Healthcare Homes (LSC) Limited

Kingsley Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Kingsley Court Care Home 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. Kingsley Court Care Home provides accommodation for a maximum of 85 people. The service has three floors and accommodates people in single rooms each with en suite facilities. The ground floor provides general nursing care for up to 30 older people. The first floor provides nursing care for up to 30 older people with dementia care needs. The second floor provides personal care for up to 25 older people with dementia care needs. Each floor has communal dining, sitting rooms and bathing facilities. At the time of inspection there were 81 people living at the service.

At the last inspection on 11, 12 and 13 November 2015, the service was rated good.

At this inspection we found the service remained Good.

People felt safe living at the service and were safeguarded from the risk of abuse. Staff recruitment procedures were followed to ensure only suitable staff were employed and there were enough staff available to meet people's needs. Risks were assessed and plans put in place to minimise these. The service was clean and fresh and infection control procedures were being followed. Systems and equipment were maintained and serviced at the required intervals to keep them in good working order. Medicines were being managed safely. The registered manager used reflective practice to consider all aspects of the service including events so that where shortfalls were identified lessons could be learnt.

People were assessed before they came to the service and their needs and wishes were recorded and being met. Staff undertook recognised qualifications in health and social care and received ongoing training to provide them with the skills and knowledge to provide good care. People's dietary needs and preferences were identified and being met, including those to meet people's religious and cultural needs. People received the input from healthcare professionals they required.

The service was decorated to provide a homely, dementia-friendly environment for people to live in. People were supported to have 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.

People, relatives, and professionals were happy with the care and support provided to people. People were offered choices about their care and support and staff maintained people's privacy and dignity. Staff understood people's individual care and support needs which they met in a kind and caring way. People's religious and cultural needs were known and respected.

Care records were clear, person centred and reviewed regularly to keep the information up to date. Activities were varied and took place each day and people enjoyed taking part. People and relatives felt able to

express any concerns so they could be addressed. Information about people's end of life care wishes was recorded so this could be followed.

The registered manager was visible in the service and spent time with people, relatives and staff to ensure people's needs were understood and met. They demonstrated good leadership and this was echoed in comments from people, relatives and staff. The registered manager kept up to date with current legislation and good practice, monitored all aspects of the service and worked hard to maintain good standards and make any improvements necessary.

Further information is in the detailed findings in the main body of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Kingsley Court 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.

This was a comprehensive inspection. This inspection took place on 4 and 5 January 2018 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. Before the inspection we also reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection was carried out by two inspectors, one pharmacist inspector 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.

During the inspection we viewed a variety of records including care records and individual risk assessments for eight people, the medicines administration record charts for 30 people and four staff recruitment files. We also viewed risk assessments for equipment, premises and safe working practices, servicing and maintenance records for equipment and premises, complaints and safeguarding records, audit and monitoring records and policies and procedures. We 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 also observed the mealtime experience for people and interaction between people using the service and staff throughout the inspection.

We spoke with seven people using the service, thirteen relatives, the registered manager, the deputy manager, three registered nurses, one team leader, six care workers, an activities coordinator, the chef, the

housekeeper, a laundry assistant and two visiting healthcare professionals. Following the inspection we requested feedback from three healthcare professionals and received feedback from one of them.

Good

Is the service safe?

Our findings

People confirmed they felt safe living at the service and relatives also confirmed that they were safe. Safeguarding policies and procedures were in place and available in the office on each floor. Staff read these and were confident they would raise any concerns so these could be investigated. Staff were confident that the registered manager and provider would take appropriate action. Whistle blowing procedures were in place, however some staff were unsure about the outside agencies they could contact as part of this process. The registered manager said this was covered in the training and would be revisited with staff so they had a clear understanding.

Staff assessed and managed the risks for people living at the service and took action to mitigate these. Each person's care file contained a pre-admission and admission assessment of needs and risks and a range of dependency and risk scores for different aspects of care such as nutrition, skin integrity and falls. There were also risk scores for dehydration and choking/aspiration. These were updated monthly, including weight records and were up to date. Risks associated with medical conditions, environmental or people's mental health were addressed in the relevant care plans and there was clear direction for staff on how to manage and mitigate any identified risk. Allergies were recorded at the front of each care file. People had call bells and people and relatives confirmed these were available and answered when activated.

