Cavendish Care Home Limited

Cavendish 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

Overall summary

The inspection took place on 13 and 14 April 2015 and was unannounced.

At the last inspection on 10 September 2014 we asked the provider to improve the records used to give staff guidance on managing people's risks. In particular risks associated with the management of behaviour that could be perceived as challenging. The registered provider told us they would meet this legal requirement by 30 January 2015. We found these actions had been met.

The service predominantly cared for older people who live with dementia and could accommodate up to 24 people. At the time of the inspection 19 people in total were cared for.

A new manager had started in post in November 2014. They were not yet the registered manager of the service however, they had applied to us to be the registered manager and were waiting completion of this process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found the service had generally improved since the last inspection in September 2014. People were safe because risks relating to their health and care had been identified and were appropriately managed. This included the improved guidance for staff in relation to managing behaviours that could be perceived as challenging. People were protected from abuse and their human rights were upheld. Environmental risks were managed and any shortfalls were addressed. Accidents and incidents were monitored and a more focused approach to addressing these had resulted in a decline in reoccurrences. There were enough staff to meet people's needs and staff recruitment practices protected people from those who may not be suitable to care for them. People's medicines were managed correctly.

Staff received training and support in order to meet people's needs. Some improvements had been made to the support staff were receiving. Staff knew what was expected of them and appropriate action was taken if staff did not perform appropriately. Best practice was promoted and advice was sought from other professionals when needed. People had access to health and social care professionals in order for their needs to be met. People who required support with their eating and drinking were provided with this. People who lacked mental capacity were protected against discrimination and poor practice because the service adhered to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Adaptions to the environment had been made to improve the well-being of those who lived there.

People were cared for by staff who were kind and compassionate. Staff demonstrated a real passion for improving the lives of those who lived with dementia. They were patient and understanding of people's individual needs. People were treated with respect, dignity and afforded the privacy they were entitled to. Staff gave explanations and guidance to people in a way that they could understand. People who mattered to those who were receiving care were also supported and made to feel included. Those who did not have family support and who lacked mental capacity were provided with independent advocacy when significant decisions needed to be made. People's independence was supported where possible.

Care was delivered in a personalised way meaning staff saw the person as an individual. People's care plans reflected this approach and were maintained well so that staff received up to date information about people's needs. People's needs were reviewed and the care delivery altered accordingly. Opportunities for activities that were meaningful to the individual taking part had improved. All staff understood the importance of engaging people and providing them with the appropriate level of stimulation. People's life histories, wishes and choices were listened to and incorporated into people's plan of care. There were opportunities for people to express their concerns or make a complaint, although the new manager had not received any since being in post.

People lived in a service that was well-led. The culture had improved and staff were happier, generally more supported and included in how the service was run. This came with additional responsibilities which included supporting the manager's visions and values and performing in a way that was expected of them. People's representatives were also included and their views were sought on how to improve the service further. The quality of the services provided were monitored by both the manager and the provider. Actions were taken to address any shortfalls, promote further improvement as well as best practice.

Summary of findings

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 was safe.

People were protected against risks that may affect them because health related and environmental risks were monitored, identified and managed.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse and their human rights were upheld.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Good

Is the service effective?
The service was effective.

People received care and treatment from staff who had received training and who were supported to meet people's needs.

People's rights were protected under the Mental Capacity Act (2005) because staff adhered to the legislation.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

People's health care needs were met and they were supported to attend health related appointments.

Good

Is the service caring?
The service was caring.

People were cared for by staff who were caring and compassionate and people were treated as individuals.

Staff were adopting a person centred approach to care and were being supported to deliver this.

People's dignity and privacy was maintained.

Staff helped people maintain relationships with those they loved or who mattered to them.

Good

Is the service responsive?
The service was responsive.

People were involved in making decisions about their care. Where people were unable to do this their representatives did this on their behalf.

Care plans were personalised and the care delivered was in line with these.

People had opportunities to socialise and partake in meaningful activities.

Good

Summary of findings

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led.

People's care records and other records were well maintained and managed appropriately.

Senior staff promoted a personalised approach to people's and there was an open and inclusive culture. People were encouraged to express their views about the service.

People were protected against poor services because there was a robust quality monitoring system in place. The management team also had plans in place to improve the service further and to ensure best practice was adopted.

Cavendish Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 14 April 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service. This included information about significant events reported to us by the provider. We gathered information from the local County Council who commission with the service.

