Ashville Care Limited

Ashville Care Home

Inspection report

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Date of inspection visit:
05 September 2017

Date of publication:
12 October 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Ashville Care Home provides personal care for up to 29 older people, some of who are living with dementia. On the day of the inspection, there were 25 people living in the home. Accommodation is provided on two floors with lift access between each floor. There are four communal areas on the ground floor which includes a large dining area.

This inspection took place on 5 September 2017 and was unannounced. At the last inspection on 14 February 2017 we rated the service 'requires improvement' overall and rated the safe domain 'inadequate' due to concerns over medicines management, risk management, safeguarding and the premises. In total we identified four breaches of regulation and issued a warning notice for Regulation 17, Good Governance. At this inspection we found a number of improvements had been made and the service was no longer in breach of regulation. Improvements had been made to the safety of the service, supported by more robust systems in areas such as medicines management and governance. However further refurbishment and decoration work was required to bring the premises up to a good standard. We also found staffing levels were not always maintained at a level to ensure a person centred approach particularly in the absence of an activities co-ordinator. We would need evidence these issues were addressed and the other improvements made were sustained before we were assured the home provided a consistently good service.

A registered manager was 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.

Medicines were safely managed. People received their medicines as prescribed and clear records were kept to demonstrate this.

People said they felt safe in the home. Risks to people's safety had been assessed and plans of care put in place to keep people safe. Staff understood how to identify and act on any concerns. Incidents and accidents were recorded, investigated and analysed to help prevent a re-occurrence.

Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people. We noted staff did not always have time to spend quality time with people and interactions were very task based. The home was without an activities co-ordinator and we noted there was a lack of stimulation and activity available to people.

Since the last inspection a number of improvements had been made to the building to make it safer. Whilst we did not identify any safety concerns, further maintenance and improvement of the building was required to ensure the building was brought up to a good standard.

Staff received a range of training and felt well supported by the manager. Staff knew people well which

helped ensure effective care was provided.

Overall, the service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was sought before care and support was offered.

People were treated with kindness and compassion by staff. It was clear that good positive relationships had developed between people and staff. People were encouraged to maintain their independence around the home. People were listened to by staff and their opinions valued.

People's needs were assessed and clear and person centred plans of care put in place. These were subject to regular review. People, relatives and staff told us they were satisfied with people's needs were met by the service.

The registered manager was hands on and knew people well. They demonstrated a good knowledge of the topics we asked them about and were very involved in how the service operated. Staff praised the registered manager and said morale was good.

Systems were in place to assess, monitor and improve the service. These had been further refined and improved since the last inspection and were effective in identifying and rectifying issues.

We made two recommendations around ensuring staffing levels were maintained at a level that provided people with appropriate stimulation and interaction, and ensuring further improvements were made to the premises.

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.

We would need assurance the previous improvements were sustained before we could rate the domain higher than 'requires improvement.' In addition, we recommended a further review of staffing levels to ensure staffing levels were conducive to people receiving regular stimulation and interaction.

Medicines were managed safely. People received their medicines as prescribed and clear documentation was in place demonstrating the support provided.

Risks to people's health and safety were assessed and clear risk assessments put in place. People said they felt safe and staff understood how to identify and act on concerns.

Is the service effective?

Good

The service was effective.

Staff received a range of training relevant to their role. Staff said they felt supported by the management team.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People had access to a choice of food which people said they enjoyed.

The service liaised with a range of health professionals over their choices.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and were kind and caring.

People were listened to and their choices were promoted and respected.

Where appropriate, people were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Whilst some activities were provided, we found in the absence of an activities co-ordinator, interactions were task based, with people not always provided with stimulation or activity.

People's care needs were assessed and used to develop clear and person centred care plans to help meet people's individual needs.

A system was in place to log, investigate and respond to complaints.

People and relatives knew the registered manager and said they were approachable.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We would need assurance of sustained improvement over time and other inconsistencies in practice to be addressed before we were confident the service was well led.

