Wingate Care Homes Limited

Wingates Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 on 21 October 2014 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. At the last inspection in November 2013 the home was found to be meeting all the regulatory requirements.

Wingates Residential Home provides residential care for 36 people. At the time of the visit there were 36 people resident at the service, though one person was in hospital.

There was a registered manager at the home. 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.

Summary of findings

We found the home to be clean and homely, although the environment offered little stimulation or support to people living with dementia conditions.

People who used the service were well presented and relationships between them and the staff were friendly and comfortable. People told us they felt safe living at the home and were able to speak to staff or the manager about any issue or concern.

People's dignity and privacy were respected and they were given choice in many areas of their life. Meal choices could have been made clearer and menus more accessible to people with confusion or living with dementia.

There were a range of activities on offer at the home and people were encouraged to participate if they wished to do so. The home had good links with the local community, enabling people to feel part of a wider society.

Staff, visitors and people who used the service said the manager had an open door policy and was approachable. Quality assurance arrangements were in place at the home.

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 

People were safe at the home. There were up to date, clear policies and procedures around safeguarding and whistle blowing. Staff were aware of the policies, had good knowledge of safeguarding issues and were confident on how and when to report any concerns.

There were sufficient staff to meet the needs of the people who used the service. The building and equipment were maintained regularly and to a good standard and safety checks were in place.

People who used the service had risk assessments within their care plans. These were regularly reviewed and updated to ensure they were current.

Medication was administered, ordered, stored and disposed of in a safe manner.

Is the service effective?

Requires Improvement 

The service was effective, people having choices around when and where they wanted to eat. Alternatives to the menu were offered, but this could have been made more formal so that people would be more aware of the choices on offer.

Staff displayed good knowledge of people who used the service and what was in the care plans. There were a number of activities on offer.

Staff had received training in Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and were able to explain the implications of these.

Is the service caring?

Requires Improvement 

The service was caring. The staff at the home were observed for the most part to offer care in a kind and compassionate manner. However, there were some missed opportunities when touch or conversation could have been used to offer people reassurance.

People who used the service felt staff were caring and visitors described staff as caring.

Care plans included background information and were person centred to each person who used the service.

Staff had completed training in a number or relevant areas and were able to explain how people's dignity and privacy was respected.

Summary of findings

Is the service responsive?

Good

The service was responsive. A thorough assessment was carried out prior to people coming into the service and any diagnosis was checked out to ensure information was up to date and relevant.

Relatives meetings were held on a regular basis and a quarterly newsletter was produced. The staff and manager were approachable and any concerns raised were responded to in an appropriate and timely way.

People's particular hobbies and interests were supported.

There was an up to date complaints policy displayed in the home.

Staff at the home worked well with other agencies and services to provide joined up care for people who used the service.

Is the service well-led?

Good

The service was well led. The manager had an open door policy and staff, visitors, relatives and people who used the service were confident to speak with her if they had any concerns or issues to discuss.

Regular audits were carried out. Issues identified via audits were addressed in a timely and appropriate manner.

Wingates Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 21 October 2014 and was unannounced. The inspection team consisted of a lead inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 also reviewed information we held about the home in the form of notifications received from the service.

Before our inspection we contacted the local authority contracts team who commission services from the home. We also contacted a range of health and social care professionals including: the practice manager of the local GP surgery; the District Nurse Team Manager, whose team visit the home regularly; social care professionals who visit the home on a regular basis and an occupational therapist.

We contacted the local Healthwatch service for information. Healthwatch England is the national consumer champion in health and care.

We spoke with three people who used the service, eight members of staff including the registered manager, four relatives and one visitor to the service. We also looked at records held by the service, including four care plans and two staff files, and we observed care within the home throughout the day.

Good

Is the service safe?

Our findings

People at Wingates were safe. We spoke with people who used the service. We asked if they felt safe from bullying, abuse and harm at the home. They were sure that they were safe. One person said, "Yes, it is the main reason to come into the home". A second person told us, "I feel very safe. They are very good at managing people's behaviour, so I know I am safe".

