Care Quality Commission

Sentinel Health Care Limited

Dunwood Manor

Inspection report

Sherfield English
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Ratings

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

Overall summary

The inspection took place on 10 December 2014 and was unannounced.

Dunwood Manor Nursing Home provides accommodation and nursing care for up to 55 older people, some of whom may also be living with dementia or have a physical disability. The home is in a rural location in Sherfield English, near Romsey. There is access to gardens and a hydrotherapy centre. Hydrotherapy is the use of water in the treatment of different conditions, including arthritis and related rheumatic complaints.

Dunwood Manor has a registered manager in post. 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.

At the last inspection on 10 February 2014, we asked the provider to take action to make improvements in respect of acting in accordance with the Mental Capacity Act 2005. This was because staff had a lack of understanding

Summary of findings

of the principles of the Act and because mental capacity assessments and best interest decisions had not been correctly documented. The registered manager submitted an action plan which stated that the home would be compliant by 30 April 2014. This action has now been completed.

People told us they felt safe in the home. Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. Staff told us they were aware that they could report safeguarding concerns to outside agencies such as the police, the local authority and the Care Quality Commission.

Specific risk assessments were in place for each person in relation to falls, bed rails, safeguarding and mental wellbeing. Support plans were written in relation to each identified risk. Staff described how they learnt about people's individual risks from handovers and care plans. The daily handover sheet included information about people's individual risks in relation to their health, risk of falls, dietary needs and behaviours.

There were sufficient staff on duty in the home to meet people's needs. Staff commented on how well the permanent staff worked together but stated that agency staff were usually less effective. Sometimes permanent staff felt pressured but did not feel there were not enough staff to meet people's needs. On the day of the inspection, it was clear that staff were busy all day; however we noticed that call bells were answered within a reasonable time (approximately two minutes).

Recruitment and induction practices were safe.

Medicines were stored and administered safely. We checked records in relation to controlled drugs and found them to be accurate. Medication administration records (MAR) were kept for each person. We reviewed a sample of the records from the day of the inspection, which showed that medicines had been administered as prescribed.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and health and safety.

Training had taken place and some had been booked for nurses in respect of clinical competencies.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. We saw that staff interacted with residents appropriately and kindly, appearing to know them well as individuals, and treating them accordingly.

Mental capacity assessments had been undertaken which were decision specific, where relevant. Where a care plan was required in relation to mental capacity, this was reviewed on a monthly basis to ensure the most up to date assessment was in place. This was important because people's capacity can fluctuate. People made their own decisions where it was established, they had the capacity to do this, and their decision was respected.

We found that the registered manager had made appropriate Deprivation of Liberty (DoLS) applications and staff were aware of which people were subject to a DoLS and the restrictions these authorised. Handover notes included information on whether a DoLS was in place or whether an application had been submitted.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day. A tea trolley came round during the morning serving tea, coffee, fruit squash, biscuits and yogurts. The meals offered were home cooked, freshly prepared and nicely presented.

People were supported to maintain good health through access to ongoing health support. Following the inspection we received feedback from several health professionals who regularly visited the service. A dental officer told us they were always contacted appropriately and in a timely fashion. Two GPs and a pharmacist told us they regularly visited the home and were complimentary about the care. People using the service had access to an onsite hydrotherapy pool. Health needs were closely monitored within the home.

Staff were cheerful and attentive and had taken time to get to know people individually. One person told us about their interest in garden birds. Staff had ensured they were sat by a window so they could see the birds. One person said "The cleaner watered my plants for me this morning; I never asked for this, I thought it was considerate." Relatives were complimentary about the home; one relative said "They're so wonderful here."

Summary of findings

People were involved in decisions about their care and were offered choices in all aspects of their daily life. Privacy and dignity was protected and staff were able to respond appropriately to people's needs due to the detailed and accurate care plans, risk assessments, daily records and handovers. Care plans contained information about people's abilities, their desired outcomes and the support they required to achieve them, including any identified risks. People were encouraged to join in activities as much as they would like to. Detailed records were kept of activities with a sheet for each person recording the activity they had partaken, how much they had been involved and whether they had enjoyed it.