During the inspection we met several people who used the service but only two were able to tell us a little about their experience of the service. We therefore gathered information about people's experiences in other ways. 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 to us. We also spoke with one relative and one visiting professional. We spoke with seven members of staff. We reviewed the care records of six people. These records included their care plans, risk assessments and medicines administration records. We looked at additional care records such as weight monitoring and food intake charts.

We also reviewed four staff recruitment files and the staff training record. We reviewed a selection of records relating to the management of the service. These included a selection of audits, maintenance records, policies and procedures and accident and incident records. The service's registration certificate was on display as was the current employer's liability insurance certificate.

Good

Is the service safe?

Our findings

Prior to the inspection we received information of concern that there were not enough staff to meet people's needs, that agency staff were not being used to support depleted staff numbers and people's medicines were being administered by staff who had not been trained to do this.

People's needs were met by sufficient numbers of staff. The manager told us they were constantly reviewing how best to use the hours allocated by the provider in an innovative and effective way. Therefore adjustments had been made regarding how hours were used in various areas of the service. For example some hours originally allocated for cleaning and to the kitchen have been reduced. However, a gradual increase in the hours allocated to activities were now open for discussion between the manager and the provider.

The service required additional night staff and were advertising for these. Instead of using agency staff and in order to keep familiar faces in the home for those living with dementia, the manager had worked various night shifts and other staff had agreed to work additional hours. A change in how staff approached their work, a reduction in set routines and a collective approach to personalised care had resulted in people's needs being met in a better way despite the drop in some allocated hours. Staff absences due to sickness were being more closely monitored and managed. One member of staff told us that the home had gone through a period of time, before the new manager arrived, where care needs had been higher and the number of staff had not been increased to accommodate this. Another member of staff spoke to us about some of the changes in the way they now work and said, "I know we have some empty beds but even with that and no more staff, more seems to get done". Another member of staff said, "(manager's name) is so supportive, he comes out and helps when we need help".

People were unable to talk to us about their medicines because they lived with dementia. People's medicine administration records, the manager's recorded quality monitoring checks and our observations confirmed that people received their medicines appropriately. Current staff training records showed that those who administered medicines had been trained to do so and the staff member's on-going competency in this task was checked. Medicines were stored correctly and in line with relevant guidance for care homes. Reviews with appropriate health care professionals as well as health care specialists ensured people were not subjected to excessive or inappropriate control through the use of medicines. For example, mental health specialists supported and advised staff on how to manage behaviour that could be perceived as challenging, in the least restrictive way.

Medicines to be used 'when required' did not have additional guidance for their use for staff to follow. On the first day of the inspection we recommended that the National Institute for Health and Care Excellence (NICE) Guidance, for Managing Medicines in Care Homes be followed in relation to this. On the second day of the inspection we saw evidence that this had been completed. The day after the inspection the manager wrote to us and confirmed that this guidance would be put in place, when needed, in the future. Staff were confident in using people's prescribed medicines appropriately. For example, two staff discussed the options open to them when one person showed further signs of distress from pain after being administered some medicines already for this. The use of a further option was checked by both members of staff and administered safely.

People were kept safe because the service had policies and procedures in place which were designed to do this and which were followed by the staff. People were protected from abuse. Staff had been trained to recognise abuse and report any incidents of concern. The service's policy and procedures on safeguarding people linked into the local County Council's wider protocol for protecting people. The service therefore appropriately shared information with relevant agencies in order to safeguard people. Staff told us they knew how to and would feel confident in, raising concerns they may have about other staff or the service generally. People were protected from discrimination which might amount to abuse or cause psychological harm.

People were protected from those who may be unsuitable to care for them. Staff recruitment records showed that appropriate checks were carried out on staff before they started work. The new manager had used appropriate procedures, when needed, to address poor staff performance and practice.

Assessments were carried out in relation to people's risk of developing pressure ulcers by using a recognised assessment tool. Depending on the outcome of the

Good

Is the service safe?

assessment people were provided with different types of pressure relieving equipment and appropriate care. For example, pressure relief mattresses and cushions, help to reposition themselves and support from visiting Community Nurses if required.

Some people's individual activities were supported by the staff so they could continue to enjoy these safely. Well documented care plans and risk assessments outlined how individual risks would be managed in the least restrictive way. For example, some people's cigarettes and lighters were kept by the staff for fire safety reasons but, people had access to a cigarette when they wanted them.

