Scimitar Care Hotels plc

Minchenden Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place over two days on 29 and 30 November 2016 and was unannounced. At our last inspection on 16 September 2014 2014 we found that the provider met all standards that we inspected.

Minchenden Lodge provides residential care and support for a maximum of 21 older people. Some of whom may be living with dementia.

There was 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.

Staff had received training on medicines administration and people were supported to take their medicines safely. Medicines were accurately recorded on medicine administration (MAR) sheets.

People were involved in decisions about their care. Where people were unable to have input, best interests meetings and decisions were recorded. Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. We saw that care plans were regularly reviewed and updated immediately if changes occurred.

Risk assessments gave staff detailed guidance and ensured that risks were mitigated against in the least restrictive way. Risk assessments were reviewed and updated regularly.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

There were activities provided for people both within the home and outside. People were also able to request activities if they wished. Activities were discussed during residents meetings.

People and relatives were involved in end of life care planning. People experiencing end of life care were treated with compassion and empathy.

Staff received regular, effective supervision and attended monthly team meetings.

Staff, people and relatives were positive about the culture of the home and the management.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care. There was a complaints procedure as well as incident and accident reporting. Surveys were completed with people who use the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

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. Staff were able to tell us how they could recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

People were supported to have their medicines safely. Staff were knowledgeable about the medicines they were giving.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink so that their dietary needs were met. Where people had specialist dietary needs, these were understood and catered for.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care.

Staff treated people with dignity and were patient and kind in their interactions.

End of life care was compassionate and planned according to people and relatives wishes.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

People were encouraged to be as independent as possible, be part of the community and maintain relationships.

People knew how to make a complaint. There was an appropriate complaints procedure in place. The home responded appropriately to any complaints.

Is the service well-led?

Good

The service was well led. There was good staff morale and guidance from management.

The home had a positive open culture that encouraged learning. Best practice was identified and encouraged.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Minchenden Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 November 2016 and was carried out by two inspectors. The inspection was unannounced.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at eight people's care records and risk assessments, eight staff files, 20 people's medicines charts and other paperwork related to the management of the service. We spoke with 15 people who used the service, five relatives and six staff. We also spoke with three healthcare professionals that visited the home during the inspection.

Good

Is the service safe?

Our findings

People told us that they felt safe. People said, "Yes, I feel safe. This is my home", "This is about the best home available" and "Oh goodness, yes I feel safe." A relative told us when asked if they felt their relative was safe, "Absolutely, definitely yes." Another relative said, "I've been on holiday and I had every confidence that I could leave my [relative]."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us that safeguarding was, "Protecting residents from harm. That we are taking care of their wellbeing. I would take it [if abuse was suspected] to my manager, head of the company and if nobody did anything I would go to CQC." Another staff member said, "It [safeguarding] is to prevent people from harm and abuse. I have to report it." Staff told us, and records confirmed, that they had been trained in safeguarding as part of their induction.

Staff understood what whistleblowing was and knew how to report concerns if necessary.

Risk assessments were person centred and written in collaboration with the individual. Staff told us that people had input into how risks were managed and mitigated against. Risk assessments were detailed and gave guidance for staff on how to support people in the least restrictive way. Where people had capacity they had signed their risk assessments. Where people lacked capacity we saw records of best interests meetings and decisions.

All risks identified were graded as low, medium or high. Each risk was documented on a separate page and colour coded according to the level of risk. Risk assessments provided staff with detailed information on what the risk was, how to mitigate the risk and what actions to take should the risk occur. All care files that we looked at contained assessments for falls. The assessments graded falls as low risk, medium risk or high risk. Where the assessment was scored as medium or high, risk assessments were in place for people setting out clear actions for staff to mitigate the risk, this included the use of bed rails and pressure sensors next to people's beds.

The home assessed people's potential for developing pressure ulcers by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. If an individual is classed as medium or high risk their pressure mattress suitability is re-assessed. Records showed that Waterlow assessments were completed each month for people. Where a higher risk was identified people were referred for further assessment for appropriate equipment to a tissue viability nurse. The home currently had no people with pressure ulcers. Where people had been assessed as being at high risk of developing pressure ulcers, risk assessments gave staff guidance on how to mitigate the risk. For example, one person's risk assessment stated, 'Encourage [person] to stand and move his body at regular intervals to relieve pressure from his sacrum area and pressure points to encourage blood supply to the area'.

