitors. The fire alarm system was regularly checked to make sure it operated effectively and there were up to date inspection reports for electrical wiring and gas safety. We spoke with the staff member responsible for maintenance. They showed us records which demonstrated repairs and checks were carried out promptly.

Good

Is the service effective?

Our findings

People told us they thought staff were well trained and able to meet their needs. One person said, "Yes, I used to visit my husband here so I got to know the staff well. This is why I chose to live here". Another person commented, "Excellent personal care". A relative told us, "[Name] is much happier since she has been here". They went on to say that their relative sometimes goes into other people's bedrooms and explained, "What I like about the staff is they never force [Name] to come out of people's rooms. They treat her kindly and hold her hand and lead her out of the bedroom. This is why I think they are well trained".

Staff received the training and support they needed to work effectively and expand their own professional development. Some training was completed online, such as infection control and mental capacity. All staff received comprehensive training on Korsakoff's syndrome (a brain injury resulting from alcohol misuse). Practical training was provided on subjects such as goal setting, risk assessing and safeguarding. Practical sessions allowed staff to learn and discuss issues in a group setting.

New staff members received a suitable induction when they started working at the service. This included shadowing other staff and attending training sessions which the provider considered essential for their role. We spoke to three staff who had started at the service in the last few months. They were all positive about their experience so far. Comments included, "I've been here two months. It's been good. I'm still on induction. It's a good chance to get to know people" and "I had induction for 12 weeks. I shadowed other staff and had training. [Registered manager] always asks if I am alright and I can always talk with her".

Staff had a regular supervision meeting with a senior about every eight weeks. Supervisions included a review of work as well as discussions on key areas such as person centred care and safeguarding. All staff had a signed supervision contract in place which provided an agreement about what it was for and expectations for supervisor and supervisee. Yearly appraisals took place, which were used to review progress and set personal goals for the year ahead. Records showed that topics discussed included reliability, attitude and willingness to learn.

We spoke with the main chef who demonstrated a good understanding of people's specific dietary requirements. The chef maintained a list of each person's nutritional needs and preferences. For example, if a person was diabetic or required soft food. The chef explained, "One person is vegetarian and I ask her each morning what she would like. I try to make soft food look appetising. I have good relationships with people and regularly speak with them".

We observed the dining area to be where people congregated and chatted during the day. The kitchen was staffed from 8.00am to 6.30pm, although some people made their own meals. People could help themselves to tea, coffee and snacks. At lunchtime, staff were attentive to people's needs and offered support where needed. Overall, it was a sociable and relaxed experience. One person described the meals as, "Great".

We noted that one person required thickening agents to be added to foods and liquids to bring them to the right consistency or texture so they could be safely swallowed. Staff were aware of how it should be used.

Where there were concerns about weight or food intake, support was provided by the local Speech and Language Therapy (SALT) team and local doctor. For those people at nutritional risk, a professionally recognised assessment tool was used to monitor weight loss and prompt appropriate action. Methods of recording and monitoring food and fluid intake were being used. We saw where people had food and fluid charts and these were recorded accurately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

The manager and staff were trained in the use of the MCA and DoLS procedures and had demonstrated a good understanding. DoLS referrals had been made as required where people were restricted in their movements. The registered manager told us there was difficulty in getting DoLS reviewed and re-authorised in a timely manner, because of local authority delays. Records showed that requests for review had been submitted as required. Where needed, up to date assessments of capacity were evident in people's care records. These demonstrated why people did not have capacity to make a particular decision and that a decision would need to be made in their 'best interest'.

As well as having a full assessment prior to admission, more specific assessments were completed in relation to people's health needs. These included assessments regarding skin integrity, moving and handling, nutrition and mental health. Care plans contained comprehensive information about how people's health needs were to be met by the service. For example, one person, at high risk of skin breakdown, was checked hourly at night time.

