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Moorlands Rest Home

Inspection report

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Date of inspection visit:
28 September 2016
29 September 2016

Date of publication:
28 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 September 2016. The inspection was unannounced. The service was last inspected in October 2013, when it was found non-compliant because care plans and risk assessments were not always up to date or consistent. A desk-top review was subsequently completed in February 2014 when the service attained compliance in these areas.

Moorlands Rest Home is a care home without nursing that provides care for up to 12 people with needs relating to old age. Twenty four hour support is provided by a small regular team of staff.

A registered manager was in place as required in the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe and well cared for by the staff and that they were consulted and involved in decisions about their care. They confirmed their views about the service had been sought and felt the registered manager was accessible.

Most health and safety issues were effectively monitored and servicing and safety checks had mostly been carried out regularly. The registered manager acted promptly following the inspection to address identified issues. These included consulting the fire authority regarding the existing fire evacuation plans and placing an order for a suitable commode pot sterilizer. Individual guidelines were needed for the administration of PRN (as required) medicines, to ensure consistent and appropriate administration.

Staff understood their role in keeping people safe from harm and knew how to recognise and report any concerns about abuse. They were confident management would respond appropriately and act on anything they reported.

People's rights and freedom were protected by staff who supported people's rights and dignity in the course of their work. Staff took time with people and didn't rush them. They engaged people in conversation in the course of supporting them and encouraged group discussions. Staff were familiar with people's needs as well as their preferences and sought consent from them before providing care.

Some changes had been made to the garden in response to people's needs. These enabled them to enjoy as much freedom as possible and provided opportunities for exercise. The environment was bright and clean and people's bedrooms were personalised with their own belongings and pictures.

A range of activities and entertainment was provided which people enjoyed. However, there remained some room for further development in this area.

Care plans were supported by relevant risk assessments and other information about people's history, likes and dislikes. External health professionals were consulted where appropriate. People's health needs were monitored and met in consultation with external medical services. Nutritional needs were risk assessed and people's intake was monitored where necessary. For example, the advice of a dietitian had been sought appropriately.

The interactions we saw showed staff and people had positive relationships and people were encouraged to make decisions and choices about their daily lives. We saw instances of humour and smiling between people and staff in the course of discussions activities and interactions.

The staff recruitment process was robust and appropriate checks took place. Recruitment files contained the required evidence of the process. Staff received an induction based on the national Care Certificate competencies. They received ongoing training through the provider's rolling programme, mainly through external courses. Staff received regular supervision, attended team meetings and annual appraisals. They felt positive and enthusiastic.

The service was subject to a range of audits by the registered manager, to monitor standards. The views of people, families and staff about the service, were sought and acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

There was a risk the service was not always safe.

People felt safe in the care of the staff and were safeguarded through appropriate risk assessments.

Not all safety checks were fully up to date or could be evidenced at the time of inspection. The registered manager took immediate steps to remedy this, provided copies of missing certification and arranged for overdue service visits to take place.

The system, for cleaning and sterilising commode pots had not been satisfactory. The registered manager took immediate steps to remedy this.

The registered manager agreed to refer fire evacuation plans to the fire officer to confirm they were satisfactorily detailed. Individual guidelines for PRN (as required) medicines administration were also needed.

The service had a robust recruitment system for new staff.

Is the service effective?

Good

The service was effective.

People felt the service met their needs and that staff involved them and sought their consent.

People's rights and freedom were protected.

Staff were trained and received regular support and appraisal. They were enthusiastic and felt the team worked well together.

People's nutritional and health needs were met by the service and external health professionals were consulted appropriately.

Is the service caring?

Good

The service was caring.

People felt well cared for and that staff were kind and caring.

We saw staff respected people's dignity and privacy and took time to chat with people in the course of their daily work.

The service was a validated member of the Dignity in Care Charter.

Is the service responsive?

Good

The service was responsive.

People felt staff responded promptly to their needs and consulted them and their families appropriately about their care.

Care plans were supported with relevant risk assessments and documents to identify their individual wishes and preferences.

