Four Seasons (Bamford) Limited

Kingswood Care Home

Inspection report

Wotton Road
Kingswood
Wotton under Edge
Gloucestershire GL12 8RA
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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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

The inspection was unannounced. Kingswood Care Home provides residential and nursing care for up to 45 older people. At the time of our inspection there were a total of 34 people in residence, 24 who needed nursing care and 10 people who needed residential care (personal care). All bedrooms were for single occupancy and the majority of rooms had en-suite facilities. One side of the home is a converted older house and the other part is purpose built.

The registered manager for the service had recently left and a new home manager had been appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The new home manager had already started the process of applying to be the registered manager.

People were kept safe because the home manager and the staff team were all knowledgeable about safeguarding issues and protected people from harm. They knew how to raise and report concerns if they witnessed, suspected or were told about any bad practice

Summary of findings

or abuse. All staff had received training in safeguarding adults. Medicines were administered to people safely and appropriate action had been taken to rectify the poor work practice we witnessed during our last visit.

Risks were assessed and appropriate management plans were in place. All the appropriate checks to maintain the premises and facilities had been completed regularly. Where people needed to be assisted to move, their moving and handling needs were assessed and a moving and handling plan was written.

Staffing numbers on each shift were calculated to ensure each person's care and support needs could be met. Staff were provided with regular training and were supported by their colleagues and their managers to do their jobs.

People were on the whole satisfied with the quality of the food and drink provided. Food and fluid intake was monitored where risks of weight loss or dehydration had been identified. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

The relationships between staff and people who lived in the service were good and staff spoke well about the people they were looking after. Relatives talked about caring and friendly staff. People's privacy and dignity was maintained. Where possible people were involved in making decisions about their care and support. Families were included where this had been agreed upon.

People received care and support which met their specific needs. They were encouraged to express their views and opinions, the staff listened to them and acted upon any concerns to improve the service. Improvements were required to ensure that plans for end of life care and do not resuscitate decisions, were recorded correctly. This would remove the potential of people receiving the wrong care and treatment.

The management of the service had improved with the appointment of a new home manager who was keen to use feedback from the staff and people who lived there to make positive changes. The staff team talked about better leadership and feeling more positive about their jobs. The quality of service provision and care was monitored and there was an on-going improvement plan in place to raise the quality of the environment and improve experiences for people.

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?

Good

The service was safe.

People said they felt safe. Staff were aware of their responsibilities to safeguard people and to report any concerns.

Risk assessment were completed where risks had been identified and were kept under review. All appropriate checks were completed to ensure the premises and facilities were safe. Medicines were managed safely.

Safe recruitment procedures were followed at all times to ensure only suitable staff were employed. The number of staff on duty ensured people's care and support needs could be met.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were well supported. Staff received training to ensure they had the necessary knowledge and skills.

People were provided with sufficient food and drink and supported to eat and drink where needed. Where people were at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

Staff sought consent from people before helping them and where people lacked capacity, they followed best interest processes. People's rights were properly recognised, respected and promoted. The service was meeting the requirements of the Deprivation of Liberty Safeguards.

People were supported to access healthcare services and to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated with kindness and the staff treated them with respect. Their privacy and individual needs were respected.

People were positive about the way they were looked after and were at ease with the staff.

People were encouraged to be as independent as possible but staff provided the support people needed

People were looked after in the way that they wanted and the staff took account of their personal choices and preferences. People were involved in making decisions about their care and support.

Summary of findings

Is the service responsive?

Requires improvement 

The service was mainly responsive.

People received the care and support they needed and this was adjusted in line with any changes. Information recorded in care planning documentation and about decisions of resuscitation status need to be improved.

There was a programme of meaningful activities for people to participate in and links had been made with local schools and other local facilities. The manager had clear plans to improve activities further.

People told us staff generally responded to any comments they made and that concerns they had were dealt with.

Is the service well-led?

Good 

The service was well-led.

People, relatives and staff felt the service was well managed. The new home manager was visible within the service. Opportunities to gather the views and opinions of people living in the service, relatives and the staff team had been re-instated.