The provider had a complaints procedure which detailed how informal and formal complaints should be dealt with including. Complaints had been appropriately responded to, in a timely way.

There was a positive and open culture within the home. Staff said they felt able to raise concerns at any level of management, and were confident they would be responded to. Staff said they were actively encouraged through meetings and appraisal to give feedback about the service.

Improvements since the last inspection included the recruitment of a new registered manager, new care plans, a training pack for care workers and a clinical training booklet for care workers. Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. The quality of the service was closely monitored through a series of audits. A business continuity plan was in place to ensure the continuing care to people in the event of an emergency.

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 told us they felt safe. Staff had received safeguarding training and knew how to recognise the signs of abuse.

There were sufficient staffing levels to meet people's needs; however staff were pressured at times. Recruitment was planned for the new year.

Medication was stored and administered safely.

Is the service effective?

Good

The service was effective. Staff had received appropriate training to meet people's needs and had detailed knowledge about people's individual preferences. Staff delivered care in line with people's individual needs and wishes.

People, who were able, gave consent to their care. For people who were unable to give consent, the provider complied with the requirements of the Mental Capacity Act 2005.

The provider knew about the Deprivation of Liberty Safeguards and had made appropriate applications in this respect.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

Is the service caring?

Good

The staff were caring. Staff treated people in a kind and compassionate way. They took time to make sure that people were safe and comfortable and felt included.

Staff described how they provided care to people and respected their dignity. People and relatives were complimentary about the care received.

Is the service responsive?

Good

The home was responsive. Staff were able to respond appropriately to people's needs due to the detailed and accurate care plans, risk assessments, daily records and handovers.

Staff had taken the time to get to know people personally so they could respond to their preferences, likes and dislikes providing personalised care.

Is the service well-led?

Good

The home was well led. There was a positive and open culture within the home where feedback was actively sought and responded to. Staff and people using the service said they felt listened to.

The provider actively monitored the quality of care and took appropriate actions where necessary.

Dunwood Manor

Detailed findings

Background to this inspection

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

This inspection took place on 10 December and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. 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 used this information to help us decide what areas to focus on during our inspection.

During our inspection we spoke with 15 people using the service and five relatives. We also spoke with the registered manager, the Director of Care, the Managing Director, the chef, one nurse, three care workers and one domestic. We reviewed records relating to five people's care and support such as their care plans, risk assessments and medicines administration records.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation of their care and support. For example, we used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who are unable to talk with us.

Following the inspection we communicated with four health or social care professionals to obtain their views on the home and the quality of care people received.

Good

Is the service safe?

Our findings

Everyone we spoke with, who was able to express an opinion, said they felt safe. One person said "Yes, I feel safe; they do all they can to make you comfortable, they are very kind and look after you." People told us they knew who they could speak to if they did not feel safe.

Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. One staff member told us "Safeguarding is about the safety and protection of residents, including from staff and relatives. Abuse can be verbal, discriminatory or physical. If I had a concern I would report it to the manager or the senior nurse." Staff were also able to explain how they would recognise signs of abuse. One member of staff said "I keep an eye on people and would notice if they behaved differently, I look out for unexplained injuries or bruising." Staff said they would take people's concerns seriously if reported to them. The safeguarding policy was available for staff to review and relevant telephone numbers were displayed on notice boards. Staff told us they were aware that they could report safeguarding concerns to outside agencies such as the police, the local authority and the Care Quality Commission.

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage. There were specific risk assessments for each person in relation to falls, bed rails, safeguarding and mental wellbeing. Support plans were written in relation to each identified risk such as daily living skills, pain management or bowel care. Staff described how they learnt about people's individual risks from handovers and care plans. One staff member said "We get told about people's risks and if I need to check anything I will look at care plans." Staff were able to describe people's risks in relation to nutrition and hydration, dietary needs such as diabetes, mobility changes, falls and equipment and restrictions such as bed rails. The daily handover sheet included information about people's individual risks in relation to their health, risk of falls, dietary needs and behaviours.