People had access to health professionals such as a doctor, optician and dentist. The service worked in partnership with other professional agencies to make sure there was a joined up approach to promoting health and well-being. For example, there was evidence in care plans of the involvement of the local Speech and Language Therapy (SALT) team and mental health team.

People were supported with issues relating to mental health. Some people had a wellness recovery action plan. This is a specific piece of work to help manage a particular mental health problem such as hearing voices or paranoia. The plans gave guidance on how to identify if an individual was becoming unwell, including their personal triggers and warning signs.

The service had a 'no alcohol' policy in place. The registered manager explained they did not provide a detoxification service to support people in withdrawing from alcohol use. To support people with this they linked up with a local detoxification clinic so that people had the clinical support they needed.

The registered manager was able to describe examples of successful outcomes for people while they had been at Kirkstall Court. They provided an overview of one person who had been able to leave the service in July 2017 to live back in the community. The registered manager told us when the person came to the service the year before they were drinking heavily and had been living in a dirty and unpleasant environment. They had lost most of their daily living skills. Following an intensive rehabilitation programme

they had regained their confidence and were able to live independently again.

A relative had written to the registered manager early on in the process to praise them for the way they were supporting the person. They had said, "I cannot tell you what that meant, to be able to see him for the first time beginning to regain his confidence".

Good

Is the service caring?

Our findings

People told us it was a caring service. Comments included, "It's nice here. I like it" and "It's fine. I'm looked after". One person felt staff validated him as a person and he was treated as, "A bloke that just happens to live in a care home. A relative told us, "Staff are kind, caring and loving. I can't fault it. I have been visiting for 10 years. It's very good".

A number of people we spoke with were not able to express their views easily. This was due to their particular condition which could lead to anxiety and/or paranoia. Some people expressed negative views about the staff but we looked further into this and found their concerns to be unsubstantiated.

We observed staff interactions with people over the course of the inspection. Conversations were friendly, positive and well received by people. For example, two staff who supported people at a lunchtime made a particular effort with people who were on their own or hard of hearing. They communicated with people in a way that was individually appropriate to them, such as getting down to eye level rather than standing over them.

One relative talked positively about a staff member who had developed, "A really good relationship" with a person who found it difficult to relate well to others. They explained that the staff member had gone to some effort to find out what interested the person and made time to arrange outside activities that specifically catered to their interests and needs. The relative described an example of this; "[Name] especially loves art galleries and this is a safe environment for him to wander. [Staff member] has made a point of offering to take him to an art gallery and for a coffee afterwards".

People were treated with dignity and respect. One person commented that they felt, "Respected, treated as an adult and listened to". Another person described the staff as being supportive of their needs in relation to their eyesight as they was unable to read letters, which staff offered to read for them. They added that staff were, "Sensitive to the fact that these are sometimes personal". A staff member told us, "We do more than care. We promote dignity and give choices. Choice of food, clothes etc. We don't impose anything. Choice is important".

Some people had specific cultural needs and the service made sure these were supported. For example, one person who had left the service in 2017 was Polish. A professional involved at the time told us, "The home placed a high emphasis on culturally appropriate support" and added, "There were numerous efforts made to support and encourage them to engage with local Polish support networks such as the Polish Men`s Over 65 group. Polish interpreters were always used to ensure that they were able to understand and engage fully in their assessments and care planning".

There was a calm, positive atmosphere throughout our visit. We saw that people's requests for assistance were answered promptly. Staff approached people in a sensitive way and engaged people in conversation, which was meaningful and relevant to them. We noted that staff had completed training in dignity and respect as part of their induction. Staff meetings were also used to discuss issues around respect. For

example in September there was a discussion about a 'personal approach', and in October staff talked about dignity. We noted that a dignity charter was displayed on a noticeboard which highlighted a commitment to offering dignified and respectful support.

People were supported and encouraged to be as independent as possible. One person told us, "They (staff) encourage you to do what you can" and gave the example of being supported to cook meals for themselves and others, then washing up afterward. Care plans focussed on supporting people to regain independence and included short term and long term goals to help people achieve this.