Regular audits and checks were carried out to monitor the quality and safety of the service.

Kingswood 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

When we inspected the service in October 2014 we found there were three breaches of legal requirements. These were in respect of the management of medicines, insufficient staffing numbers at all times and inadequate care records. Due to the number of concerns we had at the inspection we have completed a further full inspection of the service and not just checked that the provider had taken the appropriate action to meet the relevant requirements.

The inspection team consisted of one inspector. Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications the provider had sent to the CQC. A notification is information about important events which the service is required to send us by law. We had not asked the provider to submit their Provider Information Record (PIR) as this was the second full inspection of the service in 12 months. We looked at the action plan the provider had sent us following the last inspection. In this they told what improvements they were going to make in to rectify the breaches.

We contacted two GP services, the Continuing Health Care healthcare professionals and the local authority quality assurance team as part of the pre-inspection planning process.

During the inspection we spoke with 14 people who lived in the service, five relatives and 11 staff members (including the registered manager and deputy manager). We looked at six care records, two staff recruitment files, training records, staff duty rotas and other records relating to the management of the service.

Not every person was able to express their views verbally. We therefore undertook a Short Observational Framework for Inspection session (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the service.

Good

Is the service safe?

Our findings

People said, “The girls help me and are always around”, “The staff make sure I am safe when I am walking”, “I am not worried about anything living here” and “Everyone is very kind to me. They are very patient with me, I can be very slow”. Relatives we spoke with said, “I have no concerns about how my father is looked after”, “The staff are excellent and I have no concerns. They do their very best at all times” and “When I am not here I am sure that my mother is well looked after. She would tell us if she wasn’t being well looked after”.

All staff received safeguarding training. This was included as part of the essential training programme and was delivered by a computer based learning programme and a workbook that had to be completed. Those staff we spoke with had good awareness of safeguarding issues and told us they would report any concerns they had about people’s safety to the manager, deputy manager or the nurse in charge. Staff were able to tell us what constituted abuse and how they might recognise if a person was being harmed. The majority of staff knew they could report directly to Gloucestershire County Council safeguarding team or the Care Quality Commission.

The home manager and deputy had previously completed safeguarding adults training with the local authority and had a good understanding of safeguarding issues.

Risks assessments were completed for each person in respect of the likelihood of falls, use of bed rails, moving and handling tasks, continence, risks of malnutrition and the likelihood of developing pressure ulcers. Moving and handling profiles were written for those people who needed assistance to move or transfer and these detailed out the equipment required and the number of care staff to undertake any task. Other person-specific risk assessments that had been completed in respect of the risks of choking and the risks of epileptic seizures. Personal emergency evacuation plans (PEEP’s) had been prepared for each person: these detailed what support the person would require in the event of the building needing to be evacuated.

Checks of the premises, facilities and equipment were undertaken on a weekly or monthly basis. The home manager maintained an oversight that these checks had been completed. This ensured that the premises and all equipment remained in good working order.

Staff files were checked to ensure safe recruitment procedures had been followed to prevent unsuitable staff being employed. Since our last inspection there had been very little staff turnover. Each file evidenced that appropriate pre-employment checks had been undertaken. Disclosure and Barring Service (DBS) checks had been carried out for all staff (previously called CRB’s).

On a monthly basis the dependency score of each person was reviewed and rated as high, medium or low needs. These scores were used to calculate the staffing numbers for each shift. Shifts were covered with a mix of management, ancillary staff, nurses and care staff. A nurse was on duty for every shift including weekends and overnight. There were plans to introduce hostess staff who would be specifically employed to help people make choices about food, serve drinks and support people at meal times.

Staff felt staffing numbers had improved since the last inspection and were adequate. Staff told us some shifts had been worked with less staff because of last minute sickness. After the last inspection the CQC received information from an anonymous source that a night shift had been worked with not enough staff. This was investigated by us and we were advised that day staff remained on duty until midnight and another staff member started work at 6am in order to cover the shortfall. There had been little turnover of staff since the last inspection and only minimal use of agency staff. People were therefore looked after by staff who were familiar with their needs and preferences.