We spoke with visitors and people who used the service about staffing levels at the home and asked if they felt there were enough staff on duty to meet the needs of the people who used the service. One visitor said, "Yes, during the week", but went on to say that they did not visit in the evenings or at weekends. Another visitor when asked if staffing levels were adequate said, "Yes, but I feel that there should always be one member of staff permanently in the lounge. All staff rush to respond to an alarm and leave the service users in the lounge on their own". The registered manager told us that , in the event of an emergency alarm sounding, all care staff have to respond to it. Then two staff deal with the emergency and the others return to their duties. This saves confusion as to who is attending to the emergency.

A person who used the service said, "Yes, staffing levels are very good". A second person responded, "No, not when a member of staff is ill".

The building was secure and we were asked to sign in on entering. There was hand gel on the opposite wall for people to use to reduce the risk of infection. However, there was no sign advising people to use the gel and as it was on the opposite wall it was not positioned well for everyone to see.

We looked at staffing rotas for the past month. These demonstrated there were three or four staff on each shift, depending on the time of day, including a senior person to lead the shift. On the day of the visit we saw there were ample staff on duty to meet the needs of the people who used the service.

We looked at equipment at the home and asked people who used the service if they felt staff used the equipment safely. One person who used the service had observed a hoist being used by staff and felt this was done in a safe manner. Another person who used the service told us they had been transferred by hoist when they were first in the home and felt very safe and that staff were competent.

We saw that the home was clean and tidy and there were no malodours. We asked people who used the service about cleanliness. One person told us, "Everywhere is hoovered and cleaned".

We looked at the home's safeguarding and whistle blowing policies, which were comprehensive and up to date. We were told by the registered manager that all policies were updated on an annual basis.

We looked at the training matrix and saw that safeguarding training for all staff was up to date. We spoke with staff to ascertain their knowledge and understanding of potential abuse or poor practice, safeguarding and reporting procedures. We found they were aware of the policies and knew where to access guidance if needed. They were able to give examples of what would constitute abuse or poor practice.

All staff we spoke with were confident to raise any concerns and told us they would not hesitate to do so if necessary. Staff we spoke with were confident the manager and/or provider would respond appropriately to any concerns raised.

There had been no recent safeguarding alerts from the home. However, the District Nurse Manager told us their internal panel had instigated an investigation into a pressure ulcer which a person who used the service had developed. They told us there was no fault found with the home, but they had participated fully and openly in the investigation. This helped ensure all relevant information was gathered to facilitate a comprehensive and thorough investigation.

We were also told by the registered manager that there had been some issues with a person who used the service who had possibly been the victim of some exploitation in the past. The home were working closely with this person, who had full capacity and did not wish safeguarding services to be involved, and their social worker and other professionals in order to keep them safe.

We spoke with staff about their understanding of restraint and how they responded to people who required some

Good

Is the service safe?

assistance keeping safe. They were able to give examples of how the least restrictive measures were used, such as using the laser system or pressure mats for people who were prone to falls.

We looked at how people were protected from discrimination. The manager told us about a person who displayed behaviour that challenged the service. The staff had worked hard with this person, taking into account their previous lifestyle, which had contributed to their present behaviour. They were working with other professionals to provide the best care for the person whilst ensuring others were protected from upset by the behaviours. A particular medication had been suggested by the GP to help alleviate the problem. This had been tried but the staff felt it made the person too drowsy and they did not feel the person, therefore, had a good quality of life, so the medication was stopped with the agreement of the other professionals involved. This demonstrated a commitment to ensuring a good quality of life for all people who used the service The home was continuing to work closely with others around this issue and their ongoing work was backed up by records we looked at.

We looked at four care plans and saw appropriate risk assessments, which were up to date and complete. Each person had an individual fire risk assessment to ensure they would receive the support they needed in the event of an emergency. We saw evidence that the risk assessments were reviewed on a monthly basis and updated as required.

We saw service level risk assessments around fire, equipment and emergencies. The home had a contingency plan for emergencies which may occur in the building. This involved evacuating the building and taking up residence in the local church, where there were facilities for basic needs of warmth, drinks and toilets situated on one floor. The signing in book would inform staff of any visitors to the building at the time.

We looked at the kitchen area and spoke with the member of staff working in there on the day of the inspection. We observed a neat and organised work station. We saw records of fridge and freezer temperatures and cleaning records. We saw records of when ovens and hobs were cleaned, but there was no set schedule planned for this. It was left to each individual working on a particular day to decide whether or not it was necessary to do it at that point in time.