People enjoyed the activities offered although there remained room for further development and creativity in this aspect of care.

People were happy that any concerns or complaints were promptly addressed by the registered manager.

Is the service well-led?

Good

The service was well led.

People felt the service was well run and the manager was accessible.

The registered manager monitored various aspects of the performance of the service through regular audits.

The views of people, their families and external professionals about the service, had been sought through surveys and resident's meetings. Positive feedback had been obtained.

Periodic team meetings took place and staff felt positive about teamwork within the service.

Moorlands Rest 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.

We last inspected the service on 8 October 2013. At that inspection we found the service was not meeting the standard for care and welfare of people who use the service in respect of the content and review of care plans and assessments.

We carried out a desk-based follow up on 28 February 2014 and found that changes and improvements had been made to these documents. They had been reviewed, contained more detail and were better cross referenced to relevant risk assessments.

This inspection took place on 28 and 29 September 2016 and was unannounced. It was carried out by one inspector.

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. We looked at the information provided in the PIR and used this to help us plan the inspection. Prior to the inspection we reviewed the records we held about the service, including previous inspection reports, the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

We spoke with four people about their experience of the service. We observed the interactions between people and staff and saw how staff provided people's support. We had lunch with people on the first day of the inspection. We spoke with two of the staff in detail and others briefly, as well as the registered manager. Prior to the inspection we spoke with a representative of the health trust care home support team. We also contacted representatives of the placing local authority and safeguarding team to seek their views. No concerns were brought to our attention.

We reviewed the care plans and associated records for four people, including their risk assessments and reviews, and related this to the care we observed. We examined a sample of other records to do with the home's operation including staff recruitment, supervision and support records, surveys and various monitoring and audit tools.

Requires Improvement

Is the service safe?

Our findings

People said they were safe in the service. Two people told us, "I always feel safe" and "I feel safe here, another said, "I feel safe with all of the staff." People and staff related to each other respectfully.

We looked at a sample of health and safety related records, including records of routine servicing and safety checks carried out by staff. Records showed servicing and safety checks were mostly up to date, including electrical installation safety, legionella testing, lift and fire alarm servicing. However, the gas safety certificate, fire extinguisher service certificate and evidence of the servicing of hot water temperature monitoring valves were not available. The registered manager supplied a copy of the fire extinguisher service certificate following the inspection, booked the gas safety inspection and forwarded the certificate. An invoice was also provided showing the replacement of all thermostatic safety valves throughout the home in July 2016. Their ongoing servicing will be verified at subsequent inspections. Annual electrical testing of electrical appliances was due and the registered manager told us she would copy the certificate to CQC once this was done. This was provided following the inspection.

On two occasions in the previous fortnight, temperature records for bath water testing were not consistent with the record of baths given. It was therefore unclear whether water temperature testing had been carried out on every occasion. The registered manager said she would remind staff of the importance of testing and recording on each occasion.

The service's front door was alarmed to alert staff should someone open it to go out, to enable staff to check that a vulnerable person did not leave without support. A contractor was present on the day of inspection to carry out repairs to this alarm and carry out a survey with regard to fitting similar alarms to other exit doors. The exit gate from the rear garden was kept locked so people could freely use the garden without support if they were able to do so.

The service had been fitted with an upgraded fire alarm system which now included sprinklers, should a fire be detected. An evacuation aid had been installed on the first floor to assist with evacuations should someone have reduced mobility. However, the service's fire evacuation procedure required review. The manager had the document reviewed and updated by the fire authority following the inspection.

A business continuity plan was in place to provide the necessary contacts and detailed plans for managing a range of foreseeable emergencies.

The home appeared clean and a record was kept of staff responsible for cleaning tasks through daily initials in a notebook. However, commode pots were being cleaned by soaking in an open bucket of sterilising solution which is not best practice to safeguard both staff and service users from the risk of cross infection. Following the inspection visit, the registered manager provided a copy of an order for the supply of a suitable machine to sterilise bed pans and commode pots.