A number of audits and checks were undertaken by the service. These were used to monitor the performance of the service and were more robust than at previous inspections.

People's feedback was sought and used to make improvements to the service.

Ashville 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was also carried out to follow up on breaches of regulation found at the previous inspection in February 2017.

This inspection took place on 5 September 2017 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

We spoke with five people who were living in the home, two relatives, five care staff, the cook, the deputy manager and the registered manager. We also spoke with a health professional who has contact with the service.

We observed care and support and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at elements of four people's care records, staff files, medicine records and the training matrix.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in February 2017 we had concerns over the way medicines were managed. At this inspection we found improvements had been made driven by changes put in place by the registered manager.

Detailed medicine care plans and profiles were in place for each person. This provided staff with clear and person centred information on the medicines people were prescribed, why they were required and the level of support needed to help the person take their medicines. We looked at a sample of medicine administration records (MAR) which were well completed indicating people had received their medicines as prescribed. Stock checks of medicines were kept and we found all medicines were accounted for giving us further evidence people were receiving their medicines in a safe and consistent manner.

Some people needed medicines as specific time such as before food. We saw these were given effectively. Where variable dose medicines were prescribed, these were appropriately managed to ensure people received the right doses each day. Some people were prescribed "as required" medicines such as for pain relief or behaviours that challenge. Protocols were in place to ensure their safe and appropriate use and their administration was clearly documented. Where people were prescribed thickening agents for their drinks, it was clearly recorded how much they required and staff were aware of this information, giving us assurances they were managed safely.

Since the last inspection, new documentation for topical medicines such as creams had been put in place. These provided clear guidance to staff on why, where and how often to apply these creams to people. Clear administration records were in place, which provided us with evidence people were having their creams applied as prescribed.

Medicines were stored securely within locked medicines trolleys and a fridge, both located within a locked treatment room. The temperature of the storage area and fridge were monitored to ensure medicines were stored as directed.

People told us they felt safe and comfortable living in the home. They said staff were kind and caring and did not raise any concerns about the staff supporting them. Staff had received training in safeguarding vulnerable adults and were able to describe how to identify and raise a safeguarding concern. They all said they had no safeguarding concerns and were confident people living in the home were safe

At the time of the inspection, the local authority were investigating a safeguarding concern which occurred earlier in 2017. The concern prompted the February 2017 inspection of the service where we identified concerns with safeguarding systems and processes. We found safeguarding incidents were not always reported to the local authority and Care Quality Commission and there was a lack of evidence care plans had been reviewed following incidents. At this inspection we found improvements had been made. New systems had been put in place to support better reporting and acting on safeguarding issues. We saw recent safeguarding concerns had been appropriately referred to the local authority and we saw evidence action

had been put in place following incidents to help prevent a re-occurrence.

Risks to people's health and safety were assessed and risk assessments put in place for areas such as nutrition, skin integrity, falls and behaviours that challenge. These had been further developed since the last inspection. For example where bed rails were provided, risk assessment documents and maintenance checks were now in place. Risk assessments were subject to regular review.

Incidents and accidents were recorded and care plans updated following these to help learn lessons. When falls occurred, these were now recorded on a detailed form to allow more robust investigation. Records demonstrated the reasons behind falls and other incidents were investigated to help learn lessons and prevent a re-occurrence. Incidents were analysed on a monthly basis to look for any trends such as the time and location of falls. A report was written analysing the information, which provided us with assurance that the home was committed to reducing the instances of falls. Whilst these processes were detailed, we noted that people's footwear was not considered as a possible factor in falls. We observed a number of people who used the service were not wearing footwear. Staff told us this was because they constantly removed their shoes. We asked the registered manager to ensure footwear was considered in future falls investigation and analysis.