We observed that some of the electrical appliances in the kitchen were not Portable Appliance Tested (PAT). We spoke with the manager about this, who informed us they had received a pack, to carry out their own PAT testing. The training pack had not yet arrived, but they assured us they would proceed with the PAT testing immediately. However, of the two electrical appliances without PAT, one was still under guarantee and the other was just over twelve months old.

We looked at records of equipment maintenance, servicing and cleaning. There were weekly alarm and fire exit checks, monthly equipment checks, records of repairs carried out and six monthly fire drills. The records were kept up to date and complete by the handyman, who was able to explain his role and duties to us.

We looked at two staff files and spoke with eight members of staff. We saw evidence and were told that recruitment was robust, including obtaining Disclosure and Barring Service (DBS) checks, references, identification and supplying a training and shadowing period prior to commencement of employment. Disclosure and Barring Service (DBS) checks help ensure staff's suitability to work with vulnerable people.

We looked at medication and saw that all Medication Administration Record (MAR) sheets included a photograph of the person and were completed as required. Clear recordings of refusals of medication were made. The home used the bio dose system of administration and medicines pods also had a photograph on them to help avoid any mistakes with administration.

All medication was stored securely and controlled drugs were stored in a controlled drugs cupboard and signed for by two people as required.

Only trained staff were allowed to administer medication and they wore the "do not disturb" tabards when giving out medication to help ensure safe administration.

There was no one in the home at the time of the visit who self-administered their medication. However, staff were able to explain how people were supported to do this if required. There was no one receiving covert medication at the home at the time of the visit. Covert medication is a way of giving medication in or on food or in a drink. Staff understood the requirements of the Mental Capacity Act (2005) and that covert medication would only be

Good

Is the service safe?

considered when the person did not have capacity to understand the issues and decisions would be made in conjunction with other professionals and in the person's best interests.

Staff were able to explain timings of medication, for example how they administered drugs to be taken before, with or after food and how they ensured that pain medication was spaced out appropriately to ensure it was safely administered. We saw that PRN or as required medication was often refused. The manager explained that PRN medication was not given as a matter of course, but offered to the person. They were asked if they required pain relief and if they did want it, the time of taking it was clearly recorded to help ensure safe administration.

Requires Improvement

Is the service effective?

Our findings

People felt their care needs were supported well by staff at the home. One person when asked about effective care said, "Yes, I am diabetic, the nurse comes to do injections and prick my finger, and someone for teeth, eyes and feet". Another told us they went out to see an optician and chiropodist. Relatives told us they were kept informed of all events and they felt GPs were called when appropriate.

We asked three people who used the service if they enjoyed the food. All said they did and one commented, "I am happy to have what is given to me". Another told us, "There are just one or two things I don't like. You can have a sandwich or soup if you don't want what is on offer. I like to drink milk at lunch time and have a cup of tea at bed time. One person said they were diabetic and the food was always right for diabetics. A relative told us their loved one had been "built up" with a fortified diet when they returned from a bout of ill health in hospital.

We looked at four care plans and saw they contained reference to people's likes and dislikes, dietary needs and preferences and any nutritional issues. There were monthly weight charts to allow staff to take note of excessive weight loss or gain and, we saw food and fluid intake charts to monitor people's daily intake for those people where nutritional concerns had been identified.

We saw the person working in the kitchen had a list of dietary requirements of people who used the service. The menu was written on a board on the wall but none of the people who used the service, with whom we spoke, were able to say what was on the board. It may be useful to produce an alternative way for people in order to ensure they are aware of what meal is on offer that day.

There was no choice of meal displayed, though the chef explained that if anyone did not want the meal on offer an alternative would be provided. We did not observe anyone being asked if they wanted second helpings.

People were given the choice of eating in the dining room or in their own rooms. We were told by staff that those who ate in their own rooms did not need assistance with eating and would be checked on when dessert was taken in to them.

We observed a senior member of staff feeding a person who used the service. This person was very sleepy and reluctant to eat. The staff member removed the person from the dining room and took them into the lounge where they were offered a light diet. The staff member said this was more successful.