The service's procedure for supporting people with their medicines where necessary, was mostly

appropriate and medicines records were satisfactory. However, there were no individual guidelines for 'as required' (PRN) medicines, to ensure staff were consistent in how and when these were given. The quantities of medicines received, noted on the medicines administration sheets were not initialled as part of the audit trail. The registered manager told us there had been no medicines errors in the past 12 months. The service received a satisfactory report following a pharmacist inspection in August 2015.

Staff understood their role and how to keep people safe and knew to whom they should report any concerns around abuse or harm. No one had raised any such concerns but staff felt the registered manager would take any concerns raised seriously and investigate them. The registered manager had taken appropriate action to address some concerns that had been raised anonymously.

Relevant risk assessments such as for bathing, nutrition or falls, together with appropriate nationally recognised assessment tools, were on file. Where specific risks had been identified, action was taken to minimise these. For example the provision of bedside and chair sensors to alert staff should a person with a high risk of falling, try to mobilise unaided. One recent fall had been reported to the local authority and the Care Quality Commission (CQC) as required.

The rotas provided showed the usual staffing levels to be three staff in the morning and two during the afternoon and evening. They showed the registered manager working five days per week The registered manager usually worked a nine to five day but had been working some days as a carer on shift recently to cover for annual leave. The registered manager told us she was training a senior staff member up as a deputy to enable her to share the on-call cover.

Night-time staffing was one person on waking night duty. The registered manager or her senior live within a five minute walk of the service and provided off-site on-call support in the event of an emergency. The registered manager told us that it was very rare for the night staff to need to call for assistance or advice at night and no one required the routine support of two staff. She said instances of people requiring night-time support were unusual. If someone was unwell or there was a need, additional staff would be rostered to cover at night. An individual dependency profiling tool was used as part of the assessment and ongoing review of people's support needs. This was used, together with the support needs indicated in people's assessments, to plan overall staffing levels.

Staff turnover was low. One long-term staff member had retired in the past 12 months and one staff member had left having failed their probationary period. The service did not use agency staff, preferring to cover any rota shortfalls from within the team.

The recruitment records for the two staff recruited in the previous 12 months showed an appropriately robust process was in place. Copies of the required documents were on file to evidence the process. References were taken up and a criminal records check carried out. Applicants provided a full employment history and completed a health questionnaire. Where staff originated from outside the EU, appropriate evidence of their right to work was on file.

Good

Is the service effective?

Our findings

People were happy with the effectiveness of the service and felt their needs were met. One person said, "They look after us very well, If you use the call bell, you get a quick response." When staff provided support people told us they, "…ask what we want." Another person said, "I like it here, my [relatives] also say how good it is" and "…the staff are very nice, they ask before doing anything." Another person described the staff as, "…very alert." People described the home as "…very smart and clean" and said, "…visitors are always made welcome." The staff were described as, "…excellent, kind and patient [and] they always get consent."

The staff we spoke with were enthusiastic about their role and enjoyed working with the people in the service. We saw staff engaged well with people taking opportunities for initiating conversations whenever possible to encourage them to interact and remain engaged. For example one staff member escorted a person for a walk in the garden, during which she engaged her in relaxed conversation. Staff told us they had a thorough induction and had received the training they needed to perform their role. They felt the team were supportive and team spirit was positive. One said, "It's a small team, everyone pulls their weight" and another told us. "…other staff are supportive and show me [what to do]", when they were not sure of something.

Staff spoke about their role in an informed way and talked about putting people first and keeping them safe and well. They said they would immediately report any concern about a person's wellbeing to the manager or senior and they would take the appropriate action. Staff understood the importance of talking to people and one observed that some people didn't have regular visitors, so it was all the more important to spend time talking with them.

