Nottinghamshire County Council

Bishops Court Residential Care Home for Older People

Inspection report

Tuxford Road
Boughton
Newark
Nottinghamshire
NG22 9HY

Tel: 01623862043
Website: www.nottinghamshire.gov.uk

Date of inspection visit:
28 March 2018

Date of publication:
25 April 2018

Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
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 inspected Bishops Court Residential Care Home for Older People on 28 March 2018. The visit was unannounced. This meant the staff and the provider did not know we would be visiting.

Bishops 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. Bishops Court provides residential care for up to 45 people over the age of 65, some of whom are living with dementia. The home is divided into four units and comprises an assessment unit, two short stay units and a unit for people who require long - term care. There is also an assessment flat which can be utilised for people requiring assessment with the aim of returning to live in their own home. All of these are located in one building. On the day of the inspection there were 27 people using the service.

At the last inspection on 11 February 2016, the service was rated as good overall. It was rated good for effective, caring, responsive and well led and was rated requires improvement for safe. At that inspection we found improvements were needed in the reporting of incidents and also in relation to the number of staff available to support people at mealtimes. During this inspection we found the issues had been addressed, but we identified some new concerns with the management of medicines. As a result, we rated the service as good overall, with a rating of requires improvement for safe.

The service had a registered manager in place at the time of our inspection. 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 using the service told us they felt safe living at Bishops Court. Relatives we spoke with agreed they were safe living there. The staff team were aware of their responsibilities for keeping people safe from avoidable harm and knew to report any concerns to the management team.

Staff assessed people risks in relation to people's daily lives, but formal nutritional risk assessments were not always completed. The registered manager told us a risk assessment was in the process of being introduced and staff always monitored people's weight and took action if a person started to lose weight.

People were supported by enough staff to ensure they received care and support when they needed it. Appropriate pre-employment checks had been carried out on new members of staff to make sure they were safe and suitable to work there.

People were supported to receive their medicines safely, but staff did not always lock the medicines trolley when it was left unattended, which increased risk people might access medicines without permission.

Liquid medicines and ointments were not always labelled with the date of opening to ensure they were not used longer than the manufacturer's guidelines.

Staff had the knowledge and skills to provide safe and appropriate care and support. The manager had systems in place to observe practice and staff received supervision and appraisal.

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 The staff team supported people to make decisions about their day to day care and support. Where a person did not have the capacity to make a decision for themselves the principles of the Mental Capacity Act were followed. Where appropriate, applications were made to the Local Authority in relation the Deprivation of Liberty Safeguards (DoLS) and the requirements were followed.

People lived in a service which met their needs in relation to the premises and adaptions were made where needed. People had access to information in a format which met their needs.

Staff assessed people's food and drink requirements to ensure a balanced diet was being provided. Staff monitored people's food and fluid intake and kept records of these when they were identified as being at risk from not drinking or eating enough to keep them healthy.

People were supported to maintain their health. They had access to relevant healthcare services such as doctors and community nurses and they received on-going healthcare support.

The staff team were kind and caring and people's privacy and dignity was respected and promoted. People were involved when staff were planning their care, but this was not always documented.

We saw some excellent examples of initiatives to increase people's sense of well-being and increase their independence. Staff and people had access to a wide range of resources to enable them to participate in activities that interested them.

People had plans of care that, on the whole, reflected their care and support needs. Whilst the care plans for some people receiving long - term care would have benefited from more detail about their personal choices, the staff team were aware of these and there was additional personal information in "This is me" booklets.

The service was well-led by a registered manager. People using the service, their relatives and staff were unanimous in their praise of the registered manager and the support they provided. People and staff were encouraged to contribute to the development of the service. Effective auditing processes were in place to monitor the quality of the service. The registered manager carried out their role in line with their registration with the CQC.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always stored or managed safely.

People were kept safe and the service had systems in place to recognize and respond to allegations of abuse.

Safe staff recruitment procedures were followed and people were supported by adequate numbers of staff to maintain their safety.

