

Croftwood Care UK Limited

# Garswood House Residential Care Home

## Inspection report

Garswood House  
Wentworth Road, Ashton In Makerfield  
Wigan  
Lancashire  
WN4 9TZ

Tel: 02084227365

Website: [www.minstercaregroup.co.uk](http://www.minstercaregroup.co.uk)

Date of inspection visit:

24 October 2018

25 October 2018

Date of publication:

04 December 2018

## 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 an inspection of Garswood House Residential Care Home on the 24 and 25 October 2018, the first day of inspection was unannounced. This was the first time the home had been inspected since it re-registered with the Care Quality Commission in November 2017, due to a change in ownership.

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

Garswood House is a large purpose-built home on the outskirts of Ashton in Makerfield. It is registered to provide care and support for up to 40 older people. Services include a 10 bed specialist household for older people living with dementia and a 30 bed residential unit. Day care and respite are also provided. At the time of inspection 38 people were living at the home.

The service had 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had a clear management structure in place with the registered manager being supported by a deputy manager. The home was further supported by the area manager and provider's compliance manager, who were regular visitors to the home. Staff told us the registered manager was a visible presence in the home and was "always happy to help out."

People living at the home told us they felt safe and well cared for. Relatives we spoke with also had no concerns about the safety of their family members and spoke positively about the standard of care provided. We found staffing levels were sufficient to meet people's needs and keep them safe.

The home had appropriate safeguarding policies and procedures in place, with instructions on how to report safeguarding concerns to each of the local authorities who commissioned services from them. Staff had received training in safeguarding vulnerable adults and demonstrated a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

The home was clean, free from odours with effective infection control procedures in place. Hand hygiene guidance and equipment was located in bathrooms and toilets and personal protective equipment (PPE) such as gloves and aprons were available for staff to use to help prevent the spread of infections.

We found medicines were stored, handled and administered safely and effectively. Staff who administered medicines had received training and had their competency assessed. Medication Administration Record (MAR) charts had been completed correctly, as had topical medicine charts, which are used to record the

administration of creams and lotions. We found guidance for 'as required' (PRN) medicines such as paracetamol were in place, to ensure people were given these medicines safely and when needed.

The staff we spoke with displayed a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We found the home was adhering to the principles of the MCA. DoLS applications had been submitted appropriately for people deemed to lack capacity to consent to their care and treatment. We saw best interest meetings had been conducted to support decision making where people lacked capacity to make these decisions and had no legal representative to do so.

Staff spoke positively about the training provided. Training completion was monitored and promoted, to ensure staff's skills and knowledge remained up to date. Staff told us they received regular supervision and annual appraisals, which along with the completion of quarterly team meetings, ensured they were supported in their roles.

People told us they received enough to eat and drink and were happy with the choice of meals offered. Specific dietary needs, such as soft or pureed meals and/or thickened fluids, had been supplied in line with guidance.

Throughout the inspection we saw positive interactions between staff and people living at the home. People and their relatives told us staff were kind, caring and considerate, which was noted in the exchanges we observed. Staff clearly knew the people they supported, who in turn were comfortable in staff's presence.

As part of the inspection, we looked at five care files which contained detailed information about each person and how they wished to be cared for. Each file contained detailed care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained.

People's views were sought and they were actively involved in the home. Regular resident meetings were held and newsletters produced to ensure information was communicated clearly. People were involved in staff interviews and recruitment, to ensure they had a say in who supported them.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed both internally and at provider level, with action plans and checklists completed to ensure improvements were made.

## 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 we spoke with told us they felt safe living at Garswood House. Staff were trained in safeguarding procedures and knew how to report concerns.

Staffing levels were sufficient to keep people safe and meet their assessed needs.

Medicines were stored, handled and administered safely by trained staff who had their competency assessed regularly.

### Is the service effective?

Good 

The service was effective.

People spoke positively about the quantity and quality of food provided. We saw people's nutritional needs were being assessed and provided as per professional recommendations.

The service was meeting the requirements of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS).

Staff reported sufficient and regular training and supervision was provided to enable them to carry out their roles successfully.

### Is the service caring?

Good 

The service was caring.

We observed positive interactions between staff and people living at the home. Staff members were kind and respectful and knew the people they cared for and how they wanted to be supported.

Regular meetings were held to enable people to receive information and have input into the running of the home and the care being provided.

Both people and their relatives spoke positively about the care and support provided. People were offered choice and their

independence was encouraged and promoted.

### Is the service responsive?

Good ●

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person-centred way. Care plans and other records were regularly reviewed.

The home had an effective complaints procedure in place, with all complaints being investigated and outcomes documented.