We also observed a person who used the service who required food diced in a bowl attempting to feed themselves at two mealtimes. They appeared to be very sleepy and weak and did not receive assistance from staff. During the time of observation this person had very little to eat. We asked staff about this afterwards and they told us this person was unwell at present. They agreed to ensure this person was assisted and amounts of food taken observed whilst they continued to be unwell and to take further action if necessary if their appetite and demeanour did not improve.

Some people chose to have smaller portions and one gentleman liked a different kind of juice to those generally on offer. These choices were adhered to as staff were aware of people's preferences. However, the element of choice could be missed if they were not asked on each occasion what they wanted, as people's preferences vary.

We asked people who used the service and visitors if staff appeared sufficiently trained and knowledgeable. One visitor felt confident they were as their relative had responded well since entering the home. Another said they were "Quite happy", with all that they had seen at the home, and they visited on a regular basis. A third visitor told us, "I sleep at night knowing X is in here".

We had received feedback from the local health centre, District nurses, social care workers and the local commissioning service prior to the inspection. All feedback received was positive. The district nursing service told us they had a really good working relationship with the home, referrals were met in a timely way, advice was sought and followed appropriately and good care was seen to be given by staff to people who used the service.

We did feel that the environment could have been made more appropriate for the needs of older people and those with elements of confusion and/or dementia. We spoke with the manager about accessing information on relevant research about dementia friendly environments, which she agreed to look at and discuss with the provider.

Staff, according to the training matrix, had undertaken training in a range of areas, including dementia care,

Is the service effective?

moving and handling, first aid, medication, fire training, palliative care, protection of vulnerable adults and food hygiene. Those we spoke with demonstrated an understanding of these subjects.

We asked staff about other training and cross referenced what they told us with the training matrix. Staff had undertaken a number of supplementary training courses to enhance their knowledge and assist them in their roles. The training used was generally via Social Care TV, an accredited e learning system which staff could access at the home. Staff with whom we spoke felt this was a good system. The manager said that her requirement was for staff to exceed 85% in a course in order to be deemed competent. If this was not achieved, they would be required to repeat the course within a short space of time. The manager explained that the system also allowed her to review the answers given in order for her to ascertain if there was an area that the staff member was struggling with. If this was the case it would be addressed via a one to one supervision meeting to ensure staff were gaining as much as possible from their training.

We spoke with some staff about how they dealt with people with particular conditions, such as Parkinson's Disease, and whether training for these conditions would be offered to them if requested. Staff said they were given lots of information about particular conditions and were always listened to when requesting any training. The manager had arranged for a person from the Parkinson's Disease Society to come into the home to deliver some bespoke training in the very near future.

We saw in one care plan that staff monitored a person who had Parkinson's Disease. They were observing for signs of the symptoms worsening at which time the GP would be informed and would review the person.

We asked staff about their understanding of The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA sets out the legal requirements and guidance around how to ascertain people's capacity to make particular decisions at certain times. There was also direction on how to assist someone in the decision making process. DoLS is used when a person needs to be deprived of their liberty in their own best interests. This can be due to a lack of insight into their condition or the risks involved in the event of the individual leaving the home alone.

Staff had undertaken training in both MCA and DoLS, as confirmed by the training matrix, and were able to explain them adequately. They had been told that if they needed clarification on anything to do with these subjects they could speak with the manager who would try to help them.

There was one person at the home at the time of the visit for whom a DoLS application had been made. Staff knew about this and were able to tell us how they supported this person in the least restrictive way, taking her out for regular walks and using gentle persuasion to keep her from leaving the home at other times.

Requires Improvement

Is the service caring?

Our findings

We spoke with three people who used the service. One person, when asked about whether their privacy, dignity and independence were respected said, "They (the staff) make me feel independent" and went on to say they felt respected. Another told us, "Oh yes, they let me get on with things myself, they stay in the bedroom whilst I shower because they know I can do it". A third person commented that the staff were very respectful.

We then asked if staff were kind to them and if they listened to what their family and friends said. One person told us, "Yes, the regular staff are very kind, I call them my family. It's like home from home, with the bills taken care of". When we asked someone if they had been given a choice of having a male or female carer they said, "Yes, I didn't like it when I had one (male carer), so I don't now, I have a lady".