The home was visibly clean, hygienic and the required building and maintenance checks were completed, including fire safety.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service remained well-led.

Bishops Court Residential Care Home for Older People

Detailed findings

Background to this inspection

This inspection took place on 28 March 2018. Our visit was unannounced. The inspection was carried out by two inspectors 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. Their area of experience was dementia care.

Prior to the inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who monitor the care and support of people receiving care at Bishops Court to obtain their views of the care provided. We also contacted Healthwatch, the local consumer champion for people using adult social care services to see if they had any feedback about the service.

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. We used this information to inform our inspection planning.

During our visit we spoke with 10 people using the service and three relatives. In addition, we spoke with the service manager, registered manager, four care staff, an activities coordinator, the cook, and two visiting health and care professionals.

We observed staff providing support to people in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included four

people's care records and associated documents. We reviewed records of meetings, recruitment checks carried out for three staff and maintenance and safety logs. We also reviewed the quality assurance audits the management team had completed.

Requires Improvement

Is the service safe?

Our findings

The service had safe processes in place for the timely ordering and supply of people's medicines. We spoke with staff and reviewed people's medicines administration records and did not find any evidence of people missing their medicines due to a lack of availability. People and their relatives told us they did not have any concerns about their medicines and staff administered their medicines in a timely manner. However, the medicines administration records indicated that a person's night time medicines had been omitted for a period of two weeks by staff at night because they were asleep. There was no evidence staff had contacted the person's GP to ask them to review the medicines and the time they were prescribed to be given. In addition, we found some liquid medicines and skin creams and ointments were not labelled with the date of opening. This is required to ensure they are used in accordance with the manufacturer's guidelines.

We observed the administration of medicines in two of the units at lunch time. We found staff made the appropriate checks prior to administering people's medicines. A member of staff left someone with their medicines, and returned later to check they had taken them.

Medicines were not always secure during medicines administration activities. We saw two occasions when medicine trolleys was left open or unlocked and could be accessible to people who used the service or others. This meant there was a risk people may access medicines which were not prescribed for them. When we spoke to the registered manager about this they spoke immediately to staff to re-iterate the importance of keeping the medicines trolleys locked at all times when unattended.

Staff administering medicines completed training and competency assessments to ensure they knew how to administer and manage medicines safely.

People felt safe living at Bishops Court and this view was also shared by people's relatives.
A relative said, "My [family member] is safe in every respect. I have total peace of mind." Another person's relative said, "[Family member] is very safe here … and it makes it easier for me knowing they are safe and well … I can go home and relax."

Processes were in place to minimise the risk of people experiencing avoidable harm or abuse. Records showed staff had up to date training in safeguarding adults. Staff we spoke with were aware of the signs of abuse and what to look for such as changes in people's behaviour that might indicate they were being abused. They knew the process to follow if they had a concern about anyone. They said they would report concerns to the registered manager or team leader and they were very confident the management team would take action in response. When asked who they would go to if their concerns were not acted on, one person said, "Oh, but they definitely would." Another member of staff said they would go to the area manager and they gave the person's name and said they knew how to contact them.

The registered manager was clear about their responsibilities for reporting safeguarding concerns to the local authority and to the CQC. They said they had the lead role for safeguarding for the service and all team leaders were able to make the required alerts and notifications. They said they checked alerts were made

and the appropriate action was taken.

We spoke with the registered manager about two recent safeguarding notifications we had received and alerts which had been made. They were able to provide us with assurance that actions were taken to mitigate the risk of similar issues occurring in the future.

When people first moved into the service, the risks associated with their care and support were identified and assessed in order to decide how the risks could be managed by the staff team Staff did not assess people prior to admission to the service, but reviewed the assessments completed by health and social care professionals to enable them to decide whether the service could safely meet each person's needs, prior to accepting the person for admission. Records we reviewed contained evidence people were assessed for their risk of developing pressure ulcers, falls, drinking sufficient fluids, and risks associated with using equipment such as hoists and wheelchairs to enable them to move. However, risk assessments were not always reviewed in a timely manner. For example, one person was identified as being at risk of falls and the risk assessment score documentation stated the assessment should be reviewed monthly. The last risk assessment recorded for the person was completed three months previously. We considered the impact of this and found the person had not had any falls recently and the measures in place adequately reflected their current situation. The registered manager said they would review the frequency of risk assessments.