Arrangements were in place to minimise environmental risks. For example, a fire safety risk assessment had been completed by a person qualified to do this and their recommendations were followed. For example, items such as those used to maintain the premises such as paints were stored appropriately. Other regular maintenance checks and servicing of equipment was carried out in order to keep people safe. An untoward emergencies contingency plan was in place.

Accidents and incidents were monitored and likely risks associated to these identified. The service had worked closely with the local health care professionals to reduce the numbers of falls taking place. Records showed that between December 2014 and March 2015 falls had reduced quite significantly.

Good

Is the service effective?

Our findings

People were unable to tell us about how their health needs were met because they lived with dementia and were unable to discuss this. One visitor told us they were very happy with the care provided to their relative.

Prior to the inspection we received information of concern that people were not receiving the food that was recorded on the service's menus or adequate support to eat their food. We found that there had been problems adhering to a four week rolling menu. This was because the stock of food was not always the same as required for the menu. Arrangements for how the menu was devised and how the shopping was done had therefore been altered. The menu was now decided a week ahead and the appropriate shopping carried out. We reviewed the menu and records of what people had been provided with for a week prior to the inspection. These matched each other apart from where a person had either specifically requested something else or where a person had refused their meal on the day. In each case they had been provided with alternatives.

People were provided with the support they required to eat their food and to drink. Care Plans and risk assessments also highlighted where people's particular risks were in relation to this. One person was having their food and fluid intake monitored more closely as they were at particular risk of not eating or drinking enough to sustain their well-being. People's weights were being monitored and where people had lost weight, their GP had been made aware of this and the situation monitored or addressed in another way. We spoke to the chef about how they fortified people's foods. Although they had been told that all food had to have additional fortification, so they were adding extra butter and cream to for example, mashed potato, they had not been provided with specific training on how to fortify foods and why this was necessary. This was fed back to the manager who acknowledged this as a training need and said they would organise this to be provided. One person was refusing food on a regular basis. Staff were looking into how they could provide this person with the foods they were used to eating and which met their specific needs.

People's needs were met by staff who had completed varied levels of training. The service's training record showed the provider had used a mixture of external training, workbooks and electronic learning modules to train the staff. All staff completed an induction training when they first started work. A basic awareness of dementia care, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, safeguarding people, safe moving and handling, infection control and various areas of health and safety were covered. The provider's policies and procedures were looked at during this training. The majority of staff had received further training in subjects such as safeguarding adults and dementia care. Although only four out of 23 care staff had completed further training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, when we spoke to staff about the latter they understood that people could not be deprived of their liberty unlawfully. However, they were unsure of the process that needed to take place to deprive someone of their liberty lawfully. One senior care assistant had a better understanding of this process. The manager was aware of this and had planned to address this training need.

Eight staff had received further training in "Coping with Aggression and/or Challenging Behaviour". The manager had worked closely with staff to improve their understanding of behaviours that could be perceived as challenging. We noticed a marked improvement in the well-being of people with these behaviours and how staff managed these compared to our last inspection in September 2014. Staff told us they felt more supported and able to manage these behaviours. Only one or two staff had completed training in additional and relevant subjects such as end of life, nutrition and diabetes. Whilst this was recognised by the manager as needing to improve the staff received guidance on delivering people's care from the manager who was experienced and held qualifications in care and from the senior care assistants. Five other staff, including some senior care assistants held a recognised qualification in care. Other staff had either already been enrolled or were being encouraged to enrol for training in nationally recognised care qualifications. The manager told us they had identified a need for staff to be better supported and for their knowledge to improve. They had started to develop ways of achieving this and were also looking at how they would implement the newly required Care Certificate for new staff. Staff competencies were checked in some areas of care and in particular medicine administration, but this process was also to become more robust in other areas of practice.

Good

Is the service effective?

People unable to provide consent for their care and treatment were protected under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission monitors the implementation of the Mental Capacity Act 2005 and DoLS. Staff explained to us that people's ability to give verbal consent varied. They said people usually gave implied consent, meaning rather than verbally giving consent they demonstrated in their behaviour or action that they agreed to receive their care and treatment. Where people had been unable to provide consent for significant decisions, such as being admitted to the care home, records showed that the appropriate process had taken place to do this lawfully. In two people's cases an authorisation had been applied for to deprive the person of their liberty and to ensure they remained in the care home to receive the care and treatment they required. One DoLS authorisation had been formally received. During the inspection a visit was carried out by an Independent Mental Capacity Assessor (IMCA) to check if the terms of the DoLS were being adhered to. The other person had already been assessed by an appropriately appointed doctor as not having the mental capacity to agree to their admission. DoLS had been agreed in principle but staff were waiting for the authorisation paperwork to come through from the local authority (the supervisory body).