A recent decision had been made by management to increase staffing levels within the home. This was due to the lay out of the home, increased numbers of people using the service and their raised dependency levels. As this had been a recent decision staff had not yet been recruited on a permanent basis and therefore the home was reliant on agency staff until the posts could be filled. Staff commented on how well the permanent staff worked together but stated that agency staff were usually less effective. Sometimes permanent staff felt under pressured but did not feel there were not enough staff to meet people's needs.

On the day of the inspection, the staffing complement were short by two because two agency staff had not arrived. It was clear that staff were busy all day; however we noticed that call bells were answered within a reasonable time (approximately two minutes). There was mixed feedback from people using the service about staffing levels but no one said their needs hadn't been met. One person said "I do use my call bell and the wait depends on whether they are otherwise engaged but they are pretty good." Another person remarked (when asked about call bell response) "Sometimes it's longer than others, but I've never waited for too long. They're around if it really matters."

Recruitment and induction practices were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were being completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Medicines were stored safely. The building was laid out in two wings, with two floors on each wing. Medicines were stored in a locked treatment room within each wing. There was a medicines trolley secured to the wall in each room and a controlled drugs cabinet secured to the wall. Controlled drugs are medicines which require a higher level of security. Medicines which needed to be stored in a fridge, such as insulin, were stored in a lockable fridge. Fridge temperatures were recorded on a daily basis. We checked records in relation to controlled drugs and found them to be accurate.

Medicines were administered safely. Records in relation to medicines were kept for each person using the service and included a photograph of the person and their date of birth, a list of any allergies, a list of their medicines and a care plan for each medicine which needed to be administered 'as required', known as PRN. Medication administration records (MAR) were kept for each person. We reviewed a sample of the records from the day of the inspection, which showed that medicines had been administered as prescribed. The provider carried out this

Good

Is the service safe?

check on a monthly basis. The medication audit showed that some gaps or errors had been identified but that appropriate actions had been taken to reduce future errors. We reviewed physical quantities of medicines (including controlled drugs) in relation to records and found these to be accurate. Blister packs of medicines showed that all medicines had been administered on the day of the inspection up until the time of our review.

Good

Is the service effective?

Our findings

A relative told us they were extremely happy with the staff describing them as "kind" and "thoughtful" in respect of her family member's care.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and health and safety. Staff told us about other training they had received to meet the needs of people using the service. One member of staff said "I have completed training in supporting people with Parkinson's and dementia." Another member of staff referred to Alzheimer's and end of life training which they had completed. They said they also had an opportunity to complete training in catheter care and percutaneous endoscopic gastrostomy (PEG) feeding. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding. One member of staff said they had completed PEG training because "I like to know what I'm doing, I don't support the person with their PEG but I can clean and maintain it – it was good to learn about what the PEG does on the inside of the person so I can clean it safely and carefully."

Care staff were given an 'Employee clinical experience record.' This was designed for care staff to improve their clinical skills and included areas such as maintaining skin integrity and understanding wound management. Staff completed each part of the record under the supervision of a clinically qualified mentor, who then signed off the record. The records were designed to be pocket sized and carried around by staff when on duty so they could be completed accurately each time a section was completed.

The Director of Care told us about a training development plan designed in conjunction with a local university aimed at delivering in depth training about caring for, interacting with, supporting relatives and addressing challenging behaviour in respect of people living with dementia.

Training had taken place and some had been booked for nurses in respect of clinical competencies. A company which supplied PEG feeding equipment had provided training in using and maintaining the equipment and providing on going care for people who needed to receive their nutritional intake in this way. Additional clinical training had been booked for nurses in January 2015 in respect of catherisation, venepuncture (the process of obtaining intravenous access) and the use of syringe drivers, which is equipment that helps to manage people's pain during their end of life care.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. Staff described people's individual needs and how they supported them. For example, for one person who could exhibit behaviours which may challenge others, one member of staff said "If they are safe, I keep calm, leave them and come back later." This description matched records in relation to the person's care.

We saw that staff interacted with people appropriately and kindly, appearing to know them well as individuals, and treating them accordingly. Staff showed knowledge about people's individual communication methods and difficulties; we found this to be useful and accurate information, which aided our conversations and interactions with people using the service.