People we spoke with were positive about the activities available in the home. The coordinator was enthusiastic and encouraged people to take part, whilst respecting the wishes of those who chose not to.

### Is the service well-led?

Good ●

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

People living at the home and their relatives, said the home was well-led and managed and they would happily recommend it to others.

Team meetings were held to ensure that all staff had input into the running of the home and made aware of necessary information.

# Garswood House Residential 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 the 24 and 25 October 2018. The first day of the inspection was unannounced. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

Before commencing the inspection, we looked at any information we held about the service. This included any notifications that had been received; notifications are changes, events or incidents that the provider is legally obliged to send to us without delay, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also contacted the quality performance officers at Wigan Council to ask for their views of the home and any other pertinent information, to help with inspection planning. Feedback received was positive and highlighted no current concerns.

We had not asked the provider to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the course of the inspection we spoke with the registered manager, area manager and seven staff members, which included the chef and activities co-ordinator. We also spoke with five people who lived at the home and four relatives.

We looked around the home and viewed a variety of documentation and records. This included; five staff files, five care files, eight Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

# Is the service safe?

## Our findings

People told us they felt safe living at Garswood House. Relatives also reported their loved ones received safe care which met their needs. Comments included, "Do I feel safe living here, definitely" and "[Relative] has been in a few homes, but would recommend this one, she is safe and well looked after."

Staff had received training in safeguarding which was refreshed every two years. Each staff member spoken with was aware of how to identify and report concerns. The home's safeguarding file contained a list of each person and which local authority to report concerns to, as they supported people from different areas within the north west. Policy and procedures from each local authority were also present, to ensure correct reporting procedures were followed. A log had been kept of referrals, which included action taken and outcomes.

Safe recruitment procedures were in place, to ensure staff employed were suitable for the role and people were kept safe. We looked at five staff personnel files and saw references, proof of identification, full work histories and Disclosure and Barring Service (DBS) checks had been sought. DBS checks help employers make safe recruitment decisions as they identify if a person has had any criminal convictions or cautions. Annual declarations had also been completed by staff to confirm they had not received any convictions within the last 12 months.

Staffing levels were consistently appropriate to meet people's needs. Both people and staff we spoke with confirmed this. Comments included, "Yes, there's enough [staff]. Don't have to wait long" and "Yes, staffing levels are okay."

The home used a system for determining the number of staff required to meet people's needs, these are often called a 'dependency tool'. The tool had been completed and updated monthly to reflect people's changing needs. We saw weekly staffing hours exceeded the number of care hours required, which indicated more than enough staff had been deployed to provide safe care. We looked at four weeks rotas, which confirmed staffing had been allocated as per the dependency tool.

We found accidents and incidents had also been consistently documented. Falls monitoring and analysis had been completed, which included details of any falls and action taken to mitigate further incidents, such as referrals to the local authority falls team. For each person at risk of, or who experienced a fall a Falls Risk Assessment Tool (FRAT) had been completed and reviewed monthly or following an incident.

The home was clean with appropriate cleaning and infection control processes in place. Bathrooms and toilets contained hand hygiene guidance, liquid soap and paper towels and staff had access to and used personal protective equipment (PPE) such as gloves and aprons. Cleaning checklists had been used to ensure both the premises and equipment in use, such as wheelchairs, pressure cushions and mattresses had been regularly checked and cleaned.

Kitchen checks had been completed consistently, to ensure this area was clean and food had been stored

and served at the correct temperature. We saw the home had a food hygiene rating of five, the highest achievable.

The home had effective systems in place to ensure the premises and equipment was fit for purpose. Gas and electricity safety certificates were in place and up to date. Hoists, the lift and fire equipment had been serviced annually with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order. Each person had a personal emergency evacuation plan (PEEP), which explained how they should be evacuated from the building in the event of an emergency.

Medicines were being managed safely. We looked at the home's management of medicines, which included reviewing documentation, checking stock levels and ensuring staff had the necessary guidance to ensure they administered medicines safely and when people needed them. Staff administering medicines had received training and had their competency to do so, checked and reviewed at least annually.

Each person had a cover sheet alongside their medicine administration record (MAR), which contained their name, photograph, allergies and special instructions, such as how they liked to take their medicines or other issues staff needed to be aware of. An information sheet was also present which listed the medicines prescribed, an image of the medicine, dosage and administration details. This ensured staff knew each medicine a person took, what this looked like and when they should take it.

We found MAR's had been completed consistently. Where any errors or omissions had occurred, we saw these had been picked up and addressed via the home's audit process. A checklist had also been used to confirm people's medicines had been administered as prescribed.