Each person had been assessed as being unable or unwilling to look after or administer their own medicines. However some people kept their inhalers in their bedrooms. All other medicines were looked after and administered by staff at the prescribed times. Nurses administered medicines to those people who were funded to receive nursing care. Senior carers who had received safe medicines administration training administered medicines to those people who were funded for residential care.

Good

Is the service safe?

Medicines were re-ordered on a four weekly basis to ensure they were always available. New supplies were checked against the printed medicines administration record (MAR) charts and the prescriptions (FP10's) to ensure they were correct. Since the last inspection nursing staff see a faxed copy of the FP10 when additional medicines or medicine changes are requested by the GP.

All medicines were stored safely in a well ventilated locked room. A medicines refrigerator was available for those medicines that required cold storage and appropriate arrangements were in place for storing controlled drugs. Nursing staff checked twice daily that these medicines were all accounted for.

Additional safe medicine administration training had been completed by staff since the last inspection and competency assessments will be completed regularly to ensure all staff follow safe working practice at all times. Where people were prescribed creams or ointments, a topical medicines record was kept in their bedroom and the treatment was applied by the care staff. Appropriate records had been kept.

Good

Is the service effective?

Our findings

People said, "I get on very well with the staff", "They are very good at their jobs and I mean the carers, nurses, the chef and the cleaners", "The staff are excellent and very good to me" and "I could not be better looked after. The carers are very patient with me". Relatives made the following comments: "I am very satisfied with the way my father is looked after", "The staff are so kind and attentive" and "The nurses are very professional and do their jobs well".

Staff were supported to do their jobs. Training and development needs were identified during their regular supervision meetings. Records were maintained of all supervisions and a supervision contract was in place for all staff. Staff received an annual appraisal and these were all scheduled to take place in August 2015. Supervision meetings were shared between the home manager, the deputy, the chef and head housekeeper. Records in staff files of these meetings had been signed by both members of staff.

All staff were expected to complete a programme of essential training. This included health and safety and fire awareness, infection control, safeguarding adults and moving and handling training. A new system of computer based training was in the process of being implemented. At the time of our inspection the service had an overall 98% compliance with their training programme. Information that the home manager submitted after the inspection showed that 87% of the staff were up to date with their moving and handling training, 82% with safeguarding and 77% with fire training.

New staff had an induction training programme to complete at the start of their employment. Most training was completed on-line however staff had workbooks to complete as part of a knowledge check. Nurses told us they were supported to do training in order to meet Nursing & Midwifery Council conditions of their registration. One nurse told us they had recently done venepuncture training (taking of blood samples) and another had completed a manual handling 'train the trainer' course which meant they could teach others.

Five of the care staff had completed a recognised qualification in health and social care at level three and a further six had a qualification at level two and had commenced the level three award. Three newer care staff were awaiting a date to start their training.

Staff completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. Since the last inspection key staff had attended a taught session on MCA in October 2014. Staff were able to talk about what would happen if a person lacked mental capacity and how best interest decisions should be recorded.

During the inspection we heard people being asked to give consent and to make decisions about things that affected their daily lives. Examples of this included, where they sat, whether they wanted to be assisted back to their bedroom and want they wanted to eat.

The home manager and deputy were knowledgeable about the MCA and DoLS. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty. DoLS applications had already been submitted to the local authority for three people but the assessments had not so far been completed. The home manager was aware the CQC needed to be notified when the outcome of the applications were known.

An assessment of each person's mental capacity assessments was made in respect of all aspects of care and daily living. The assessments were reviewed when there were changes in the person's needs. Where people lacked the capacity to make decisions best interest decisions were recorded having been made with other key people (family members, GP or other health care professionals).