Risks associated with people's behaviour were managed effectively. We observed a member of staff reminding another staff member to encourage people to sit more than an arms-length away from a person who had previously been known to strike out at others. This was in accordance with information provided by the registered manager when we spoke with them about safeguarding incidents.

Where accidents and incidents occurred we saw evidence that they were investigated and action taken to reduce the risk of reoccurrence. Staff told us they were encouraged to report incidents and they received feedback from the registered manager in relation to changes needed and learning as a result.

The premises were well maintained and adapted to maintain the safety of people living there. For example, there was appropriate disabled access to bathroom facilities and adaptations such as safety rails and raised toilet seats were in place. The service had a contract for the servicing of equipment such as hoists and beds to ensure they were maintained. Fire safety checks were carried out and the staff team were aware of the procedure to follow in the event of a fire. There were personal emergency evacuation plans in place for the people using the service. These showed how each individual must be assisted in the event of an emergency and an emergency plan was in place in case of foreseeable emergencies.

There were enough staff to meet the needs of people who used the service. People and their relatives told us they felt there were enough staff to meet peoples' needs although one commented, "I do think they have a lot of agency staff – but regular ones - so that's not so bad maybe."

The registered manager used a dependency tool to assess staffing requirements. They had some staff vacancies and the registered manager told us there were challenges in recruiting staff. However, they told us four staff were moving to the service from a neighbouring service shortly. In the meantime, they were using agency staff who were familiar with the service and worked regularly with them. We spoke with an agency care worker and they told us they were able to access people's care plans and they showed they were conversant with peoples' care needs. Staff rotas were planned in advance and demonstrated there were enough staff members allocated on each shift to provide the care and support people needed.

Staff told us they felt there were enough staff to provide the care and support people required. They said

there was 'a good group of regular agency staff' who worked in the service to cover shortfalls in staffing.

Records showed that prior to staff being recruited the registered manager carried out checks to ensure applicants were suitable to work with people who used the service.

The provider had measures in place to prevent and control infection. The environment was visibly clean and audits were completed of cleanliness. The provider had taken steps to rectify issues that were identified in an external audit of infection prevention and control. Personal protective clothing and equipment was provided and we observed staff wearing this when providing care.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed and their care and support was planned and delivered in line with legislation, standards and evidence-based guidance. Policies and procedures were based on national guidance. 'Health action plans' were completed to ensure care could be provided consistently when people moved between services.

The registered manager was able to demonstrate they kept themselves up to date with changes to practice and made efforts to look at new ways of working and improvements to the care provided. They had obtained funding from the local authority to provide 'Dementia Coach' training, a certified programme in dementia care and had investigated and utilised other initiatives to improve the well-being of people living with dementia.

People were supported by staff who were trained to support them safely. Staff told us, and records confirmed, staff completed mandatory training in a range of areas required for their role such as, infection prevention and control, health and safety, fire safety, moving and handling and equality and diversity. The training records indicated generally high levels of completion of training. Some innovative training opportunities were being offered such as puppetry in care homes, and the 'Soundtrack to our Lives ' initiative which explores the use of music for people living with dementia, as well as training specified as mandatory by the provider. The registered manager stated the soundtrack training had been useful and staff were using it in practice, whereas the puppetry has not been used yet, but staff were considering how it could best be utilised.

A relative said they were happy with the care provided by the care staff and they thought the staff were competent and trained. We observed staff supporting people and that they were confident in what they were doing and had the skills needed to care for people appropriately. We observed staff discussing the fact a person had just been admitted and their care plan was not fully developed, but that they had adequate information to assist them to move safely to a comfortable chair. We saw they worked together to assist the person and observe them carefully, to maintain the person's safety as they went about the task.