Where people lacked capacity and had been refusing their medicines, authorisation had been sought from the GP to administer medicines covertly, which is without their knowledge. Although the authorising GP had confirmed the method of administration, such as crushing and mixing with food, we could not confirm guidance from the pharmacist had also been sought, which is best practice, to ensure medicines were safe to be administered in the way detailed by the GP. The registered manager told us they would contact the pharmacist for this information. We will follow up on this at the next inspection.

We saw 'as required' (PRN) protocols in place for people who took medicines, such as paracetamol. These provided staff with information about how much to give, when to administer and what signs to look out for to determine if it may be required. This is particularly useful when the person is unable to tell staff themselves. This ensured medicines had been administered safely and when needed.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found CD's had been administered as per guidance, with the register completed correctly and consistently.



## Is the service effective?

### Our findings

Staff told us they received sufficient training and support to carry out their roles. Comments included, "We get a lot of training, face to face and videos and then we fill out questionnaires to test our knowledge" and "We always seem to be doing training. We have supervision every three months and an annual appraisal."

We looked at the homes staff training documentation which was stored electronically. The training matrix showed staff had received training in a number of areas relevant to their role, including moving and handling, safeguarding, dementia awareness and infection control. The matrix was colour coded to indicate training was in date or required updating. Where updates were required, these had been scheduled. We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

We saw supervision and appraisals had been scheduled and completed in line with the providers policy. Each staff member had a file in which training certification, supervision and appraisal documentation had been stored.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The home was acting in accordance with the MCA. Staff told us they had received training in MCA and DoLS and when questioned demonstrated a clear working knowledge of both. One told us, "This is to do with whether they have capacity to make decisions, are able to go out on their own, things like that." Another stated, "If people are not capable to make their own decisions, these need to be done for them in their best interest."

The home used two 'trackers' to monitor DoLS applications, one for those still awaiting assessment and one for those assessed and granted. We found applications had been submitted timely and for all people who met the requirements. Dates for renewal were clearly documented, to ensure ongoing compliance.

Where people lacked capacity to consent and did not have a legal representative, such as a Lasting Power of Attorney (LPA) for health and welfare in place, we saw mental capacity assessments and best interest meetings had taken place to make important decisions. Where people had capacity, care files contained signed consent forms which covered a range of areas including provision of care and support, use of photographs, involvement in care planning and signing of these and professionals having access to records.

People told us they liked the food provided and received enough to eat and drink. One told us, "The food suits me, I like it. We choose what we eat and get plenty of it." Another said, "The food is okay, we get enough to eat and drink."

The home operated a marvellous mealtimes initiative, which aimed to ensure dignity and choice was maintained. Considerations included where people ate, who they sat with, times meals were provided and expectations of the staff to ensure the process ran smoothly and met people's needs. We found the dining experience to be positive. People were offered a choice of meals; the dining area was nicely set out and staff all knew their roles. People were engaged in conversation with their peers and those who required support to eat received this discreetly and in line with their care plan.

We saw people who required a modified diet, such as soft or pureed meals or thickened fluids, received these in line with their assessed needs. Similarly people who required a fortified diet and/or supplements, received these as per recommendations. People's weights were monitored in line with their care plan, with a formal nutritional monitoring system, the Malnutrition Universal Scoring Tool (MUST), being completed monthly.

People's pressure care needs were being met. The home followed React to Red, a national pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them. The Waterlow was being completed each month, this is a formal prevention and monitoring tool, used to assess people's risk of skin breakdown. Care plans were in place which detailed any equipment in use and how and when pressure relief was to be given. Positional change or 'turn' charts viewed confirmed guidance had been followed.

People told us they received help to stay well. Comments included, "Yes, I do [get help to stay well]. You only need to ask and they will sort it for you" and "I had the doctor visit last week, after I asked to see one." We saw the home worked closely with other professionals and agencies to meet people's health and welfare needs. We noted referrals had been made to professionals when any issues or concerns had arisen, these included, speech and language therapists (SaLT), dieticians and GP's. Involvement had been documented in care files, including any action taken and outcomes.

The home had taken some steps to ensure the environment was suitable to meet people's needs. Corridors were light and airy with contrasting coloured handrails to make them easier to identify. Large pictorial signage was in place on all bathrooms and toilets. Memory boxes were located outside of people's bedrooms, in which they could place objects, items or pictures which meant something to them.

We saw building work was underway which had commenced in September 2018. This was to create an extra 10 en-suite rooms and two new lounges. The works had resulted in some disruption and change to functionality, for example one lounge had been closed off for safety reasons and a temporary lounge created elsewhere. People had been consulted about the building work in advance and would be updated during meetings and through a monthly newsletter. We suggested the registered manager and provider complete some additional research into dementia friendly environments, so this could be incorporated into the renovations.