We saw that care was delivered in line with people's wishes. One person using the service said "Staff ask me about what I like" and another person said "Staff listen to me and I think they know what I like." Staff told us they ensured that people were happy for their care to be provided. One staff member said "I can see from their faces or if they are not happy they will tell you." Another member of staff said "I try to communicate with people talking calmly and if they don't want to do anything, I would never force them."

1. We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. We found that staff had received training and were able to describe some of the key principles. Mental capacity assessments had been undertaken which were decision specific. For example one person had requested bed rails and had signed consent for these, however for two other people using bed rails, mental capacity assessments had been carried out followed by a record of a best interest decision because the people lacked capacity to make the decision for themselves. Where a care plan was required in relation

to mental capacity, this was reviewed on a monthly basis to ensure the most up to date assessment was in place. This was important because people's capacity can fluctuate. There was also recorded evidence of a decision made by a person not to use bed rails, but to use a crash mat by their bed at night. A crash mat is a thick padded mat used to cushion a landing or fall. People made their own decisions where it was established, they had the capacity to do this, and their decision was respected.

The Care Quality Commision (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Relevant applications had been submitted and staff were aware of which people were subject to a DoLS and the restrictions these authorised. Handover notes included information on whether a DoLS was in place or whether an application had been submitted. Staff were able to describe the support they provided to a person who had a DoLS, for example they described the restrictions on a person's movements within the home to protect the safety of other people.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. Fruit squash was available in the lounge all day and we saw staff pouring drinks for people. A tea trolley came round during the morning serving tea, coffee, fruit squash, biscuits and yogurts. We saw staff encouraging people to eat the yogurts. One person told us "I've only got to say I'd like a drink of milk and they get it, there is always a jug of water in my room."

The meals offered were home cooked, freshly prepared and nicely presented. There was a choice of two main courses, with alternatives like fish or omelettes, for those not wanting the main choices. There were also two puddings with an alternative of fruit. One person said "The food's very good, and the people are good – they get you anything you want. Yeah – I like it here – it's fine!" Another person told us the food was "very nice – they know I like my steak pie." The atmosphere during lunch was pleasant and enjoyable; we observed lively conversation and interactions between everybody. People who needed support to eat were assisted by either staff or relatives. Meals were quickly taken to those people who had chosen to eat in their room. They were attractively served on a tray and covered with a lid to ensure they were still hot on arrival.

Staff were aware of any special diets or people's dietary preferences. The chef showed us a list of people's special diets which was kept in the kitchen and also a list of everyone's likes and dislikes. A member of care staff accurately described people's dietary preferences and needs. They knew about people's vegetarian diets, diabetic diets and pureed diets. Care plans included risks assessments in relation to each person's risk of choking or malnutrition and there were plans in place to address any identified risks. Staff explained that they ensured people got enough to eat and drink by encouraging fluids and checking monitoring charts. Handover notes which were discussed at each change of shift included information about people's dietary requirements such as whether they required a soft diet, supplements, pureed diet, thickened fluids or assistance to eat and drink.

People were supported to maintain good health through access to ongoing health support. One person said "If I am not well, I stay in bed and they get the GP to see me." Following the inspection we received feedback from several health professionals who regularly visited the service. A dental officer told us they were always contacted appropriately and in a timely fashion. Two GPs and a pharmacist told us they regularly visited the home and were complimentary about the care. People using the service had access to an onsite hydrotherapy pool.

Health needs were closely monitored within the home. Care plans included information about people's health needs such as skin integrity, nutrition and fluids, oral health, pain management, falls and breathing. A monthly skin inspection record was kept for everyone and there were individual plans for anyone who needed wound care. This included a treatment plan about how to clean and dress the wound. Daily records were maintained in relation to fluid intake, urine output, diet, repositioning and whether bowels had been opened.

Good

Is the service caring?