People, relatives and staff told us they thought there were enough staff at all times to ensure people's safety. One person said, "always enough staff for assistance." A relative said "there always seems to be enough staff." A dependency tool was used to inform staffing levels which showed they were enough staff to meet people's needs. Since the last inspection staffing levels had been reviewed and an additional member of night staff placed on shift from 5am, as they had identified a number of people started to become active at this time. We spoke with this staff member who said this had improved staffing levels which were now manageable. During the day there were three or four care staff on duty, supported by the registered manager who was 'hands on' and assisted by undertaking the medicine round and helping out with care and support. Domestic staff, laundry and an administrator were also employed.

During observations of care and support, whilst we saw staff were able to respond to people's requests for support, staff were very busy and interaction was very task based with times when people were left without meaningful stimulation with an over-reliance on the television for entertainment. The home was currently without an activities co-ordinator, however staffing levels had not been revised to provide additional support to compensate for this.

We recommend further review of staffing levels to ensure people are provided with suitable interaction and occupation.

We found safe recruitment procedures were in place. We checked new staff files which provided evidence staff were required to complete an application form and attend a question based interview. Staff had provided two references and undertaken a Disclosure and Baring Service (DBS) check to help ensure they were of suitable character to work with vulnerable people. Recent improvements had been made to the recruitment procedure by the registered manager, for example they had implemented a more detailed application form to gain more detail about candidates.

At the last inspection we had concerns over the home environment with some safety risks not adequately controlled and areas of poor maintenance. At this inspection, we found the specific risks that we found at the previous inspection had been addressed. Safety checks took place on the building to ensure that it was kept safe. This included to the gas and electric systems. A fire risk assessment had been completed in March 2017 and there were a number of risks to address, which had been completed by the registered manager.

Safety features were installed on the building, for example wardrobes were attached to the wall and window restrictors installed to reduce the risk of falls. Whilst we did not identify any safety risks, some areas of the building were tired and in need of general decoration and refurbishment. We saw an ongoing programme of maintenance was in place. For example we were told new dining chairs had been ordered and corridor areas were to be decorated. People's bedrooms were pleasantly decorated and well maintained, and personalised to people's individual likes and preferences. On the day of the inspection, we identified there were a large number of flies within the building which appeared to be coming through the dining room window. This was causing some irritation to people. Staff said this was unusual and not typical of the home. We spoke with the registered manger about this who ordered some fly screens and fly control products to help control the situation. We did note, some of the taps in areas of the building were difficult to operate with some taps difficult to sustain a flow of water without repeatedly pressing the tap which would be difficult for a person with dementia to operate. We saw plans were in place to replace these.

We recommend further redecoration and maintenance of the premises to ensure all areas provide a suitable and desirable area for people to live in.

We saw at the last food standards agency inspection of the kitchen they had awarded them 5* for hygiene. This is the highest award that can be made. This showed us effective systems were in place to ensure food was being prepared and stored safely. We found the building to be generally clean with no offense odours. However, one relative said that although they were very happy with the care and support, the only thing that could be improved was "the cleanliness."

Good

Is the service effective?

Our findings

People and relatives said staff were competent and had the right skills to care for them. We saw there was a low turnover of staff within the home, which meant staff were able to build up knowledge about the people they were caring for.

New staff were required to undertake an induction, complete mandatory training in topics such as manual handling and safeguarding and complete the care certificate. The Care Certificate is a set of standards for social care and health workers which were devised to equip health and social care support workers with the knowledge and skills they needed to provide safe and compassionate care. We checked the training records of three new staff members, which showed they had completed a range of training, and were working towards the completion of the care certificate.

Existing staff received regular training updates such as moving and handling, dementia and safeguarding. Staff we spoke with told us their training was kept up to date and felt the training provided was to a good standard.

Regular supervision and appraisals was provided to staff and they told us they felt well supported. These are some of the things staff told us: "We are supported by management, I can't fault it. We receive supervision and appraisal so we look at what we've done and what we can improve on." "We have good communication and regular team meetings where we can highlight anything." Supervision records were kept electronically, and would benefit from more detail as they were predominately a tick box format.