There was a personal emergency evacuation plan for each person, which specified levels of mobility and the equipment and staff support that would be required in the event of an emergency evacuation such as in the event of a fire. Risk assessments for premises, equipment and safe working practices including fire and legionella assessments were in place and were reviewed annually to keep the information current. Any action points from the various risk assessments were identified and were being addressed. Unannounced fire drills were carried out monthly at differing times to cover the day and night staff and the staff responses had been satisfactory and prompt.

Recruitment processes were in place and being followed to ensure only suitable staff worked at the service. Application forms were completed and included explanations for any gaps in employment. Health questionnaires were also completed. Pre-employment checks included a minimum of two references with one being from the previous employer, a photograph, proof of identity including copies of passports, evidence of people's right to work in the UK and a Disclosure and Barring Service (DBS) check.

We observed that there were sufficient numbers of nursing and care staff to meet the needs of those living at the home. Staff responded promptly if people required assistance and were not rushed when assisting at mealtimes or with personal care, with time to chat to people and their visitors. The majority of people and relatives we spoke with felt there were enough staff to meet people's needs. We received comments about occasional times when more staff would be helpful and the registered manager said that staffing levels were based on people's dependency levels and that this was monitored. Bank staff were available to cover planned and short notice absences and the service only rarely used agency staff. The registered manager explained that recent pregnancy rates amongst the staff had meant that there had been some challenges to cover short notice sickness and they had worked hard to provide cover when this occurred.

All prescribed medicines were available and were stored securely in locked medicines cupboards or trolleys within the treatment room areas. Daily fridge temperature readings were taken and were in within the range of 2-8°centigrade. Room temperatures were also recorded on a daily basis and were below 25°centigrade. This assured us that medicines were being stored at safe temperatures.

People received their medicines as prescribed. We found no gaps in the recording of medicines administered on the MAR charts we viewed. We found there were separate charts for people who had patch medicines prescribed to them (such as pain relief patches), those who were on warfarin (a medicine to thin the blood) and also for those people who had topical medicines such as creams. These were filled out appropriately by staff. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this (in line with national guidance), along with any allergies to medicines that were recorded appropriately. Running balances were kept for all medicines which had a variable dose (for example one or two tablets) and there was a record of the exact amount given, so the efficacy of the medicines could be monitored.

Medicines to be disposed of were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs (CD) were appropriately stored in accordance with legal requirements, with twice daily audits of quantities done by two members of staff. We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. For example, we saw 14 PRN forms for a pain relief medicine. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit.

We looked at three MARs for people who were administered their medicines covertly. We found that they had a best interests meeting and the appropriate authorisation to enable them to have their medicines administered covertly. This assured us that these people received their medicines in an appropriate manner in accordance with legislation and recommended guidance. Medicines were administered by nurses or team leaders that had been trained in medicines administration. We saw a nurse giving medicines to a person and they demonstrated a caring attitude. For example, a person refused their medicines initially but the nurse went back to them and was able to then administer their medicines a short time afterwards.

Procedures were in place for infection control and were being followed. The service was clean and fresh throughout and we saw the domestic staff carrying out their cleaning duties and following the cleaning schedules in place. Staff received training in infection control and protective personal equipment such as disposable gloves and aprons were available for use.

Accidents, incidents or other events were recorded and investigated. We saw reflective practice conversations were held with staff so that lessons could be learnt and practice improved. For example, a recent improvement made was that discharge summaries for people admitted from hospital were included with the MAR chart, which could then be reviewed by the visiting GP and supplying community pharmacy. This had been highlighted from previous medicines audits and showed the provider had learned from medicines related incidents to improve practice. Staff said there were daily handover meetings on each floor to discuss any concerns or incidents and unit managers were able to cascade any shared learning from incidents or accidents and information from the daily meetings held for senior staff.

Good

Is the service effective?

Our findings

People were assessed and care was planned to meet their assessed needs. Each person's care record contained a comprehensive assessment of their needs across a range of different aspects of care including physical, medical, nutritional, emotional, cognitive, social, and cultural/religious needs. Assessments were carried out on admission and this information was used to develop care plans in consultation with the person and their family members, so their wishes were known and included. Information was available to staff so they knew the care and support to provide. One care staff said, "We usually get information from the nurse about new admissions as they do all the assessments. Or new staff can talk to the more experienced staff."