# Is the service caring?

## Our findings

People and their relatives spoke positively about the care provided at Garswood Care Home. Comments included, "The girls here are great, it comes out top of the homes I have been in", "I'm well looked after here" and "I would definitely recommend it, the care given to [relative] is very good." We were also told people were being cared for in a way they would like, with this information clearly documented in people's care files.

We spent time observing care provided in all areas of the home. We saw people appeared relaxed, settled and were well-groomed. Staff were attentive to people's needs, responding promptly to requests for assistance or if a person was unable to verbalise, when observing an intervention was required.

The atmosphere was calm and staff were seen to be polite and patient, whilst also engaging in 'banter' with people and having a laugh during interactions. It was clear from observations, staff knew each person well and people felt comfortable in staff's presence. We observed appropriate physical contact between staff and people; for example, hand holding or placing an arm around a person's shoulders. These interactions were received positively by the person involved.

Each person we spoke with felt staff respected their dignity and privacy, for example, by knocking on bedroom doors before entering and asking before providing care. A relative told us their family member could be difficult when it came to being supported with personal care, but felt the staff were discreet and "manage this very well".

We asked staff how they maintained people's dignity and respect. One told us, "I make sure the door is shut, they are covered when washing and always provide choice." Another stated, "I treat them as an individual, do things privately, talk through what I am going to do and make sure they are happy with this."

Staff were knowledgeable on the importance of promoting independence. One told us, "We promote independence as much as possible. Encourage people to do things for themselves, only help when they need it." Another said, "We encourage people to do things like brushing their own teeth, washing themselves or shaving. We may need to get the stuff together and talk them through what to do, but if they can manage, we let them do the task."

People were able to express their views, be involved in the running of the home and in making decisions. Resident meetings had been held quarterly, which included discussions about plans for the home, forthcoming activities and events, menus and anything else people wished to raise. People's views had been sought through annual questionnaires, with written feedback provided on the findings and actions the home intended to implement as a result.

We saw people had also been actively involved in the completion of staff interviews. People had sat on the interview panel, been responsible for asking questions of their own devising and making final decisions on who to employ. We spoke to one person who had been involved in this process. They spoke positively about

the experience and expressed pride in having selected staff who had proven to be very good.

There was a positive culture at the home and people were provided with care that was sensitive to their needs and non-discriminatory. Staff were mindful of the importance of catering for people's diverse needs, whether these be spiritual or cultural. Care files contained sections which captured people's needs, wishes, religious and cultural beliefs or requests. At the time of inspection nobody living at the home had any specific requirements, however staff told us these would be catered for. We saw representatives from both the Catholic and Church of England faiths, visited the home regularly to provide communion.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service had met this standard. Care files contained communication support plans, which detailed how the person communicated, any difficulties in doing so, any help they required and how staff would know this worked. This included use of body language and facial expressions for those with limited verbal communication skills.

In regard to wider communication, we saw the home produced their own monthly newsletter, which provided information about future plans, outings, resident meeting feedback, along with more personal information such as birthdays and testimonials.

## Is the service responsive?

### Our findings

People we spoke with and their relatives told us they had been involved in the care planning process, including making choices about their care and how they wanted to be supported. Comments included, "I feel involved with the help and care I get and can make choices", "Yes, I am involved in the care plan" and "They discuss the care with me, communication is very good."

Although people confirmed they had been involved in care planning, we found this had not been consistently captured within the care files we viewed. Some people had chosen not to sign care plans, which was documented on their consent form, however this was not the case for all. The home was in the process of changing to a new care plan format and the registered manager told us they would ensure people and/or their legal representative who wished to, signed the new care plans upon completion and following reviews.

We saw the service provided care which was both personalised and responsive to people's individual needs and preferences. We reviewed five care files, which contained 12 sections that covered care plans, assessments and daily records. A pre-admission assessment had been completed for each person, which included important information about them, their areas of need and the support they required. This information had been used to help complete the initial care plans.

Each person's file contained a 'life plan', which stated at the beginning, 'My life plan will help you know who I am and what we can do together to help me enjoy a satisfying lifestyle'. We saw a range of personalised information had been captured on a 'past experiences' form including people's life history, educational and work background, hobbies and interests. This ensured staff knew what was important to each person and helped inform the care planning process.

We found care plans clearly explained how people wished to be cared for and were written in a way that made them easy to read and accessible to all. For each area covered, the care plan listed the person's needs, how they lived/coped with any difficulties, what help they wanted from staff and how staff would know this had worked.