Staff received supervision (one to one management support) and annual appraisals to develop their skills. Staff told us supervision was constructive and they had the opportunity to identify any training they would like to do. The registered manager said they encouraged staff to undertake training and development, and staff confirmed this.

People's needs in relation to accessing information were considered. Each person had information about the service in their rooms and a range of accessible information in 'easy read' format was available. For example, complaints information was available in easy read and pictorial format. Picture menus were available, but we did not see them used during the inspection. A member of staff speaking about people living with dementia said, "Often for some people we write things down to help them remember." They explained they had written the bedroom number down for a person who had just moved to the service .

People's diverse needs and characteristics were recognised and accommodated to ensure people were not subject to discrimination. The staff we spoke with and the care plans we reviewed, showed these characteristics had been considered when providing care for people. People had access to representatives of different faiths when they wished. A member of the clergy visited a person using the service during the inspection and the registered manager said a church service was held in the home on a monthly basis. In addition, staff accompanied people to the local churches when they wished. . Equality and diversity training was part of the mandatory training programme, although not all staff were up to date with the training.

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).

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."

People were supported to make decisions on a daily basis and we observed people decided how and where they spent their time and made decisions about their care and support. Where people's capacity to make certain decisions was in doubt, assessments were carried out and if the person was assessed as not having the capacity to make a decision, a best interest's decision was made which ensured that the principles of the MCA were followed.

Documentation within people's care records demonstrated the staff understood the principles of the MCA and there was a good record of the assessment and how the best interest decision was made. We did note one person had a sensor mat in place in their room as they were at risk of falls and no consent or best interest decision was recorded in relation to the decision for its use. We drew this to the attention of the registered manager who said they would correct this immediately.

People had enough to eat and drink and were offered support as needed. We spoke with people about the food and they told us they had enough to eat and we observed people were given regular drinks. They were offered drinks and snacks throughout the day. The dining experience was relaxed and at the residents own pace. People we spoke with said they had enjoyed their meal and we observed people had chosen their meal. We observed a person being offered lots of alternatives when they were reluctant to eat. When people required the texture of the food to be modified to reduce their risk of choking, this was provided. We saw a person needed a lot of encouragement to eat and a member of staff sat with them and assisted them, encouraging them as they went along.

People's weight was monitored regularly but formal nutritional risk assessments were not completed. The registered manager told us risk assessments were in the process of being introduced and we saw documentation to support this. When people were at risk of poor food or fluid intake, staff recorded the amount they ate and drank. Food and fluid targets were set for these people to ensure they were offered enough to eat and drink. Records of food and fluid intake were generally consistently completed and indicated people received adequate drinks throughout the day.

People were supported with their day to day healthcare. We saw people were supported to access their GP when they were unwell and we saw evidence of other professional involvement in people's care when required, such as occupational therapists and dietitians. We spoke to two visiting professionals about staff knowledge and competence and received differing views. One person, identified a time when they thought medical assistance should have been sought sooner for a person, however when we spoke with the registered manager they were able to explain the circumstances surrounding this issue and why staff had not called for medical assistance initially. Another professional spoke highly of staff and their competence. A family member of a person using the service said they were happy with the care provided by the care staff and they thought the staff were competent and trained.

The premises were adapted to meet peoples' individual needs. The creation of small units within a larger building meant distances between the bedrooms and communal areas were short and it was easy for people to find their way from their bedroom to communal areas. We saw areas of the building had been developed to meet the needs of people using it. For example, there was a self-contained flat within the main building, with its own external entrance door. The manager told us this could be used if someone was preparing to go home with a care package. They were able to live independently and staff attended at intervals in the same way as if care staff were visiting them at home. They had an alarm to call staff if needed in between visits. This eased the transition to their home environment and encouraged their independence.

A sensory room was created for people who wanted some quiet time. It was equipped with a range of sight and sound systems such as heartbeats, bird song etc. and bubble lamps. There was also a machine which produced calming aromas.

A vintage tea room had been created, with traditional cups and saucers and cake stands, along with home-made chutney and lace table cloths.