Staff felt they received enough training to give them the skills and knowledge to care for people effectively. One staff member told us, "The training here is really good – you always come out learning and remembering new things even on refresher training." The service had a qualified full time trainer who facilitated the training for staff. New staff completed a five day induction training programme and then they shadowed experienced staff for three days or more, depending on their experience. The trainer had attended a Dementia Friends awareness day run by the Alzheimer's Society and received training and a guidebook for facilitating training. Dementia awareness training was now included as part of the induction training for staff, which the trainer said had positive outcomes for people and staff. The registered manager, trainer and other senior staff carried out observations, for example, the mealtime experience and they then provided feedback to staff and identified any areas for additional training to improve practice. As well as the mandatory training staff had training in specialist topics relevant to people's needs, such as catheter care, stroke awareness and epilepsy awareness.

People and relatives confirmed the food provision was good and drinks were freely available and encouraged. Care plans for eating and drinking which covered information on nutritional status with detail on any special dietary requirements such as a diabetic diet, need for pureed or fortified food and any risks such as difficulty swallowing/risk of aspiration. There was a good level of detail on preferences, any food likes and dislikes and any allergies. For example, one person specified that they preferred small portions, while others stated that they preferred meals to be served in their rooms, so their wishes were known and could be met. Any cultural requirements were noted, for example halal food. There was a dietary notification form in each plan which summarised nutritional/dietary needs. The menu offered a varied and balanced selection of food. Cooked breakfasts were available for those who wished it and there were choices of food at lunch and supper including vegetarian options. People made their food choices on the day although people were able to change their minds if they wished when meals were served.

After admission people were weighed weekly and had their food and fluid monitored for the first two weeks, to get a baseline and ensure they were taking in adequate food and drink. Weight was thereafter monitored monthly along with assessments to indicate nutritional status and track any weight gain or loss and risk of malnutrition. People were referred to dietitians where there were concerns about their food intake and advice and recommendations were recorded in the care plans. Where people needed close monitoring, daily food and fluid charts were seen in the person's daily folder. We checked a sample of these and they

had been well maintained with targets for fluid intake and a calendar to indicate any days where fluid targets had not been met. This information was reviewed by the nurses so the risk of dehydration could be flagged early. Drink dispensers were available on every floor so that drinks were available to people at all times.

There was evidence in all care files of liaison with other agencies involved in the care and support of people including hospital services, local authority assessment and review teams as well as specialist input from a range of health professionals. The service had worked with higher education establishments who carried out research projects in topics including person-centred care and leadership and management. They had also been part of the local authority falls champion and the NHS Foundation Trust pressure ulcer champion training programmes. The staff put their learning into practice and the service had seen a reduction in the number of falls. One of the healthcare professionals fed back to us, "As at 31/12/2017, Kingsley Court had 268 days free of pressure ulcers and that represents harm free care to our residents there. We are very happy with their progress and are working closely with the manager to maintain the continuum and training of staff as required."

People and relatives confirmed that people's healthcare needs were being met in the home. Healthcare professionals confirmed that staff were proactive in referring people for treatment and carried out any instructions. Visits from health care professionals and the outcomes of the visits were recorded and included the optician, chiropodist, dietician, dentist, specialist nurses such as palliative care and tissue viability and details of hospital appointments and relevant correspondence. The GP visited three times a week and as required for consultations or to conduct general health or medicines reviews, and these were also recorded. Each care file contained a 'Care Passport' with an overview of the person's needs, medical history and current risks and conditions. This was a useful document for all staff to read and was sent with the person to hospital so the hospital staff had the necessary information about the person to make a proper assessment of their needs.

The service had two floors for the care of people living with the experience of dementia. The corridor walls were painted as streets, with a telephone box, a letter box and flowers painted on the walls and there was a hedge with artificial foliage. Several areas of the walls and the foliage were tactile and people seemed to enjoy going along the corridors. There were memory boxes outside people's rooms with photographs and other memorabilia to help people recognise their room.