Each person's nutritional needs were monitored on a monthly basis and the level of risk of malnutrition was assessed. The catering staff were notified about those where risks had been identified in order that they could provide fortified foods for people with weight loss. Nutritional care plans recorded any advice given by the GP

Good

Is the service effective?

or other healthcare professionals. Weekly weights were recorded for those people at risk and everyone else was weighed each month. In addition an oral assessment was completed monthly to look at people's teeth, dentures, speech and risks of choking. One person who was at risk of choking needed to have drinks thickened and this information was also recorded on the notice board in the kitchen. Food and fluid charts were maintained where a person's eating and drinking needed to be monitored.

We spent time with the chef and were told that even though the service was not contracted to purchase food from local suppliers, this was now under review. The chef and kitchen staff were fully aware of people's dietary needs. Specific dietary information, preferences and allergies were all written on the diet board in the kitchen and updated weekly. There was a rolling four weekly menu plan in place which provided a variety of food and choice for each meal. They were changed four times a year in line with the seasons. Since our last inspection the chef had begun to put together a library of pictures of the meals to assist people in making choices. The chef met with all new people to the service about the food they liked to eat. A board in the kitchen displayed people's names and their specific dietary requirements for example soft consistency diets, vegetarian or diabetic.

The chef advised that all festivals were celebrated. Birthdays were celebrated with a special cake with afternoon tea, plus there were themed food days. Examples given were Chinese Days, Indian days and fish 'n' chips.

People were generally positive and satisfied with the meals they were served with. One person said "On the whole the food is good and at least I don't have to cook". Other people made the following remarks about, "the varied menu", "puddings are lovely", "the home made cakes" and "looking forward to meal times". One person said that the meat portions were "scanty" however when we mentioned this to the chef we were told that when this person was offered larger portions they declined. On the first day of our inspection a barbeque had been planned and about 15 people had their lunch time meal outside in the sun under the umbrellas. There was a lovely sociable atmosphere and it was very evident that people really enjoyed the event, and enjoyed the different food.

We spent time watching the staff and people in one of the lounges and on the patio, part way through the lunch time meal and for a period of time afterwards. People were asked what they wanted to eat and were served with their choice of food. The staff were attentive and provided assistance as required. People were chatty and staff interacted with them regularly and asked them if their meals were alright, whether they needed help to cut up their food and what they would like to drink.

Each person was registered with one of two local GP practices. One of the GPs visited on a fortnightly basis and saw those people the nurses had identified as needing a GP visit. Nurses also requested home visits whenever people were unwell or when people asked to see the doctor. We asked both GP surgeries for their views and opinions about how their patients were looked after. They told us "On the whole things are much better organised now when we visit" and "When we are contacted by the nurses they are quite clear about who they need us to see. They know our patients well".

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The home worked alongside community and hospital social workers, occupational therapists and physiotherapists in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People said “The staff are kind to me, don’t make me feel as if I am a nuisance and are very patient”, “I couldn’t be any better looked after”, “I have lived her a long time and all the staff are very friendly. It is like having lots of grandchildren, I am very fond of many of them” and “The staff are always very willing to help me when I ring for help”. Relatives said “The staff are always friendly and keep me informed of how things are going and any changes”, “We have been visiting the home for a long time now and have never had any concerns. The staff are very caring” and “We cannot fault a thing here. The staff are kind and caring”. Relatives said there were no restrictions on visiting and they were able to visit at any reasonable time.

Most of the people in the service had previously lived in the local area. The service employed many staff from the local area and this meant that people and staff had local knowledge of events and were able to share stories about life experiences. From our conversations and observations it was evident staff had built up trusting relationships with the people they were looking after. This was apparent in the relaxed and confident manner people interacted with the care staff. One person told us their children had been at school with members of the staff team and they felt comfortable being looked after by someone “who knew them and the family”.

Each person had a key worker to “act as their friend and champion”. Staff told us they would spend time with the person they were keyworker for, would help them keep their belongings tidy and check if they needed any toiletries. They also said they would be involved in reviewing the person’s care and daily living experiences on a monthly basis if they were on duty that day. The service has a system in place where each day there was a ‘Resident of The Day’. On this day the person was visited by the chef and asked for feedback about the meals provided and any changes they would like to see. Their bedroom was given a more thorough clean and nursing and care staff reviewed their care plan and risk assessments with them. Care staff were able to tell us about the people they were a keyworker for however one newer member of staff said they had not been allocated anyone as yet.