People's records demonstrated that their mental capacity had been assessed. One person's records demonstrated they lacked mental capacity to give consent for staff to deliver personal hygiene care. The care plan outlined the risks to the person if this was not delivered, this included damage to their skin from body fluids. It also outlined how this person's care would be delivered following a best interest decision that the person's personal hygiene needs could not be neglected. On the day of the inspection staff had planned to bathe this person. It took several attempts to get the person to agree to enter the bathroom. Once in the bath they were distressed and verbally abusive to the staff. Staff spoke to the person in a reassuring way and did not react to the verbal abuse. Staff maintained the person's dignity as best as they could and carried out the bath as quickly as possible. After the bath staff supported the person to feel calm again which was quickly achieved.

The manager confirmed that since they had been post they had reviewed other people to ensure the service was acting lawfully in light of the clarification given on the Deprivation of Liberty Safeguards legislation by the Supreme Court in March 2014. This clarified what may constitute a situation whereby someone can legally have their liberty taken away and this referred to the levels of control and supervision people were receiving. As a result they had made further referrals to the supervisory body.

People had access to health care and adult social care professionals when needed. People were supported to attend health related appointments. One person had been supported by staff several times to attend a hospital appointment but the person had refused the required examination. Hospital appointments were still provided in case the person agreed, on one of their visits, to be examined. In the meantime their health needs were managed by their GP through discussion with their hospital Consultant. The service had good arrangements in place with local GP surgeries who visited when needed. Community Nurses provided nursing care or specialised assessments. For example, they carried out wound care or visited if staff required a person to be assessed for

pressure relief equipment. The Community nursing teams also became involved in the care of people at the end of their life. For example, they would ensure people who wanted to spend the end of their life in the care of the care home staff, received their end of life medicines appropriately and safely. People also had access to professionals that delivered foot, eye and dental treatment.

Areas in the home provided visual stimulation for people in order to help them make sense of their surroundings. A fish tank had been a new purchase since our last inspection in September 2014 and had been placed in an area just outside one of the lounge areas. The manager explained that this provided a calming effect on one person in particular and was generally enjoyed by others. The manager informed us they had been granted financial support by the provider to turn a specific room into a sensory room. This would offer people gentle and controlled stimulation of the senses (sight, sound, touch, taste, smell and movement). Stimulation could be increased or decreased to match the interests and therapeutic needs of the person. The garden space had also been made more visually stimulating and was used on a regular basis when the weather permitted.

Good

Is the service caring?

Our findings

One person said, “It’s nice here, they (the staff) are friendly”. Another person told us the staff gave them help when they needed it and told us they were kind.

Staff were observed to be kind and compassionate when delivering people’s support. Staff were very patient with people who repeated themselves, explaining to them, sometimes several times over, the same thing in the same reassuring tone of voice. Staff also used diversional tactics to help people move away from situations or behaviour that was causing them distress.

People were seen by staff as individuals with different needs and the care they delivered was personalised. The staff knew the people well, what their likes and dislikes were and what would trigger positive and negative reactions from people. People’s life histories, preferences and what was important to them had been sought from family members and recorded. The ‘This Is Me’ document by the Alzheimer’s Society had been used to record this and a copy had been placed in people’s bedrooms for staff to reference. When we looked at people’s care plans, some of this information had been used to plan care that was specific to the individual. A personalised approach to care had been promoted by the previous manager of the home, but staff had been given a lot of support by the new manager on how to deliver this. One member of staff said, “We realised that not everyone has to do things or wants to do things at set times, like going to the toilet at 12 midday before lunch. They can want to go at anytime and it is actually alright for us to take them at anytime”. Another member of staff said, “It is a different place to work in since (manager’s name) has been here. People are less agitated and I think that is because the staff are more relaxed and we are working around them and not the other way round”.