One of the small lounges was being turned into a multi-faith room and the windows had stained glass effect and it was work in progress. Another lounge was going to be turned into a tea dance room and the ceiling had been painted as a sky with clouds and one of the walls had been painted as a brick effect. One person liked to see pebbles on a beach and the lower section of a wall had been papered with pebble effect paper, with a seating area nearby so they could sit and enjoy looking at the pebbles. There were several little seating areas throughout the service with pictures and items to help with reminiscence, for example household items and pictures of royalty, politicians and celebrities of yesteryear.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments and best interests decision forms were available in people's care files. DoLS applications were made and people had been assessed and if a DoLS authorisation had been granted the information was included in the care files. Action to be taken to address any conditions stated in the DoLS authorisation, for example if there was a recommendation to refer a person to see a particular health care professional, was carried out.

Staff were clear about ensuring people were able to make choices about their lives. One said, "We have to allow people to choose what they want if they are able to." There was a comprehensive consent form covering consent to care and treatment as outlined in the agreed care plan, consent to access documentation as required and consent to photographs. The consent form had a section to indicate whether the person had capacity to consent and if not consent had been sought from someone with the legal right to act on the person's behalf. Forms had been consistently well completed and were signed by the person or their representative and by a senior staff member. Some were not dated and the registered manager said this would be addressed.

Good

Is the service caring?

Our findings

People said the staff were caring. One told us, "The staff are good, they all are." Another said, "Yes they are all very friendly." Comments from relatives included, "They are lovely. They are very caring" and "They are very good and kind." People were enabled to live the life they wanted to as much as possible at the service, which also respected the input from their relatives. One relative explained how they helped their spouse in the evening to go to bed and how they watched television together like they would have done at home. We observed a nurse taking time with another relative to find out their family member's care preferences to include cultural and religious needs, offering reassurance that staff could meet these needs and thus respect their wishes.

Staff received training in customer care and team work and in dignity in care. We observed gentle, cheerful and empathetic care throughout our inspection, with staff providing appropriate and attentive care to people. This was extended to relatives and visitors too and the atmosphere was friendly and welcoming, with staff providing sympathetic support and information to family members when needed. Staff were familiar with people's needs and routines and knew how to support and communicate with them. In one case we saw a member of staff conversing with someone in their own language and for another there was a notice with key words in the person's language to assist staff to communicate with them.

Staff were respectful of people's privacy and dignity, knocking on doors before entering, closing doors when providing care, offering people choices and supporting them to spend their time as they wished throughout the day. Staff described the methods they used to ensure that they respected people's privacy and dignity such as offering choice before delivering personal care, explaining what they were doing before helping people and making sure that they were covered as much as possible when assisting with washing and dressing. Staff were careful and unhurried when assisting people to move around the service and were prompt to attend to call bells or other requests for assistance. Staff engaged with different people throughout the day so that no-one was left alone or isolated for prolonged periods. However, where people wished to remain on their own in their rooms this was respected, with periodic visits from staff to check on their wellbeing.

We observed the lunchtime experience on each floor. Staff asked some people if they would like to wear a 'clothes protector' and provided these where appropriate. People were offered a choice of meals, either by staff reading the menu which was available on each table to them or by showing them plated up meals to choose from. Staff listened to people and provided them with the meal of their choice. Ethnic or cultural requirements, for example halal, vegetarian and Asian food, were also met. Where people were reluctant to eat staff gently encouraged them and gave them time to eat their meal. Staff took time to support people with their meals. There was music playing in the background and a good atmosphere in the dining rooms.

Catering staff attended lunchtime service and this was a useful way to obtain feedback of the food served and to talk to people and visitors. The chef also visited people and attended resident and relative meetings at which food choices and menu suggestions could be discussed. In addition nurses or unit managers kept feedback books and communicated any relevant comments to the kitchen and changes were made. For

example, the chef explained that mustard was no longer used as an ingredient in macaroni cheese as a result of people's feedback.

Care plans were person centred and recorded a good level of detail in relation to individual preferences and routines. We saw people were offered choices about what they wished to do or what they wanted to eat and staff were careful to allow them time to express themselves. People we spoke with and their relatives confirmed that people were free to follow their own routines, for example people went to bed and got up when they chose.

Good

Is the service responsive?