Each person also had a care plan overview in their file, which summarised the care they required in key areas such as mobility, nutrition, personal hygiene, memory and understanding. This provided staff with a quick reference guide, to help refresh their knowledge and provide care on line with each person's wishes.

People and their relatives knew how to complain. One told us, "I would go to a senior staff member or the manager if I had any issues." Another said, "Yes, I know how to complain. I would tell them if I wasn't happy, don't you worry."

Copies of the complaint procedure were clearly displayed on noticeboards within the home. The complaints file contained a copy of the providers policy and procedures, which we noted had been followed when investigating any issues or concerns received. A feedback log had been used to record any complaints, comments or queries raised, regardless of their severity. Where a formal response had been required, we

saw copies of any correspondence had been kept on file, along with any other evidence or documentation linked to the complaint, to demonstrate the action taken and outcomes.

People provided mixed feedback about the activities provided, although acknowledged this was due to personal choice. Comments included, "We do bingo, I like reading and going into the TV room", "We tend to do things in the afternoon, [coordinator] does this, she's very nice" and "Yes, we do things, though can get a bit boring, though this is because I am more active than some and prefer going out." The home employed a co-ordinator, who was responsible for organising and facilitating activities within the home. They split their time between the 'household' and the residential unit, spending the morning on one and afternoon on the other. We saw they had been nominated for a Wigan Council Care Home Staff Award in 'recognition of the outstanding contribution they made every day'.

An activities schedule was displayed in the home and people's engagement recorded in care files. These included a weekly tea dance at a local social club, visiting artists, such as singers and musicians as well as in-house activities such as bingo, games and crafts.

People's end of life wishes were being met. At the time of inspection, no-one living at the home was receiving end of life care, however the home had documentation in place to capture people's wishes when nearing the end of their life. These included things people wanted to have achieved before they died, their preferences before and after, help they wanted to achieve their wishes and the people they wanted to be involved and kept informed. An additional document, listed specific instructions, special cultural or religious requirements, such as which church to use and where they wished to be buried or cremated. We saw the home worked closely with GP's and district nurses, to ensure people who wanted to remain at the home when approaching the end of their life, could do so safely and respectfully.

## Is the service well-led?

### Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered Persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives knew who the manager was and felt the home was well-led. Whilst not each person we spoke with could remember the registered manager's name, they were able to point them out to us. Comments included, "Oh yes, the manager is [name]", "Not sure what their name is, but it's her over there [pointing to registered manger]" and "This is a lovely home, it's clean, with good staff. I have no complaints."

Staff also spoke positively about the home and support they received from the registered manager. One told us, "I love my job, we get lots of encouragement and get good support." Another said, "I love it here as every day is different. I definitely feel supported."

Staff told us they had regular meetings, which enabled them to receive information about the home and their roles, as well as provide a forum for them to have their say. We saw meetings had been held with each designation of staff, to ensure the content of the meetings was relevant and each felt listened to.

Staff also completed an annual survey, which asked them to rate the home in 10 areas, which included communication, training, supervision, receiving recognition and job satisfaction. The questionnaire used a one to 10 scale, with one being dissatisfied and 10 very satisfied. The latest survey was dated August 2018, when 46 out of 50 questionnaires had been returned. We saw the overall response was positive, with over 75% of staff reporting being satisfied with the company, communication and receiving recognition and over 90% with feeling respected, staff support and supervision.

We found the home to be an inclusive and empowering environment. Both people and staff's views and opinions were sought and acted upon and they were also involved in making decisions about how the home was run.

There was a clear audit and quality monitoring process in place at the home. The provider's compliance manager completed regular audits; at least monthly, to assess the quality of service provision as a whole. Following each audit, the home received a rating, which was in line with CQC's ratings of inadequate, requires improvement, good and outstanding. We saw action plans had been generated following each audit, which had been followed up and signed off during the next visit.

The home completed a range of internal audits, the frequency of which varied depending on the area being assessed. Areas covered included workplace safety, cleanliness and infection control and staffing, through to care based areas such as safeguarding, accidents and incidents. nutrition and pressure care. For each audit we saw actions and outcomes had been recorded, to ensure continuous improvement was

maintained and the home was meeting regulations.

We found accidents, incidents and safeguarding had been appropriately reported as required. We saw the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with the requirements of their registration and copies of all notifications submitted were kept on file.

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; which meant that the most up to date copies were always available. We spoke with staff who were able to demonstrate a good understanding of the policies which underpinned their job role such as safeguarding people, health and safety and infection control.