People said the food was of high quality and tasty. One person said "meals are lovely." A relative told us that the food was very nice and was always prepared at the right consistency to ensure it was safe for their relative to eat. People had a good choice of meals. For example at breakfast time people were offered a choice of cereals, porridge, toast with jam or marmalade and hot and cold drinks. At lunchtime and in the evening there was a choice of two options which varied from day to day. Although we saw people were verbally offered choices at mealtimes, nobody was shown the two options which may have helped people living with dementia make a more informed choice.

We observed the meals which were served at Ashville, they looked a good quality and a sufficient amount of food was provided. People seemed to enjoy their food and this was reflected by empty plates at the end of the meal. For individuals who had a smaller appetite they received smaller plates, the chef explained this was so people didn't feel over faced. We saw some people required assistance from staff with their meal and although this was given with patience and kindness staff did not explain the individual components of the meal. We saw people were provided with snacks and additional food throughout the day, for example buns and cakes were provided mid-morning. One person said they were hungry shortly after breakfast and staff proceeded to make them some more toast.

Where people were nutritionally at risk, we saw their weight was monitored and a nutritional screening tool had been completed. We saw these were correctly completed and appropriate actions taken such as referral

to the GP or speech and language therapy. The cook had a good understanding of individuals need and had their own record of these in the kitchen.

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.

We found the service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to consent to their care and support arrangements, the management had assessed whether the restrictions placed on each person constituted a deprivation of liberty. A number of DoLS applications had been made and three authorisations were in place with others awaiting assessment by the local authority. We saw a well organised system was in place to track when DoLS expired and to ensure any conditions were complied with. Records confirmed where people had conditions these were complied with. This demonstrated the service was acting within the correct legal framework.

We saw staff involved people in decision making and asked their consent on day to day tasks such as what they wanted to eat and what they wanted to do. Where people lacked capacity, we saw evidence that in the most part best interest decisions were held where important decisions needed to be made. These covered areas such as medication, equipment and managing falls in the home. We identified further best interest documentation was needed to demonstrate the home had followed a best interest process for the increased monitoring of people who were at risk of falls at night. Following the inspection, the registered manager provided us with assurances this had been addressed.

Where relatives had a Lasting Power of Attorney (LPA) order in place such as for property and finance, we saw a copy of this order was on file, which meant the registered manager had assured themselves the relative was authorised to deal with these people's financial affairs. This showed us they understood their responsibilities in this area

People's healthcare needs were assessed and appropriate plans of care put in place. We asked staff if they though people's healthcare needs were being met. Staff told us if they had any concerns the nurses were quick to respond and would arrange for GP's or other relevant healthcare professional to visit. One care worker said, "Healthcare is really, really good."
We saw people had access to a range of health professionals including GP's and district nurses and diabetic nurses. Care records provided evidence professionals had been contacted for check-ups and if people's health needs had changed. A health professional we spoke with said they thought the service provided effective care, adhered to their advice and contacted them appropriately. A relative said the service was good at obtaining external advice if needed. They said, "If there is a problem they call the doctor straight away."

Adaptions had been made to the building to assist people living with dementia, albeit the overall

environment was tired and required modernisation. For example, a range of different environments had been created including a bus stop and sensory material and memories were on display. People could walk a route around the downstairs without meeting a dead-end and we saw this route was enjoyed by several people during the inspection. The manager consulted National Institute of Health and Care Excellence (NICE) guidance on dementia and had completed a university course in dementia care as part of a strategy to be up-to-date on the latest and most effective care and support techniques. All staff had received training in dementia.

Good

Is the service caring?

Our findings

People and relatives we spoke with were highly complementary about staff, and the standard of care that was provided. One person said "Its brilliant here, very relaxing for people." Another person said of a staff member "[Staff] is a very nice lady. I wouldn't know what to do without her, she looks after me." Another person said "I get on brilliantly with staff." People reported that staff always treated them with dignity and respect. A relative said, "[Relative] receives fantastic care and support. I have confidence in the staff and the manager is great. Staff always communicate with me, especially if [relative] has had a fall. [Relative] feels very secure here, everything is always done. The thing that could be improved is the cleanliness."