Our findings

People and relatives confirmed they were involved with the care records. Care plans were person centred with a clear and detailed description of routines and preferences, for example waking and night routines, food likes and dislikes, clothing and personal care preferences. Preferred names were clearly noted at the front of the care plan as well as preferences for the gender of care staff. Care plans also contained details of daily life, activities and social engagement as well as a comprehensive and detailed section on life history for each person including photographs of their earlier life. These provided a comprehensive picture of each person, their needs and wishes and how to meet these. Six monthly care reviews were carried out with people and their families so that people's needs and wishes could be discussed to ensure they were still receiving the care and support they wanted and to note any changes.

Wound care records were clear and up to date and reflected that where necessary people were receiving the wound care and treatment they required. Daily care records were up to date and people were getting the care and support they required, for example, baths and showers at the frequency they had requested. Staff said they read the care records or were kept up to date by the nursing staff. One told us, "The nursing staff are great They are always willing to make time for you for example if you want to read a care plan and they really want you to improve your knowledge." There were monthly evaluations of each care plan carried out by nursing or other senior staff and the updates were meaningful and clear. Care plan audits were carried out and recorded any actions to be taken with timescales for completion, which were signed off when the staff had completed them.

There was a 'Resident of The Day' system in operation on each floor which involved focussing on a specific person using the service on a rolling basis. This entailed a review of their care records, discussion at the daily senior staff meeting and visits to the person from the chef and housekeeper to ensure all aspects of their care, support and environment were considered and reviewed. People's religious and cultural wishes were recorded and the service had regular input from Church representatives for Christian and Sikh religions and could request input as required for people. Staff took the time to get to know people and their wishes. One care staff said, "We can look at the care plans when we need to but we get to know the residents and what they like to do by talking to them."

Feedback about the activities provision was positive. Comments from relatives included, "They are brilliant. [Activities coordinator] was playing darts with [relative]. [Relative] used to play darts", "She does not join in the activities, but occasionally goes into the main room for the singing" and "They are brilliant. [Activities coordinator] asked me a lot of questions about [relative]. What activities she likes to do. At the Christmas party it was nice to see my [relative] up dancing with [staff]." There was an activities coordinator on each floor and also a schedule of activities for the week. These were varied and people were consulted about their hobbies and interests so staff could plan activities accordingly. The activities coordinators had access to information from organisations specialising in the provision of activities in care settings and used this in their planning.

We saw activities taking place and these were inclusive and staff encouraged people to participate. For

example, a game of floor darts started with people choosing teams and team names, and then the activities coordinator encouraged each person to take part in the activity, including discussing the scoring after each person's turn. The activities coordinators were enthusiastic and provided activities that prompted conversation and memories. People were contributing to the sessions, for example, when handling spices, the smell of cinnamon reminded one person of a particular cultural dish they used to eat. The activities coordinator said they would arrange to get the meal for them to try again. Another session was listening to and naming sounds and this generated animated discussion. An arts and crafts session also took place and people were engaged and enjoying themselves. The activities coordinators carried out one to one sessions for people who did not wish to participate in communal activities. If people did not wish to participate at all this was also respected.

People and relatives felt able to raise any issues they might have so these could be addressed. One relative said, "I would speak to the nurse and she will speak to the manager. There is nothing to complain about." There was a complaints procedure displayed in the reception area and on each floor. In the complaints file we saw that complaints had been recorded, investigated and responded to in line with the procedure.

People's end of life care wishes were ascertained and staff received training in end of life care to be able to provide people with the care and support they needed and wanted at that stage. People were consulted about their care wishes for when their health deteriorated and they were nearing the end of their lives and care plans had been completed accordingly. The level of detail varied depending on people's current condition and there was information on any religious or spiritual requirements as appropriate. There was also evidence in some care records of input from palliative care staff to provide support at the end of life. The registered manager said there were weekly visits from the palliative care nurse specialist and currently people's conditions were stable. For those who did not wish to be resuscitated, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were available in their care records. These had been completed by the GP following consultation with the person or, where appropriate, their representative. People's wishes in respect of resuscitation were also recorded in the end of life care plans.

Good

Is the service well-led?