Staff training was provided through a mixture of face-to-face and computer based learning. Staff, aside from more recent recruits, had received training updates within the provider's stated timescales. Three of the staff had completed the national Care Certificate induction via the local authority computerised system. They were awaiting the registered manager's completion of an assessor's course, so she was able to sign off their competencies. The registered manager planned for existing staff to complete the care certificate workbooks and competencies in due course. Five staff had been assessed by the registered manager as competent to administer medicines in the meantime. Individual staff had attended relevant training in more specialist areas including palliative care, nutrition awareness, dementia care, catheter care and avoiding urinary tract infections.

The registered manager's aim was to provide staff with individual supervision support, approximately six to eight-weekly, which she informed us, and staff confirmed, was mostly achieved. Staff each had an annual performance appraisal to assess progress and identify future goals. Appraisals were up to date for staff who had been employed for over 12 months and each staff member had a training and development plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The service encouraged people to make decisions and choices for themselves at whatever level they were able to. Where people were felt not have capacity with regard to specific decisions or issues, a capacity assessment had been completed. Where one person was assessed to be at high risk of falling, a best interest process had been carried out to agree the use of alarmed bedside and chair mats to alert staff, should they attempt to get up unaided. Appropriate family and external healthcare professionals had been involved in the best interest decision and a copy of the 'best interest decision record' was provided following the inspection. However, the record provided was not fully completed and needed additional detail. The registered manager agreed to address this.

Where people had given power of attorney to others, the service had obtained copies of the authorisation so they were clear who had the legal authority to make decisions on the person's behalf. Care consent forms were signed, where possible, by the person receiving the care or by someone with the legal authority to do so.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met. DoLS authorisations had been applied for on behalf of five people where the service felt they placed limitations on individual's freedom, due to their needs. Responses from the local authority were still awaited in these cases. The other seven people were considered to have the capacity to understand the risks, for example of going out unaided, and would ask for staff support.

People told us they liked the food. One said, "The food is good, there is a choice every day." People were happy they had a choice of meals and said that another alternative was offered if they didn't like the two menu options. One person gave an example of a menu item he said staff were aware he didn't like, so they prepared him an alternative option. Another commented, "…nice dinners." People told us a bowl of fresh fruit was available for them to help themselves.

People's nutritional and fluid intakes were assessed using a recognised risk assessment tool to identify their support needs. Where a risk or need had been identified, intake charts were in place, properly completed and the advice of the Speech and language therapy team or dietitian, had been sought. Dietary supplements were used on dietitian advice, where appropriate and some meals were pureed.

People felt the service looked after their health needs. One person told us, "The GP is called in promptly" and another told us, "They call the doctor in if I need it." One person had some impairment of eyesight and was supported to mobilise by staff. Appropriate healthcare involvement had been supported.

People's files contained evidence of health monitoring where necessary and of regular healthcare appointments, although dental healthcare was not always clearly evidenced from the files. The registered manager provided the dates for the most recent dental appointments. She had also arranged for a visiting dental service to come to the service to ensure everyone had the opportunity for a dental check-up and oral examination.

An end of life care plan had been completed where appropriate, so that it was ready to be implemented when necessary. An external health professional gave us positive feedback about the end of life care

provided and told us the service had positive relationships with district nursing and GP services and sought external advice appropriately.

The premises were bright and clean and were free of unpleasant odours throughout. People's bedrooms were individualised with their personal belongings and photographs. The one double bedroom was only used with the specific consent of the occupants.

Improvements had been made to the service's garden. A circular paved pathway had been provided to encourage people to take short walks to assist with maintaining mobility. New planting and raised beds had been included to provide points of interest to stimulate discussion or the senses. Seating was provided as were parasols in hot weather. People had been encouraged to become involved in planting projects including growing strawberries. The garden provided an enclosed space where people could spend time walking or just sitting. People told us they had used the garden during the warmer weather. We saw some people use the garden during the inspection, both with and without staff support. To date, no one required the assistance of hoists for transfers, except in some cases to get in and out of the bath. The bath was provided with a suitable hoist.

Good

Is the service caring?