People were supported to make decisions about their daily care and daily activities as and when they were able to do this. Several people were able to make simple day to day decisions which included when they wanted to get up, what clothing they wore, where they ate, spent their time and what activities they wanted to take part in. Staff were observed listening to people’s answers and accommodating their wishes. When people wanted to be and when they were able to be independent staff supported them. For example, we observed people being able to use the garden when they wanted to. One person told us they really enjoyed being able to sit in the fresh air and the sun, when they wanted to do so. Where people were unable to make decisions about their day to day activities people who knew them well, such as family members, were involved in this. People who mattered to those that were receiving care were welcomed and actively supported to maintain a relationship with their relative or friend. One relative told us they had carried out some research into their relative’s illness so as to better understand it, but they had found the staff to be really supportive and helpful in doing this.

There were no restrictions on visiting except when this had been authorised as part of safeguarding the person or a best interest decision had been made in relation to this. People who did not have family or representatives to help them make important decisions were appointed an Independent Mental Capacity Assessor (IMCA).

People were treated with respect and their privacy was maintained at all times. We observed this being carried out in simple ways. For example, one person took themselves to the toilet but did not close the door, so staff did this for them as soon as they were aware of the situation. One member of staff was observed to pull down a person’s skirt which had become caught in their underwear. This was managed in a kind way and in a way where quiet humour was used to reassure the person. One person had a specific care plan which identified the need for staff to maintain the person’s dignity whilst they were in bed. Their bedroom was along a main thoroughfare and the person preferred the door to be open. Staff had completed relevant training on the subject and to further promote this in practice, the new manager had introduced the National Dignity Council’s 10 steps to dignity in care. All staff had signed up to this and how the steps could be embedded into the staffs’ practices were being discussed in staff meetings and one to one support sessions.

Good

Is the service responsive?

Our findings

People's care records included care plans and these were all kept secure. Where it had been possible for people to be involved in the planning of their care they had been, but most records told us that family members or representatives were predominantly involved in doing this. One relative confirmed that other family members had been very involved in this process on behalf of their relative. Records showed representatives were also updated with changes in their relative's care or health.

Care plans had been personalised to reflect people's different needs. The care which we saw delivered was usually in line with the person's written care plan. Care plans and other care records such as risk assessments had been reviewed, monthly, as expected by the provider. This ensured staff received up to date guidance from the person's care plans and risk assessments. One person's care plans contained guidance for staff based on the information given to staff on the person's admission. Some areas of this information needed updating as different issues had been identified since admission. For example, there was no reference to the person's chosen form of communication, which was now quite evident and no reference to some dietary needs that had been identified since admission. Despite the need for some adjustment in these care plans the person's needs were being met. Other care plans for this person had been updated when specific interventions and actions had taken place. For example, in this person's case, to alleviate distress caused by a misinterpretation of what they were seeing, caused by their dementia.

Staff also attended a hand- over meeting at the beginning of each shift, which ensured they were kept up to date with important information or changes in people's abilities or care. These meetings were particularly helpful to staff if they had been on days off and changes had occurred.

We did not see any recorded evidence of care plans being reviewed with people's main representatives. We discussed this with the manager and we were informed that relatives were generally not keen to carry out a set review of their relatives' care with the staff. Following our inspection visit the manager sent out formal invites to people's representatives. The review could be done face to face or by telephone and would give the representative the opportunity to express their views and thoughts about people's individual care delivery. It was planned that this invite would be sent six monthly. We were told that when any review of a person's care took place with a relative, however informal, this would be recorded in the future.

People were being supported to socialise and partake in activities that were meaningful to them and which they enjoyed. The activities co-ordinator belonged to a local forum which promoted a whole home approach to activities. This meant all staff understood the value of meaningful activities, promoted this and were supported to be involved. During the inspection an external activity provider led an exercise group helped by the activities co-ordinator. Other staff provided help to those that required more support. This resulted in this activity being meaningful to people with different abilities. Space had been made to accommodate activities in each lounge area and we saw a significant improvement in how these had been generally promoted, delivered and enjoyed by people since our last visit in September 2014.

People had the opportunity to raise their concerns and complaints about the service. There was a complaints policy and procedure which people received information about when they were admitted. The complaints procedure was visible within the service and the manager operated an open door policy. A relative told us they knew how to raise a complaint but had not needed to do so, so far. No complaints had been received since the new manager had been in post. They were unaware of any having been received since our last inspection in September 2014. The manager informed us that any concerns or complaints received would be taken seriously and used as an opportunity to reflect on the services provided and improve them.

Good

Is the service well-led?