We spoke with a number of relatives. One told us lots of input from relatives was encouraged. They also said, "It's immaculate. Anything I've asked for they've done. The food is excellent and the patience they (the staff) have had with my X is unbelievable". Another relative commented, "Nothing is too much trouble. Any concerns are addressed as soon as possible. I have peace of mind".

We asked people who used the service if they were kept waiting for assistance. One person said, "No, not unless there has been an accident somewhere and they are busy". Another told us, "I spend most of my day in my room, but they come if I ring for them, but I only call if I really need help".

All the relatives we spoke with said their loved ones always looked clean and tidy, smelled fresh and cared for.

A regular visitor to the service who was a lay preacher with the local church and brought communion fortnightly told us, "People here are treated lovingly. They go beyond their duty". They went on to say that they were called in, if wanted by the person nearing the end of their life. They said, "When they are dying they are not left alone and they (staff) respect their dignity". The home had a designated bedroom on the third floor, for relatives' use if they wished to stay with a loved one at the end of life or during an acute episode of illness.

All visitors we spoke with told us the staff and manager were approachable and they were confident to ask for anything they needed. They told us communication between them and the home was excellent, and they were kept fully informed of all incidents and occurrences.

We observed staff on the day of the visit demonstrate kindness and compassion when dealing with people who used the service. However, they did miss opportunities for offering stimulation by conversation, reassurance and touch with people who used the service. We saw there was a light hearted approach to verbal communications and staff were always respectful.

We observed a person who used the service being transferred via hoist from a wheelchair to a dining chair at tea time on the day of the inspection. This person seemed very uncertain about it. They told us they had not been moved by this method before and usually sat in their wheelchair. They were not keen to be moved this way again. A limited amount of reassurance was given by the staff member at the time. We were unsure why this method of transfer had been used given the points outlined above.

We spoke with the manager about this matter at our feedback. The manager agreed to look into why this was done and check the care plan to ensure moving and handling methods were outlined clearly for this person and followed by staff.

Staff were also able to give examples of how dignity and respect were protected. They explained about methods used, such as keeping doors and curtains closed and covering people's bodies as much as possible when assisting with personal care. The District Nurse Manager we spoke with also told us dignity was maintained through the use of a dedicated treatment room. This meant interventions, such as dressings or injections, could be carried out in privacy The nurse told us told us, "Privacy and dignity is always maintained".

We observed, on the day of the inspection, that all the people who used the service were wearing coordinated clothing, were clean and if they spilt anything they were changed with a minimum of comment or fuss.

Good

Is the service responsive?

Our findings

We spoke with visiting relatives who told us they felt able to approach the staff or manager any time they had any concerns or comments.

Staff responded to any concerns appropriately. For example, one person had discovered their relative had missed their usual bath and brought this up with the staff. The bath book had been checked and the mistake acknowledged. An apology had been given and the issue had not reoccurred.

We asked the three people who used the service we spoke with if they had ever expressed any concerns or complaints. They said they had not, but would have no difficulty in doing so and felt the staff would listen to them.

We saw there were a range of activities on offer and people who used the service told us about trips that they had been on, or were looking forward to. We saw there were parties, entertainers, armchair zumba and trips organised. There was a two week programme of events displayed on the wall in the entrance corridor, but this could have been made more prominent and colourful to attract the attention of people who used the service and their relatives who may wish to join in the planned activity.

In the afternoon we observed the manager playing a picture recognition game with people who used the service in one of the lounges. Other staff assisted people to participate. Some other people were chatting, watching TV, doing word search or reading. There was evidence of dominoes and other games.

The home took people who used the service to a hotel in Blackpool twice a year. They tried to take different people each time. One of the visitors told us this had proved to be a popular event.

The home was very involved with the local community, including the church who provided communion regularly at the home. Occasionally trips out to the local pub were organised. Staff took people occasionally to the local school when some event or entertainment was taking place. The children from the local school often visited the home to provide some entertainment, such as singing and dancing.

We looked at four care plans and saw they included background information, personal preferences, likes and dislikes and end of life arrangements for those who had specified these. There was information about people's choices with regard to times for getting up and going to bed and times they liked to eat. Staff and relatives confirmed that these choices were respected. We saw that historical information, such as diagnoses, was always checked by the home to ensure it was still current. This demonstrated a commitment to person centred care.