Our findings

People described staff as, "…kind and patient" and said, "They look after our dignity", describing how doors were always closed and they were covered up. One person explained how staff assisted them into the bath, then enabled them to wash themselves and only helped with drying them afterwards. Other people said, "Staff don't rush me and look after my dignity" and, "They are good to me, I get on well with all of the staff."

We saw staff responded to people with warmth and patience and were proactive in engaging the in conversations. In the afternoon staff initiated group discussions on a variety of subjects and involved those who wished to take part. Staff responded positively when people became unsettled and provided them with reassurance or support. People had positive relationships with staff and often smiled when engaging with them.

The registered manager and staff were aware of people's needs in relation to diversity. Assistance was offered to people to enable them to take part in events and activities. People's needs in relation to their cultural origins or spirituality were discussed and arrangements made to address them if appropriate. A monthly Church of England service took place in the building and a visiting pastor met one person's needs. People's families were encouraged to visit to maintain important relationships. People's care plans contained input from people themselves, demonstrating they or their representatives had been involved in discussing and planning their care.

People were involved in making day-to-day decisions as much as they were able and wished to. Options were offered verbally although the registered manager told us she planned to obtain some aids such as menu photos to assist people to make meal decisions where necessary. Where possible people were encouraged and supported to do things for themselves, and staff talked about this as being their role in discussions with us. The service had involved a physiotherapist to assist individual to regain mobility. We saw staff encouraging people to make decisions and take part in activities.

Staff had been provided with training on supporting dignity and privacy and the service had signed up to the local authority dignity charter. Representatives of the local authority had visited the service in April 2015 and found the service met the validation process to remain on the 'Dignity in Care Charter'. A copy of their report was provided immediately following the inspection visit. The NHS trust care home support team had also provided input to staff in these areas as part of their support. Staff described to us, various ways in which they supported people's dignity including by involving them in their care, seeking their views and obtaining consent before providing support. Personal care was delivered behind closed doors and people confirmed staff kept them covered up as much as possible when supporting them. One person said, "They let me do for myself, what I can." The information gathered from people or their representatives included an indication of any preferences about the gender of staff providing them with personal care support, which was respected.

Good

Is the service responsive?

Our findings

People were happy the staff responded to their needs, One said, "You only have to ring and they come". People had been involved in discussions about their care needs and these were reviewed with them periodically. One person said, "We discuss what support we need in a meeting every so often" and another commented "They discuss my care with me."

Most people said they enjoyed the activities provided and could decide whether they wished to be involved or not. One person said they, "…join in with the activities, they are good" and went on to explain they also chose to spend time in their bedroom. Another person told us they enjoyed the exercises, dancing, the Christmas party and the nice dinners." They also remembered when the 'pat dog' had been brought in and some rabbits and hamsters. They liked the bingo and the group discussions and reminiscing with staff and mentioned a discussion about Reading the day before. One person said they didn't wish to join in with any activities and preferred their own company. People mentioned the regular church services held to meet their spiritual needs and recalled when a local choir had visited to sing for them.

The range of activities had increased since the previous inspection. However, there was still some room for more creativity and the introduction of additional variety in the options available to engage as many people as possible. Some people opted not to take part in the activities and staff spent time chatting with them in their rooms to help combat the risk of them becoming isolated. Staff had also worked with some people to encourage their participation in activities so they became more involved in the day-to-day life of the service.

An external activities leader visited twice a week to lead the activities and the care staff led these at other times. We saw both the activity leader and care staff did this effectively particularly in terms of group discussions about people's lives and experiences. A 'pat dog' had previously been brought in for residents to pet and a local school choir had visited. In house activities included gentle exercise, ball games, quizzes, bingo and discussions. Some people were supported to go out shopping at times and people's families were encouraged to visit and take their relatives out.

People had individual care plans supported by relevant risk assessments and monitoring systems, where required. Care files contained the details staff needed to provide individualised care and support people in the way they wished, although not all of it was within the care plan itself. Care plans had standardised typed entries within each section including some tick-boxes, followed by some additional individual hand-written detail. Each care file also contained an Alzheimer's Society "This Is Me" format containing a record of the person's life history, interests, preferred routines and preferences. The format included information about how the person preferred to take their medicines, things that might cause them anxiety and how staff should respond should they become anxious. Individual dependency profiles were also completed as well as an initial assessment of needs.