Good

Is the service responsive?

Our findings

Prior to admission, people's needs and dependencies were assessed to make sure the service was able to support them. From the assessment information a care plan was developed which showed how the service would meet their needs.

The care plans we looked at were comprehensive, up to date and reviewed regularly to make sure any changes in people's needs were identified. Information was updated after review, where required, and more frequently if necessary. A positive aspect of people's records was that care plans gave a summary of what had been achieved so far, not just their current needs. This gave staff a good overview of people's progress. The clinical care coordinator, who was responsible for care planning, was pleased that we had noted this and explained, "I wanted to achieve a bit of background in the care plans". We noted that to support staff in writing care plans, the registered manager had written a guide in booklet form. This contained very useful information about how care plans should be written and explained what should be included in the different sections.

A professional who had worked closely with the service had provided written feedback about care plans. They stated, "The quality of risk assessment, needs assessment and therapeutic interventions come together in perhaps some of the most comprehensive and fully detailed care plans I have seen in any residential or nursing placement".

Areas covered in care plans included health, personal hygiene, medicines, communication and mental well-being. Each person also had a personal profile which gave an overview of their history and personality. This provided staff with an insight into the background of people so that they had a better idea of their character, likes and dislikes.

Care plans included short term goals which people had decided they wanted to achieve. For example, one person's goals were to send out Christmas cards and swim 50 lengths in a pool, which they had achieved.

Each person also had a moving forward plan which included longer term personal goals for people to achieve. For example one person's goals were to take their own medicines and live in the community. There was a separate plan for each goal which provided personalised information about how it was to be achieved and progress updates.

The main aim of the service was to rehabilitate people to live back in the community. A rehabilitation plan was in place which included the support people needed to gain greater independence. The plan for one person showed that they had been supported by the service to eat and drink independently and they no longer needed checking at night time for their safety. This provided evidence that there were successful outcomes for people. This was confirmed by a relative who explained, "[Name] can cook now. He has started going home to his flat".

Rehabilitation plans included sections such as, 'What I can achieve' and 'What I want to achieve' in areas

such as personal hygiene, budgeting and social activities. These were assessed on a daily basis to review progress. Achievements were recorded on to a graph for each week so that people had a visual overview of how they were doing.

People and their relatives told us they were included in discussions about care plans. The partner of one person said, "We have both been involved in the care plan". One person told us that care plans were agreed, "Pretty much by mutual consent" and that, "All things are assessed quite regularly". Another person commented, "I know of my care plan, feel involved and know what is going to happen next".

To support with providing person centred care, each person had a social care assessment which included their likes, dislikes, interests and cultural or religious needs. Individual preferences were included, such as a preferred name, best way to communicate and when they liked to have meals.

Procedures were in place with regard to complaints and compliments. Complaints were clearly recorded and the records showed they had been investigated and responded to in a timely manner. Action was taken where necessary to resolve the complaint and minimise the risk of the same issue arising in the future.

People told us they were able to make a complaint if needed, but were not all aware of the complaints procedure. Comments included, "I am able to speak with [registered manager] if I have a complaint", "I feel comfortable approaching staff and [registered manager] with any concerns" and "I have complained informally to staff and they dealt with it". One person explained, "Residents are encouraged to share any problems with the management. It's noticed if you're not acting as you normally would. Staff pick up on residents acting differently or out of character". This was important, as some people may not express unhappiness about something and this showed that staff were pro-active in identifying any concerns.

On occasion the service supported people at the end of their lives. The registered manager told us, "There is mandatory training for this. Management have higher level training. We liaise with doctors and create a palliative care plan. District nurses support with us and provide a specific care plan. We also have a 'sleeper' nurse who stays with the person to support and monitor them". Records confirmed that end of life training was provided to staff. We noted that the service was linked with a local hospice who provided support as needed.

Good

Is the service well-led?