Our findings

People and relatives knew who the registered manager was and were positive about her presence in the service. One relative told us, "[Registered manager], she has been a diamond to us. It's lovely, they make us so welcome here. If we have any problems we can go straight to [registered manager]." Another said, "Yes [registered manager] is lovely, she is one you can talk to." The registered manager was flexible in her times at the service and would attend at weekends and in the evenings as well as during the weekdays, so she could monitor the service. This gave people, relatives and staff the opportunity to speak with her. Meetings for people using the service were held monthly and people were encouraged to discuss any areas they wished, with minutes recorded and action taken to address any points raised. Relatives meetings were held quarterly, however attendance was very low and the registered manager felt this was because they approached her with any matters for discussion at the time and did not need to wait for the meetings.

All the staff were extremely positive about the service and displayed a sense of pride to be working there. They said that there was an inclusive and supportive working environment at the service with good communication between senior staff and those on individual floors, with no sense of any 'them and us' separation. Their comments included, "There's a good atmosphere in the home. The manager and deputy are both very friendly", "It's a very positive place to work. It's very inclusive and they really try to support your cultural needs and feelings", "I feel 100% valued. I've been hugely supported here. All the staff work very hard and I cannot fault them" and "We're proud of what we do here – a lot of effort has been made to make this a home for our residents." Staff supervision took place every two months and all staff had an annual appraisal and the opportunity to discuss their performance and ongoing training and development. Staff meetings were held every month and there were daily meetings of the heads of department and senior staff on each floor. We attended this meeting on the first day of inspection and the discussions were clear and made sure everyone present was up to date with what was going on in the service and could cascade the information to the staff in each area.

The registered manager held a qualification in management and was undertaking an advanced level management qualification. They had also been involved with a leadership in management university research programme. They also attended local authority managers meetings and a variety of conferences and training days to keep up to date with current good practice and continued learning. It was clear from our discussions that empowering the staff team by providing them with the knowledge and skills to give people the personalised care and support they required was paramount.

The registered manager and the staff were welcoming of our inspection and provided the information we required to evidence the good service that was being provided to people. Each file we viewed, for example, safeguarding, complaints and accidents and incidents had a copy the relevant Health and Social Care Act 2008 regulation and other good practice guidance for staff to refer to. The provider's policies and procedures referenced relevant regulations and good practice guidance and these had all been reviewed in 2017 so the information was being kept current.

The provider followed current and relevant professional guidance about the management and review of

medicines. For example, we saw evidence of several recent audits carried out by the senior staff including safe storage of medicines, fridge temperatures and stock quantities on a daily, weekly and monthly basis.

The registered manager and other senior staff carried out a series of monthly audits including care records, infection control, mealtime experience, health and safety and equipment, kitchen, fire safety, people's weight and nutrition monitoring, accidents and incidents. Where a shortfall was identified an action plan was drawn up with timescales for completion and we saw that these were done and signed for. The registered manager carried out day and night spot checks to monitor the experience for people and to follow up on any issues raised by people and their relatives, so these could be addressed. There were quarterly visits on behalf of the provider and the reports were comprehensive and action had been taken to address any issues identified. The service was well maintained and there was an appropriate budget for materials and equipment to maintain the environment in good order.

The provider did not carry out surveys but rather provided feedback forms and a suggestions box in the foyer and also comment cards for the carehome.co.uk website, where 12 people had provided feedback in the last 12 months. The service had an overall score of nine out of a maximum of 10 and people and relatives had expressed their satisfaction with all aspects of the service. We discussed one criticism regarding a staff matter with the registered manager who was able to provide a satisfactory explanation. The registered manager carried out reflective conversations for any aspects of the service that were audited and monitored so that the findings were discussed, lessons learnt and also so that good practice was identified and praised.

The registered manager worked hard to maintain good contact with other agencies, for example, they had invited stakeholders to the Open Day in June 2017 and several had attended. At Christmas they had run a 'decorate a Christmas Tree' competition and had entries from the local primary school, the GP, the dentist, the pharmacist and the local Church. The entries had been judged by people living at the service and their relatives and on the second day of inspection there was an award ceremony that included the best tree and several other awards for people from events over the Christmas period. This was a very inclusive event and people and relatives enjoyed it. Involvement with university research projects meant the staff had the opportunity to be involved with innovations for care topics relevant to people's care needs. The registered manager was signed up for Care Quality Commission newsletters to keep up to date with relevant legislation and good practice guidance. The activities coordinators accessed information from the National Association for the Provision of Activities for older people to inform the activities provision for people.