Care plans were evaluated by the registered manager monthly and any amendments hand written in the relevant section. Periodically, discussion took place with the person and/or their representative to discuss any changes in their needs.

People told us they were satisfied with the service and not had cause to complain. Two people said, "We have not had anything to complain about, they would sort it out anyway." Another person told us, if there were any problems they'd just "...speak to the deputy and she'd sort it out. Complaints and moans are sorted out quickly."

The service's complaints procedure was posted in the entrance hall, the conservatory and available in bedrooms as well as being included in the service user guide. Additionally, the registered manager had introduced comment and complaint forms, available In the entrance hall, enabling people to provide feedback anonymously if they wished to. There had been three complaints and four compliments recorded in the previous 12 months. The registered manager took appropriate action to address the complaints and apologised to the complainants. The compliments were from a relative and the representative of the care home support team, both of whom complimented the care and support provided by staff.

Good

Is the service well-led?

Our findings

People were happy with the way the service was run and felt the registered manager was readily available. One person told us, "The manager is available to talk to if anything is bothering us", another said, "The manager is very good and the deputy is very good too." People confirmed their views about the service had been sought via a survey. On said, there had been, "…a survey recently and they ask around monthly if we are still happy."

The registered manager was present in the service at some point most days and delivered some care herself. This enabled her to directly observe the care practice of staff and experience any issues they might be experiencing for herself.

Four staff meetings had taken place in the previous 12 months and the minutes noted attendance by both day and night staff. The minutes showed the meetings covered a range of expected topics. Care practice reminders were provided as well as seeking staff views about changes in people's care needs, observations or activities ideas. Staff felt the meetings were constructive and supported them in their role.

Staff felt the team was positive and supportive and that they could go to other staff or the registered manager for support or advice. They felt the expectations with regard to care standards were made clear to them. The registered manager was described as, "Approachable." One staff member told us, "We all work together well here."-

Daily handover meetings took place between shifts to help ensure continuity of care and the transfer of information between the staff team.

The registered manager told us she had notified us about all relevant incidents in the service. A notification is information about important events which the service is required to tell us about by law. We had received notifications regarding people's deaths and about two injuries following falls. The registered manager was aware of the legal requirement to display the outcome and rating from this inspection within the service.

The registered manager carried out a range of monthly audits to monitor the service's operation, including of infection control, health and safety, premises cleaning and medicines. However, these had not always identified issues or led to proactive resolutions.

A programme of regular resident's meetings took place throughout the year. Six had taken place in the previous 12 months. People's feedback had been sought about changes to menus, activities and the developments in the home. The minutes noted positive feedback from people about their care, activities and outings as well as some requests, such as for additional quiz sessions to be held. One person had asked to be taken out to the local pub and this had been done. People thanked the registered manager for the Christmas celebrations and carol service. It was noted that people were pleased with the garden developments and changes to the menus and additional choices being made available. One person specifically thanked staff for meeting their dietary requirements. The minutes noted acknowledgement

where people had died and the opportunity to discuss their memories of the person. People were also notified of any staff changes.

The registered manager had an annual development plan for the service which identified her priorities for the ensuing 12 months, some of which had been addressed. However, it did not include review of the level of achievement of the previous plan, or set specific target dates for the achievement of or progress towards current plans. The registered manager agreed to develop this document further.

A survey of people and relative's views about the service had recently been completed which had resulted in positive feedback. People and relative's comments included: "We are very pleased with the care that you all give to [name]", "An extremely well kept home" and "Very friendly staff and management who are devoted to the residents." One person had requested specific meals and these were provided. The registered manager also met with individuals and relatives as part of reviewing people's care needs.

A survey for care managers and external healthcare professionals had been carried out in 2016 which had elicited three positive responses. The registered manager planned to carry out a staff survey but this had not yet taken place.