Our findings

The manager had made improvements to the service in the five months they had been in post. They demonstrated that they had strong leadership skills and staff were happy to be working with them. Staff told us the home had changed since this manager had arrived. One member of staff said, "I now actually enjoy coming to work, it is so much better". Another member of staff told us how supportive the manager had been in sorting out issues and supporting the staff.

The manager told us they had been very clear with the staff about their vision for the service, how they intended to implement this and what values and behaviours they expected. This had been done through regular staff meetings, by working with the staff and during one to one staff support sessions. The manager had been aware of the main challenges and risks they faced in promoting these. They had put together a team of senior care assistants who supported this vision and their values and who would help them promote and implement these. Where staff had not been able to support the service moving forward appropriate action had been taken. This had resulted in some staff turn-over but this was now settling.

Staff had been issued with reviewed and revised job descriptions. Their roles and the manager's expectations had been explained to them. We found senior care assistants to be more empowered and confident in their roles. Staff were following the senior care assistants' instructions and were working more as a team. The atmosphere was generally happier and more relaxed.

The manager was well supported by the provider to promote their vision and values and regular support meetings with a representative of the provider had been set up. This enabled the manager to feedback their progress and get the support they required. The manager was still going through their own probationary period so this time was also used to monitor their performance. The manager was also completing further qualifications in leadership and management and in dementia care.

The manager explained that the actions required to move the service forward had included a review of the staffing hours allocated by the provider and improving staff morale and team working. More robust management of staff absences and staff sickness had also taken place. Other actions included improving the standard of care by supporting staff to deliver personalised care and providing more meaningful activities for people. They told us they had made some progress in all these areas. The manager told us there had been three main achievements so far, which were a decrease in the levels of distress and agitation experienced by people. This had been achieved by introducing the correct behaviour management strategies and supporting staff to implement these. Secondly, an improvement in staff morale and thirdly an improvement in stimulation and activities for people. We were able to confirm that this was the case during the inspection.

In order for these improvements to be embedded and sustained successfully quality monitoring checks took place. Both the provider's representative and the manager carried these out so that shortfalls and further required improvements could be identified. The manager completed their own audits on various systems in the home and monitored the accuracy of the records maintained. They also completed the provider's rolling program of audits. They put actions in place to address any identified shortfalls or to implement additional improvements they wanted to make. A report was then submitted to the provider. We reviewed a selection of the quality audits completed. These included a medication systems audit, fire safety audit and grounds and maintenance audit. The latter did not show dates for completion of the actions recorded. The provider's representative explained that the actions resulting from this audit were managed by another Director who held the budget for all maintenance issues. This Director organised the completion of all maintenance jobs. There was evidence of a lot of refurbishment having taken place in the last year and we were informed that this was on-going. The manager explained that any immediate maintenance issues were addressed swiftly by the provider. People's care and treatment was monitored by the manager, both through an audit process but also by the manager carrying out hands on care and working alongside the staff. Monthly quality monitoring visits by the provider's representative went through the manager's recorded actions and either signed these off as completed or waiting for completion. In-between these meetings the provider's representative visited and spoke with the manager on a regular basis.

Views on the service were sought predominantly from people's representatives. An annual satisfaction

Good

Is the service well-led?

questionnaire was used to gather feedback and the manager also did this during informal discussions with people's representatives. Satisfaction questionnaires had been sent out in March 2015 and six had been received back so far. These had asked people to give a rating of 'poor', 'fair', 'good' and 'very good' to various questions. The questions focused on key areas; the environment, cleanliness, care, staff, food, activities and raising concerns. The responses so far all indicated ratings of 'good' or 'very good'. The manager told us he may also use the questionnaire method in the future to gather feedback on more specific areas that they may want to focus on.

The views of the people who used the service were gathered in a more informal and more immediate way. This was done when people were actually experiencing what it was that the staff wanted the feedback on. For example, they sought people's views on an activity or a meal when people were actually taking part. This feedback was recorded and helped staff plan future activities and meals around those which they knew people had previously enjoyed.

The manager told us they were currently organising for appropriately trained professionals to carry out a dementia mapping process. This process is well established in helping to embed a personalised approach to care and is recognised by the National Institute for Health and Clinical Excellence (NICE). As part of their quality monitoring process and wanting to embed best practice, they particularly wanted the mapping process to provide them with information on people's engagement with activities and the quality of staffs' interactions when following behaviour management strategies.

The manager had kept us informed of all significant events as required under the relevant notification process.