Good

Is the service caring?

Our findings

People we spoke with praised staff highly for their kind and caring nature. One person said, "They are all so kind and caring towards me… I know what it's like and they are all very kind and caring here. Another person said about staff, "You can't fault any of them."

All the relatives said they felt the staff were kind, courteous and polite and they treated their relatives with respect and dignity. A relative of a person who used the service said, "They also treated me so well too when I visited, just like one big family… it's always a pleasure to come and visit."

We observed staff supporting people and saw that support was carried out in a caring way. Staff spoke to people in a friendly way and offered support in a relaxed manner. We saw staff members getting down to people's eye level, calling people by their preferred name and engaging in conversation, which people clearly enjoyed.

Staff were attentive to people's needs and responded patiently when a person became anxious despite reassurance from staff. They used distraction techniques by engaging them in an activity to provide a different focus. When the presence of the person appeared to be upsetting others in the vicinity, staff encouraged them to a nearby table to participate in a table top activity. We observed a person who arrived at the service that morning was welcomed and encouraged to join in a game of dominoes with other people using the service. They said, "They (staff) have made me very welcome." We observed some staff saying goodbye to people as they left at the end of their shift, telling them when they would be back and who was working with them for the rest of the day. Some people were given a hug to say goodbye.

Staff protected people's privacy and dignity. We saw them knocking on people's doors before entering and speaking sensitively to people when they needed assistance. We observed a member of staff speaking to another in hushed tones when they explained a person's needs and spoke about them in a dignified manner.

We noted the registered manager had put on a series of events on a 'Dignity in Care' day the previous month. This had included events to raise awareness of privacy and dignity and included social activities including a vintage afternoon tea.

People were involved in deciding what care and support they needed but records did not always document their involvement. We observed staff speaking with a person about their care and support needs and seeking their views. People told us staff spoke with them about their care and explained things clearly to them. Relatives said staff kept them informed of any changes in relation to their family member.

People's independence was encouraged and promoted. The manager told us that one of the people who stayed at the service regularly brought their tools with them and spent time with the caretakers, assisting them with projects. They also mentioned a person who collected their clothes from the laundry to put back in their room. A person told us they had been out into the garden to pick daffodils for the home. Although

the assessment flat was not being used at the time of the inspection, it was available to enable people to gain confidence in living independently, prior to returning home.

We observed and spoke with relatives visiting during the inspection who confirmed they were able to visit at any time. One relative we spoke with told us, "We can visit any time. I am made very welcome."

Good

Is the service responsive?

Our findings

Staff told us they were given a good level of detail about people's care and support needs at the staff handover at the beginning of each shift which enabled them to support people correctly They also said they were able to access and read people's care plans to ensure they knew about people's individual needs.

The care plans we reviewed were generally reflective of the care individuals required. They demonstrated a consideration of the person's individual support needs and the areas of their care they could manage themselves. Some people were admitted for assessment or for a short term stay prior to returning home or to other services. The registered manager had reviewed the care plan format to enable sufficient information to be gathered about people who were admitted for a short period, without unnecessarily adding to documentation for staff. Care plans we reviewed for people who were receiving short term care were clear and concise and contained sufficient information for staff to care for the person safely. Staff told us they added to the care plans as they learned more about the person over time.

Care plans for people using the service that required long term care, contained the necessary information about their care and support needs, but did not always link with their risk assessments and provide an appropriate level of detail about the interventions in place to reduce the risks. For example, a person was at risk of falls. Their mobility care plan stated they should be reminded to use a frame, but did not mention the use of a sensor mat and low bed which was being used to alert staff when the person tried to get out of bed and to reduce the risk of falls. They did have a care plan to ensure the sensor mat was used correctly, but this was not linked with the person's mobility care plan.

Another person had diabetes, but their care plans did not provide information for staff on the signs of low and high blood sugar levels and the action staff should take if the person showed these symptoms. A person had some behaviours that others may find challenging, but we did not see any information for staff on how best to support the person at these times. However, staff were knowledgeable about people's care needs and the appropriate equipment was in place. The registered manager told us they had recently changed the format of the care plans and staff were adjusting to them. They told us they welcomed feedback on the content and format to enable them to improve and would ensure the changes were made immediately.