Staff spoke about people in a kind and respectful manner and were aware of the different way people liked to be looked after. Staff addressed people in an appropriate manner, generally by their first name. This preference was recorded in their care plan. Staff received training in equality and diversity and this enabled them to provide support that took account of individual’s specific wishes.

During our visit we observed numerous examples of positive and meaningful interactions between people and the staff members looking after them. We heard staff gently talking to and reassuring one person who was being assisted to move from their lounge chair, using a hoist to transfer into a wheelchair. We saw people being encouraged to have their barbeque meal outside on the patio. One person had not initially been keen but afterwards told us “I really enjoyed that. Sitting outside in the sun has done me a power of good”.

Requires improvement

Is the service responsive?

Our findings

People told us "The staff have reviewed my care plan with me and my family", "I came here after a stay in hospital and my family chose the home. I am glad I am living here because I feel amongst friends", "The staff help me whenever I need support and most of the time they are very prompt" and "Everything is done for me and I don't have to worry about a thing. They are always asking me if I am happy with things – I say of course I am". Relatives said "My father is well looked after, I believe he gets all the help he needs" and "Mum gets very confused now but the staff are very patient with her and look after her like she is their own relative".

On the whole care documentation was satisfactory however there is one area which **Requires Improvement**. Conflicting information was recorded in people's care notes in respect of Do Not Attempt Resuscitation decisions (DNAR). Where decisions had been made about end of life care the GP's had completed and signed a Do Not Resuscitate yellow sticker and these were placed at the front of the care records. These forms have however been replaced with formal nationally recognised Resuscitation Council forms (approved for use across all care settings). These forms allowed any consultations with relatives to be recorded along with the members of nursing staff included in the decision-making process. Three of the six care files did not contain accurate information regarding the person's DNAR status and one of the yellow stickers had been incorrectly dated by the GP. Two people's care file had two different decisions recorded – for resuscitation and not for resuscitation. The home manager agreed to address these discrepancies and to check all care files.

People's care needs were assessed prior to admission to make sure staff would be able to meet their care needs and any specific nursing equipment was available. These assessments were then reviewed on at least a yearly basis. Information gathered in the assessment process was used to develop a personalised care plan for each person. The plans included people's likes and dislikes and what was important to that person. Plans provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, managing continence and wound care management where required.

In those plans we looked at there were examples of good person specific care planning. For one person who was at risk of falls, their care plan stated "we have reduced the risk of falls by anticipating his needs and offering regular toileting". Since January this person had only had one fall whereas prior to this there had been many. In another person's plan it stated that he wanted to return to bed in the evening at a specific time in order to be able to watch a particular television programme from his bed. He told us this was important to him and "the staff never forgot".

Last time we visited we commented that the plans had been difficult to follow because there was a lack of distinction between what was the care plan and what was an evaluation of that care plan. Although some improvements had been made there was still the potential that changes that had been made in the review had not been made clear in the care plan. Care plan reviews were carried out on a monthly basis to ensure the support provided was in line with the person's specific needs. The home manager advised us that there was an imminent review of all care planning documentation in order to make the separation of plan and review clearer.

There is one full time activity person in post but they were not available during this inspection. They had been instrumental in organising the barbeque and musical entertainment that happened on day one but the rest of the staff team, chef and maintenance person rallied round to make the day a success. Other staff were doing a 'knit and natter' session on the afternoon of the second day. Activity boards advised people of planned events. Examples included bible stories, a worship session, visits by the hairdresser and visits by children and students from two local schools. Pictures were displayed of people enjoying hobbies and staff fund raising events – pancake day, Mothers Day, St Patricks Day and Burns Night. People made the following comments about the activities: "I really enjoyed the music today, it was so jolly", "It is really lovely when we have entertainers in. The man singing today was really good" and "I like having my hair washed and set. I like to have my hair done every week".