A number of people could not communicate verbally with us. We therefore observed care for several hours in the home including using the Short Observational Framework for Inspection (SOFI). Whilst our observations found there were periods when people were not provided with stimulation and interaction, those that did occur with universally positive. On one occasion, we observed a staff member come into the room, and four people's faces lit up with smiles. There was laughter and friendly conversation between staff and people. Staff responded well to people's individual communication methods whether verbal or non-verbal. It was clear these people felt comfortable and relaxed in the company of staff.

Staff were able to given examples of how they respected people's privacy, for example allowing them privacy in their rooms and maintaining privacy and dignity during personal care. During observations we saw staff knocked on doors before entering and spoke discretely to people about matters concerning personal care.

Staff had developed good, positive relationships with people. Information had been sought on people's likes, preferences and past lives to help provide a person centred approach to care and support. Staff we spoke with demonstrated a good knowledge of the people we asked them about. People were cared for by familiar faces and the relatively low turnover of staff helped develop and build relationships.

People's independence was promoted by the service. For example a number of people managed their own bedroom keys to give them control and independence over who accessed their room. Another person told us they like to help out around the home with cooking and setting tables at mealtimes. Our observation of care, review of care plans and discussions with staff led us to conclude the service was effectively promoting people's independence.

We saw people were listened to by staff and given choice and control over their lives. For example staff regularly asked people how they were and listened to their responses. People were given choices in terms of what they did, where they sat and what food they ate. Staff had recently received training in 'communication approaches' aimed at improving the effectiveness of their interactions with people living with dementia. Staff spoke positively about this training and said it had been valuable. One staff member explained that they had a good relationship with people especially one gentleman. They explained that person couldn't communicate by speech and they has taken time to get to know this individual and the noises and signs he used. Our conversation gave us assurance a good deal of time and effort had gone into building and

maintaining this relationship.

Discussions were held with people about their end of life needs and wishes and this was recorded within plans of care to assist staff to ensure people had a comfortable experience at the end of their lives.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race. We saw no evidence to suggest anyone who used the service was discriminated against and no one told us anything to contradict this. One person who had recently started using the service could use Makaton to communicate. We saw staff were being supported to attend Makaton courses in September 2017 to increase the effectiveness of their communication with the person. This example demonstrated the service was making reasonable adjustments to ensure people's individual needs were met.

Requires Improvement

Is the service responsive?

Our findings

During the inspection, we noted that there was a lack of planned activities for people following the departure of the activities co-ordinator in May 2017. We observed care and saw there was not enough activities to keep people occupied with people often becoming withdrawn or falling asleep. Whilst care staff gave examples of activities they undertook with people such as domino's, cards and other games, we found interaction was very task based. For example we saw the same film playing in both the morning and afternoon in the lounge. When staff interacted with people we saw this was positively received by people, but there were too few interactions observed. One person said "We used to have someone who did activities, but don't know what happened to them." We spoke with the registered manager about this who explained the previous co-ordinator had left in May 2017. We saw efforts were being made to recruit an activities co-coordinator with the registered manager in the process of interviewing a number of people. External entertainers periodically visited the home such as a music man and people who undertook chair exercises with people.

People and relatives praised the care and support provided by the home and said it was appropriate and met people's individual needs. We saw staff checked regularly on people's personal care needs and for example took people for toileting when required. Whilst we found people were generally clean and well dressed, we did note some people would benefit from support in maintaining clean finger nails.

Handovers took place between each shift of staff to help ensure responsive care was provided. Staff informed us that they were all involved with the handover, so all receive the same information. The registered manager showed us a handover record which was a colour coded system, red, amber, green to ensure all risks were highlighted and monitored.