The service employed activities coordinators who had access to a wide range of resources for people to use. There was evidence throughout our inspection visit of many activities having taken place recently, for example there were large colourful Easter displays in communal areas. We saw people playing dominoes and some people told us they had had their fingernails manicured and painted recently. We saw there was a full programme of planned activities and people told us they had visits from external entertainers. A programme had been developed with a local school and children attended on a weekly basis for an 'after school club' where children and people using the service spent time together, writing letters, exchanging stories and experiences.

The registered manager said they were trying to increase the number of activities they provided in the evenings, including film nights, card evening, and pamper sessions and the range of individual pastimes

tailored to the interests of the people using the service.

There was a garden area for people to enjoy which was well maintained and safe. They had a sensory garden and some of the people using the service participated in maintaining the garden.

People's concerns and complaints were listened and responded to and used to improve the quality of care. The provider had a complaints policy and an easy read version and flow chart were available and displayed within the home. The service had only received one complaint over the previous 18 months. It did not relate to the care or service provided and was not from a person using the service or family member. It was addressed and responded to in timely manner. Residents and relatives meetings were held and we saw people's views were listened to and changes made.

There was no one currently at the home who was receiving end of life care. Staff told us they would involve the wider multi-disciplinary team such as the person's GP and community nurses in planning care for people at the end of their life.

Good

Is the service well-led?

Our findings

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 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 registered manager was aware of their responsibilities under the Health and Social Care Act (2008) and made the required notifications to the CQC. People and their relatives praised the registered manager highly; one relative described the registered manager as a 'diamond' and went on to say, "She's an absolutely superb leader and manager and knows the residents and staff so well." Another relative said, "[The manager] has their finger on the pulse."

People's relatives had confidence in the service and the quality of the care provided. They said they had no concerns about the staff's ability to provide the care people needed and they were always kept up to date with information about their family member's care.

The staff worked in partnership with other agencies to enable people to re-gain their independence and move on to other services or to return home. A visiting professional said, "The service has a good reputation with the team and my colleagues." They praised the quality of the information staff provided and the support they provided when people moved to other services.

The provider promoted and supported fairness, transparency and an open culture for staff. Staff were made to feel valued and this motivated them to do their job well. A member of staff said, "The (registered) manager is really good and can be approached to speak to about anything. I am completely certain that [the registered manager] would act to make people safe if ever a concern was raised, and have seen actions in the past when things have been brought to their attention." They told us the registered manager would also assist with care when needed, rather than people having to wait.

Staff also felt empowered to report any signs of poor practice to the relevant authorities via the provider's whistleblowing process. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it. A member of staff said, "If I had a grievance or if I needed to whistle blow, I could talk to the (registered) manager and they would sort it out. [The registered manager] likes us to go to her with ideas too, and is always around to help us solve problems."

The registered manager and the provider had a number of quality assurance and audit documents that looked at different aspects of the service. We reviewed the results of the audits and saw that when improvements were required, action plans were developed and completed to address the issues. The most recent medicines audit had identified the same issues we found with the labelling of liquid medicines, but there had not been sufficient time to fully address this. We saw other improvements which had been identified and rectified.

The registered manager and a representative of the provider spoke with us about ways in which they were moving the service forward. The service was continually changing as more people were admitted for assessments and short stays and fewer people were receiving long - term care. A wireless network was being installed to allow people to use computer technology to keep in touch with friends and family while in the home. They were also looking at the use of more assistive technology, to monitor people's health and alert staff when the person's health changed.

Regular meetings were held for people using the service, for relatives and staff. We reviewed the minutes of the meetings and saw a range of topics were discussed relevant to the service including the future plans and new developments. Issues and areas for improvement were discussed and feedback given on actions from previous meetings.

The CQC ratings from the inspection in October 2015 were displayed in the front entrance and on the provider's website.