People and relatives we spoke with felt able to raise any concerns or complaints with the care staff the nurses of any of the managers. One person said "If I wasn't happy about something I would say" and their relatives agreed with this statement. People were asked to share their views or make comments about things during their care plan reviews and when they were resident of the day and visited by the chef and housekeeping team.

Good

Is the service well-led?

Our findings

People said "Everything is done for us", "There is a new manager. She comes and see's us every day which is nice" and "Everything is fine, I am looked after very well". One relative we spoke with was aware that there was going to be a relatives meeting arranged soon and said they would attend if "the time was convenient".

Since the last inspection a new home manager had been appointed (in March 2015) and was to have worked alongside the out going registered manager. However these arrangements fell through. The home manager had previously been a registered manager in another care service and was therefore experienced. She had already been booked on a two day management and leadership course in May. Staff said "The new manager has made me feel more positive about my job", "She gets things done" and "The manager has done a couple of shifts and worked alongside us. I think this is really good and I hope she does this again".

Staff said the new home manager provided "better" leadership and was more involved in the day to day running of the service. They also felt that the home manager worked well with the deputy who had been in post for many years and had previously been "running the home". The home manager's office was scheduled to move to the front of the service on the day we arrived for the inspection and this was completed during our visit. At the last inspection it was felt the manager's office was not in an accessible position for relatives or people who lived in the service.

The home manager was supported by a deputy and an area manager. The post of administrator was vacant but due to be filled from 5 May 2015. A 'flash' meeting was held each morning to enable the home manager or nurse in charge to communicate with heads of department and senior staff. We sat in on the meeting on day two: this meeting was used to update staff on any changes in people needs, organise which people needed to see the GP and identify which person was 'resident of the day'.

Several different staff meetings were already scheduled to take place the week after our inspection and 'resident' and relative meetings were scheduled for the week after that. The home manager had been told that relative meetings had failed in the past and she expressed her commitment to engaging with relatives. Records were kept of the staff meetings held since our last inspection in October 2014. The home manager will attend regular meetings with other home managers and the area manager.

The home manager submitted a weekly update to the area manager and reported on any accidents and incidents, health and safety issues, complaints, staffing issues and issues regarding people's care. These measures ensured the provider was aware of how the service was being run.

The home had a programme of audits and quality checks and these were shared out between heads of departments, the manager, deputy and nurses. Audits were completed in respect of health and safety, the management of medicines, nutrition and care documentation. Full quality audits were completed on a six monthly basis and the area manager visited the service on a two weekly basis to check how things were going.

The home manager was aware of when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. The CQC used information sent to us via the notification process to monitor the service and to check how any events had been handled.

All accidents and incidents were entered on to an electronic record system. At the end of each month the home manager follows up on each report and can analyse the number of falls or the number of events for a particular person. All accidents and incidents would be analysed to identify triggers or trends so that preventative action could be taken.

A copy of the complaints procedure was displayed on the noticeboard in the reception area and stated that all formal complaints would be acknowledged, investigated and responded to. Information was also given to people about the complaints procedure in the service user guide and home's brochure. Since the last inspection the service had received three formal complaints and these had been dealt with in accordance with the complaints procedure. Each of the complaints were about different issues. The home manager said they would use information from any complaints to review their practice. All complaints were recorded electronically which meant head office were also able to monitor they were handled correctly.

Good

Is the service well-led?

A customer satisfaction survey had last been completed at the end of 2014 and the percentage of good and very good responses had been determined. Some of the percentages were low and an action plan had been put together to improve the experiences for people. People were not satisfied with some parts of the service, namely their bedrooms, the halls (and link corridors), bath and shower rooms. Since our last inspection a number of improvements had already been made to the environment. Rotten window sills had been replaced in both link corridors, the roof had been repaired over the dining room, the conservatory was now being used as an activity room and some of the bedrooms had been redecorated. The action plan in place was basic but the home manager was in the process of preparing a more detailed improvement plan with timescales. Other improvements the new home manager intended to introduce for the service included more meaningful staff appraisals, an improved programme of activities and introduction of a “You said, we did” book. There were also plans to continue the refurbishment of the service and to relook at the catering contracts.