Our findings

Staff who were bringing people into the lounge and settling them for the morning activity were careful to greet and chat to people already in the lounge, increasing the feeling of inclusiveness. We saw that staff were cheerful and attentive and had taken time to get to know people individually. One person told us about their interest in garden birds. Staff had ensured they were sat by a window so they could see the birds and we also saw that a member of staff had brought over a magazine for the person which was laid open at an article about birds, including lots of interesting pictures. Another person said "The cleaner watered my plants for me this morning, I never asked for this, I thought it was considerate," they went on to say "this morning I was all scrunched up and a carer came in and fixed my pillows for me and used a slide sheet to help make me more comfortable, they do their best to meet my needs." Relatives were complimentary about the home, one relative said "They're so wonderful here," and another said "We find it really good here. The care is good and the people are nice, particularly (the registered manager)."

A member of staff described how they provided care for people. "I treat people here like the friends and family I have cared for at home, I talk to families if I notice people need things, for example a lady with twisted legs would be more comfortable in a skirt than trousers and I have told the family this." They also told us they ensured that men were shaved and women had scarves, jewellery and make up if they wanted it. They said "I like to keep people to the standard they kept themselves before." We asked another staff member how they provided support in a kind and caring way and they said "It's the way I speak to people and have a smiling face. I ask how people are and offer them a cup of tea, for example."

People's care plans included a 'This is my life' record which gave a brief life history. It included what name people liked to be known as, the places they had lived, their school, job, hobbies and interests. A member of staff told us "When people come in we have their history and what is important to them explained to us in handover, we also get background information from people's families." One person's care plan had a named advocate. An advocate is someone who offers one to one support to someone and speaks on their behalf. The person told us about their advocate and the registered manager confirmed they had discussed elements of the person's care with their advocate and acted on the information.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. A member of staff said "We show people choices like food and clothes; it's not difficult to understand what they want." They went on to say that people were offered choices about bed times, activities, what they ate and drank, when to get up and if they wanted a bath. One staff member described how they communicated with a person who had no verbal communication to understand what they wanted "They can understand me but I have had to learn about their way of communicating their needs, I have got to know them and now I do understand what they are asking for."

People's privacy and dignity were protected. A member of staff said "We use (privacy) screens in double rooms, I make sure people are washed properly and have their pads changed and I dress people properly." Another member of staff said "When I take a person's top off, I cover them, I use (privacy) screens in double rooms and I ask people quietly if they need the toilet." Staff described how they used a blanket to cover people when they were being hoisted in case their clothes rode up. A person using the service said "Staff wash me sensitively, it's their job and I don't feel embarrassed."

Good

Is the service responsive?

Our findings

People said that staff had responded to their needs. One person described how they had two friends they liked to sit with in the lounge, and staff ensured they always sat together. Staff were able to respond appropriately to people's needs due to the detailed and accurate care plans, risk assessments, daily records and handovers. Staff had taken the trouble to get to know people personally so they could respond to their preferences, likes and dislikes providing personalised care.

Care plans contained information about people's abilities, their desired outcomes and the support they required to achieve them, including any identified risks. People's personal histories were included in their care plan and their choices and preferences were reflected. Where other people had been involved in discussing a plan of care, this was recorded. For example, a care plan for a person who lacked capacity included a Power of Attorney (POA) for health and welfare. The person with the POA had signed to confirm their involvement in the care plan. At the start of each care plan there was a statement which said 'On admission you will have a personal care plan. An RGN will sit with you and discuss and explain your care. We will place your needs, wishes, preferences and decisions at the centre of our assessment.' A date was recorded when it had been discussed with the person. An RGN is a registered general nurse.

Staff were knowledgeable about people's needs and preferences, for example, the moving and handling equipment they required, what they liked to eat and wear and where they liked to spend most of their time. One staff member said "We find it all out bit by bit, for example some people have baths in the evening now, which is when they want them, as opposed to the mornings." Another staff member said "If I notice something different about people's needs, I report it to the RGN at handover, I saw that what I raised was then included in the following handover which meant the change was communicated."