We spoke with staff who demonstrated a good understanding of person centred (individualised) care and could explain how they delivered this, following the individual care plans. They told us handovers were comprehensive, both written and verbal, and staff meetings were useful in keeping them up to date with changes within the home.

People were given choices in a number of areas, such as where and when to eat, when to get up and go to bed, their preferred activities and hobbies and what they liked to wear. One person had expressed a wish to continue their hobby of bird watching and reading. These wishes were supported and the home had allowed the person's family member to install a birdfeeder in view of their room. The manager kept the person supplied with reading materials.

Some people liked to receive communion and this was offered on a fortnightly basis for those who wished to join in. This was recorded in people's care plans.

The lay preacher who gave out communion told us the number of those participating could vary from two or three to as many as 20. They were supported no matter what the numbers. There were no people who used the service who required any other form of religious or spiritual services at the time of the visit.

We were shown a copy of the minutes of a recent relatives meeting. This contained a request for ideas to be put forward for future activities and trips. Information was included about volunteers and meals. We saw that the next meeting had been scheduled to fit in with dates that suited relatives best, showing a commitment to being responsive to their needs and wishes.

One person who used the service had been supported to use the home's internet system to Skype their family. This allowed the person to "attend" their grandchild's wedding. They had also been supported to dress up for the occasion and a celebration had been held at the home.

Good

Is the service responsive?

One staff member commented that the home's ethos was "To try to keep a resident happy for each day if you can".

We noted that there was an up to date complaints policy, which was on display in the entrance hall, but no complaints had been received by the home recently. The manager told us they made themselves available for any concerns or comments anyone wanted to make. They said if concerns were raised they tried to address them at once, but always gave people the option of making a formal complaint if that was what they wished.

Good

Is the service well-led?

Our findings

There was a registered manager at the home. The registered manager operated an open door policy. Both visitors and people who used the service with whom we spoke confirmed that this was an active policy. The staff we spoke with were all able to explain the management structure. All said they felt able to voice any concerns at any time.

We had reviewed notifications, which are reports of incidents sent to us by the service, prior to our visit. These were sent in to the Care Quality Commission as required.

We saw the home had very strong links with the local community. People who used the service were supported to attend local events and activities and people from the community, such as the local church and school were welcomed at the home when they visited to offer a service or entertainment.

Contingency plans were in place for the use of the local church in the event of an emergency evacuation from the home.

A junior member of staff said that they felt involved in the team and found the manager to be very supportive. They demonstrated they had learned good practice whilst assisting in the dining room, talking to each person as they served them. A volunteer was clear about their role and could explain what they were expected to do at the home. They also described the registered manager as very supportive.

We saw a copy of the most recent newsletter, which was produced four times per year. This included information about activities, such as the home's garden party, which had taken place, suggestions gathered for changes to the menus, updates on renovations, minutes of the recent relatives meeting and the date of the next one and news of forthcoming trips. There were a number of colourful pictures in the newsletter so that people who were unable to read it would still see what was contained. This ensured relatives and people who used the service were kept up to date and involved with all that was happening at the home.

The home produced an annual survey as another means of gaining feedback from relatives and this was due to go out imminently.

We had received one "Share Your Experience" form, which was extremely complimentary about the service. We were shown a number of thank you cards and complimentary comments within the home's comments book, such as, "Thank you for looking after our X. You gave them much love and care and made our family welcome".

We saw that accidents and incidents were logged appropriately and that learning was taken for them. For example, equipment or management plans may be tried if a person was seen to be suffering a number of falls. The accidents and incidents were reviewed regularly to pick up on trends and patterns in order to address these.

The home had recently achieved the Investors In People Award, which is a management framework for high performance through people. This demonstrated a commitment to providing a good service.

We were told by a visitor and saw evidence of people whose loved ones had passed away still being involved in the home and visiting on a regular basis.

We saw and heard evidence of good partnership working with other services and agencies such as GPs, District Nurses, Opticians and Dieticians.

We saw evidence of a number of audits carried out by the home, such as care plans, health and safety, hygiene, accidents and incidents, fire safety and cleaning. These were up to date and complete at the time of the visit and we saw that shortfalls identified were addressed in a timely manner.