At the last inspection we identified some care records did not contain sufficient detail on people's care needs with generic statements recorded. At the inspection we saw improvements had been made. Care records demonstrated a person centred assessment of people's needs had been carried out. Detailed information on people's likes, dislikes and specific requirements in areas such as activities, personal care, medicines and mobilising was recorded. Plans of care for skin integrity provided specific information to staff on how to manage any risks and equipment, including the setting air mattresses needed to be on. During observations of peoples care and support we saw that staff understood individuals care plans and support needs. Care plans were subject to regular review on a monthly basis or more frequent if needs changed, by the registered manager

Electronic daily care records provided evidence of the care and support provided to each person. We looked at these which were well completed and saw people received regular checks on their health and welfare. A relative told us that their relative was always regularly checked up on when they spent time in their room.

People and/or relatives were also involved in annual care plan review. We saw this was an opportunity for people to discuss any changes needed to their care and support to aid the service be responsive in the care it provided. A relative said "We have a review and I can always have a catch up with the manager."

A system was in place to log, investigate and respond to complaints. We found no complaints had been received since the last inspection, however our review of the system, discussion with people, relatives and staff gave us assurance that these would be appropriately dealt with by the management team. A relative told us "I have never had a cause to complain, [registered manager] is approachable though." The registered manager was "hands on" and known by people and relatives. They were accessible for people to raise any concerns and demonstrated they were committed to ensure people's experiences were positive.

Requires Improvement

Is the service well-led?

Our findings

Following the previous inspection we saw a number of improvements had been put in place. This included new systems for medicine managements and improved care plans. Changes to staff rotas had also been made to allow more scrutiny and oversight of working practices. However, for us to be assured the service was well led we needed assurance that the recent improvements would be sustained and the remaining inconsistencies in quality were addressed. For example, around the environment, and ensuring there were consistently enough staff to allow a person centred approach to care and support.

A long established registered manager was in place. In the most part we found the Commission had been notified about the incidents such as safeguarding. However, one serious injury had occurred within the service in 2017 which had not been reported to the Commission. We reminded the registered manager of their statutory duties to ensure all notifications are reported to us.

People and relatives spoke positively about the overall care experience provided at Ashville. One relative said, "It's not a palace, but the staff are absolutely brilliant. I am delighted with it". People said they felt able to approach the registered manager and staff about any queries or concerns. Staff said morale was good within the service and they were "a happy team." Staff felt well supported by the registered manager and said they would be happy for their own relatives to live in the home.

People, relatives and staff confirmed the registered manager was very involved in care and support. They spent a significant amount of time overseeing the care and support being delivered by staff as well as regularly undertaking care and support tasks. For example, they regularly administered the morning medicines round, including on the day of our inspection, both to take pressure off existing staff and monitor the medicines management system. The registered manager started work at 6.30am each morning. They told us that this enabled them to participate in shift handover, and speak with night staff before they left, as part of a strategy to provide oversight and leadership to the home. They were able to answer all the questions we asked about, this provided us with assurance they had good oversight of how the home was operating. We found they open and honest with us and demonstrated a commitment to address the areas of improvement we discussed with them during the inspection.

A range of audits and checks were undertaken to help assess, monitor and improve the service. These included more extensive medicines audits which looked at medicine stocks, practice, storage and the management of topical creams. We saw there had been effective in identifying issues and making improvements to the service. Issues found were risk categorised using a traffic light system to determining the priorities for addressing them. Audits took place in other areas such as equipment, the environment, accidents and care plans. The electronic care recording system, prompted the registered manager to review and update care plans depending on the agreed frequency of review and helped monitor when people's health appointments were due. This helped the registered manager have an oversight of people's care and support needs.

People's feedback was regularly sought. This was done in both informal and formal ways. An annual

satisfaction questionnaire was sent to people and relatives to ask them about the quality of care provided. We saw the results of the 2017 survey were unanimously positive. In addition, people had been consulted over decoration and the food that the home provided.

We saw the registered manager sought best practice guidance and specialist training in order to stay up to date with the latest dementia care best practice. For example, they consulted NICE guidelines and had completed a university dementia course to further improve the quality of dementia care within the home.