People were engaged in a 'sing a long' to a CD of Christmas songs in the lounge. The member of staff conducting the activity was keen to involve each person as much as they would like to, and went from person to person with smiles and encouragement. Detailed records were kept of activities with a sheet for each person recording the activity they had partaken, how much they had been involved and whether they had enjoyed it. Notes were also kept about one to one activities and social sessions which were held with people who preferred to stay in their rooms. The home had recently employed a part time social care observer. Their role was to observe social interactions in communal areas and report on the quality and whether any changes or improvements were needed. The home was monitoring social interaction to ensure that everyone was included on whatever level they wished to be.

The provider had a complaints procedure which detailed how informal and formal complaints should be dealt with including; who deals with the complaint, acknowledging the complaint, the timescales for response, the investigation and responding to the complainant. Records of complaints showed they had all been responded to in good time and included actions taken to address the complaint. From our discussion with the registered manager it was clear that information from complaints was used to make improvements to the home. Staff told us that if any complaints were raised with them, they passed them on to nurses or the registered manager. Records were also kept of cards and letters of thanks. One letter referred to staff's compassion and gentleness and there was another card thanking staff for a lovely birthday.

Good

Is the service well-led?

Our findings

There was a positive and open culture within the home. Staff said they felt able to raise concerns at any level of management, and were confident they would be responded to. One member of staff said "I have no hesitation in speaking to the manager or team leader as they are kind and good and calm. The atmosphere is good and the staff are like family. I feel part of the family and I am learning something new every day." They went on to say that staff have meetings "All the time and we speak to the owner too, who is very kind." Another member of staff said "I feel happy and confident about the manager, they have made a big difference here, we raise things and they sort it out." Staff said they were actively encouraged through meetings and appraisal to give feedback about the service.

Feedback was sought in other ways for example an annual family and friends questionnaire was sent out. There was documentary evidence of an action plan based on the results of the last survey. The action plan had been completed. We observed new furniture in the lounge, an updated activities programme and an increase in staffing levels, all done in response to the survey. Minutes of monthly residents meetings were available which documented that people were asked if they were happy with the food. People also put forward ideas for activities such as a visit to the Watercress Line.

The Director of Care discussed improvements since the last inspection. These included the recruitment of a new registered manager, new care plans, a training pack for care workers and a clinical training booklet for care workers. Clinical audits were now carried out twice monthly and the provider had recently recruited a social care observer to improve social interaction across all the homes run by the provider. She also discussed challenges which the home had faced such as getting to grips with the Mental Capacity Act 2005 and staff recruitment, especially at this time of year and with the recent increases in shift numbers. The home had not been successful to date in recruiting a deputy but it was felt that would be possible in the new year.

Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. There were policies in place which included a staff recruitment policy, an induction training policy, staffing levels policy, incident policy, staff supervision policy, mental capacity policy and a DoLS policy. On admission to the home each person was given an information pack which included a company mission statement and a statement of values. These were linked to providing a standard of excellence around core values of dignity, choice, respect, fulfilment, inclusivity, independence, diversity, security, equality, rights, dignity and empowerment. Our observations around communal areas in the home, reviewing care plans and speaking to staff, people and relatives showed that care within the home was delivered within the core identified values. This was particularly reflected in the caring nature of staff and their attention to small details which can make a big difference to people.

The quality of the service was closely monitored through a series of audits including care plan audits, infection control audits, health and safety audits, bladder and bowel care audits and medication audits. The health and safety audit was carried out by an external company on an annual basis and identified actions from the last audit in February 2014 had been completed. Identified actions from infection control and medication audits had also been completed. Quality assurance audits were carried out by the provider and actions included the purchasing of a new television and two new sluice machines, the identification of a room for decoration and the chef being booked onto a course about allergens. An allergen is a substance which causes an allergic reaction.

The home also completed a monthly accident analysis identifying the number and type of falls and ensuring that relevant risk assessments and safety measures were in place. A monthly tissue viability return monitored types of wounds for example pressure ulcers or skin flaps, actions taken and progress of the wounds.

A business continuity plan was in place to ensure the continuing care to people in the event of an emergency. The plan considered accommodation loss, catering disruption, emergency lighting, frozen food, disruption to gas supply, loss of water supply and disruption to the laundry service. It described the circumstances in which the plan would be activated and also considered debriefing and learning lessons after the event.