Our findings

People who used the service and relatives made positive comments about the management of the service. Comments included, "[Registered manager] is the biggest part of the improvement. She brings a lot here. Very capable and professional. I have been impressed with the place" and "The home is well managed". One relative described how well run the home was and attributed this directly to the registered manager.

Staff members were also positive about management. Comments included, "The manager is really understanding, very considerate and knows what she needs to do. Structured and organised. Says it as it is", "[Registered manager] is good. Organised" and "It's good in terms of leadership".

We spoke with a visiting professional who told us, "I have a lot of respect for [Registered manager]. I've always been quite impressed with her effectiveness and responsiveness. Another professional who had been involved with the service provided written feedback; "I cannot praise Kirkstall Court staff and particularly the manager, highly enough. The high quality of this placement as a resource for the local authority and the extremely high standard of the support is invaluable".

We spoke with the area manager who told us that Kirkstall Court was the only specialist Korsakoff's service in the area. They had a great deal of confidence in the management of the service and recognised the improvements that had been made. They explained the registered manager had been supported to develop policies and procedures specific to the specialist service rather than use the organisations standard guidance.

The manager had been registered with the Care Quality Commission for six years. Throughout the inspection they demonstrated a wealth of experience and knowledge of Korsakoff's syndrome. They were able to respond to our questions about individual people's care and support promptly and without reference to records, occasionally backing this up with written information provided just for the inspection. We were impressed with the passion and commitment they showed for their role and the service as a whole. They had a clear understanding of the requirements of relevant regulations and how the service should be run.

The registered manager talked about the aims and ethos of the service and told us, "We focus on individual needs. Involve other professional services. We work with the community and promote information about the service to the community. Service users are stigmatised. I have an incredible passion about the work. We aim to support our service users in the community by offering educational material to help the community understand alcohol related brain injury".

The registered manager was passionate about sharing expertise and good practice and regularly attended professional conferences and meetings. For example, they talked about giving a presentation to a group of professionals to talk about Korsakoff's syndrome and share ideas.

The registered manager talked about some of the achievements over the last year. These included

accreditation with Headway, which is a national brain injury association. They had also improved the environment to make it more friendly and homely and implemented wellness recovery action plans, which has helped reduce hospitalisation and suicide risk for those people coping with mental health issues. In addition, support had been provided to people and their families to help them understand the Mental Capacity Act 2005 and end of life care.

There were regular opportunities for people, relatives and professionals to be involved in the service and put forward suggestions and ideas. Each month there was a resident meeting and a separate team meeting for staff. A comments box was also available in the lobby area. We noted that at a recent resident meeting in September 2017 people discussed the CQC guide, 'What can I expect from a good care home'.

Care staff told us they were involved in service development. Feedback included, "We can take suggestions to the manager. They listen and take them on board and act", "At team meetings they ask me what I think" and "I am able to contribute suggestions. Ideas are taken on board".

The registered manager and provider carried out a number of quality assurance checks and audits to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

Audits were compiled in a file each month and included audits of care records, medicines, infection control and health and safety. Action was taken to make improvements where required. For example, it was identified that there were missing signatures in medicine records. The registered manager had sent out letters to staff reminding them of their responsibilities and had followed this up with competency checks.

The registered manager also completed a weekly report which covered areas such as care plans, medicine management, notifications, complaints and training.

The area manager carried out monthly visits of the service to review practice. The manager told us that action was taken immediately where audits identified issues. There was no specific action plan or record that remedial actions had taken place following these visits, but we found evidence that the required improvements had been made.

The registered provided sought more formal feedback on a yearly basis through quality assurance surveys. Feedback questionnaires for people who used the service had been undertaken in April 2017. Where issues had been raised there were action points to make improvements. For example, some people had raised issues about meals and meal times. Actions included making sure individual requirements were catered for through person centred care planning and reviews, as well as discussing menus at resident meetings and regular feedback. We noted that these actions had been put into practice.

The local authority which funded placements at the service had also carried out a recent Quality Assessment Framework visit in September 2017. The registered manager told us they were awaiting the final report.