Two people required fluid charts to monitor their fluid intake. Records showed that staff were documenting that people had been checked on a regular basis and provided with fluids. However, these charts did not document how much fluid the person had been given or should be having to maintain hydration. The deputy manager showed inspectors documentation about how much fluid was required but this had not been attached to the fluid charts. We spoke with staff who were able to tell us what people's requirements were. Updated fluid charts were put in place by the end if the inspection.

There were sufficient staff to allow person centred care. We saw, and rotas confirmed, that there were six staff on morning shifts, five staff on afternoon and evening shifts with three waking night staff. Records showed that the home completed a dependency assessment for each person on a monthly basis and submitted the results to the provider's head office. A dependency assessment looked at the level of support a person requires throughout the month and allows the home to adjust its staffing levels accordingly. The deputy manager told us that the home over employed staff to ensure that staffing levels were kept at a good standard. The home did not use agency staff. Even if the monthly dependency assessments stated that the home required less staff, staffing levels were not decreased. The deputy manager told us that when people were going out and required support the home looked at staffing and would book extra staff if necessary. Relatives were positive about new staff. One relative said, "When staff leave and new ones come in its seamless. The standards [of care] have never dropped."

The home had a clear medicine administration policy which staff had access to. People's medicines were recorded on medicines administration record (MAR) sheets and used the biodose pack system provided by the local pharmacy. A biodose pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. This includes tablets and the correct dosage of liquid medicines where required. It is usually provided as a one month supply. We checked MAR charts for 20 people for September, October and November 2016. People's medicines were given on time and there were no omissions in recording of administration. One person told us, "They are very good with my tablets. I always get them."

Two people were receiving end of life care. The home had medicines to ensure that people were comfortable in the event of failing health. The home had appropriate storage for controlled drugs. There was a separate controlled drugs cabinet. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. We saw that there were detailed administration records for people that received controlled drugs.

One person was diabetic and insulin dependent. Records showed and we observed a district nurse visiting to administer the person's insulin each morning. The MAR chart was signed by the district nurse.

Three people were receiving covert medicines. Covert medicines are where the home administers medicines without the person's consent. There were detailed records in place which documented the medicine to be given covertly and how it should be administered. This had been signed off by the GP. However, covert administration had not been signed by a pharmacist. The deputy manager told us that the pharmacist had seen the covert medicine forms and verbally agreed but had not signed the forms. We raised this with the deputy manager during the inspection. The deputy manager discussed this with the pharmacist who faxed and authorised the documentation and showed the inspector.

Where specific medicines were not appropriate to be in the biodose packs and these were clearly labelled with the person's name and kept in separate sections in the medicines cabinet. Homely remedies were stored separately in a locked cabinet. Records showed when people had received homely remedies and what they had been given for. We saw that the GP had authorised specific homely remedies to be used

within the home. This included remedies for coughs, colds and constipation.

There were records for 'as required' (PRN) medicines. As required medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious or require pain relief. For each person that had PRN medicines there was a separate sheet that detailed what the medicines were, in what event they should be given and guidance for staff on how to administer the medicine.

The service followed safe recruitment practices. We looked at eight staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Each person had a personal evacuation plan (PEEP) in place, in case of a fire. A PEEP assesses how people should be evacuated if they have mobility issues and the best way for staff to support them. Records showed regular testing of the fire alarm systems and fire drills.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records were detailed and noted the issue, if there had been any investigation, the outcome and any learning from the accident or incident. Staff meeting records showed that incident and accidents were discussed at team meetings.

All bedrooms and bathrooms had a call bell system in case people required help. Inspectors checked the response times when call bells were rung. Two staff responded to an active call bell within 30 seconds. People told us that staff were quick to respond if they rang their call bells for help. There was a system in place for the registered manager to monitor how often people used their call bells and if this meant that people needed a higher level of support.

The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

The service employed three cleaners, one of whom was due to start following appropriate reference checks. During the inspection we observed that the home maintained a high standard of cleanliness. Relatives and people that we spoke with confirmed that the home was always clean and well maintained by the provider.

Good

Is the service effective?

Our findings

Staff had a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures, medication training and manual handling. Training records showed that staff received regular training that supported them in their role.

Staff told us and records confirmed they were supported through regular supervisions. The home provided four supervisions a year, including an annual appraisal of staff performance. Staff told us, and records showed, that they received supervision every three months. Staff members said. "Supervision is to ensure we are getting on well with our work, to discuss any issues and look at training we have done or need" and "It's [supervision] every three months. To make sure that everything is ok. That we are comfortable with what we are doing. Also, for the senior to know out progress." All staff that we spoke with said that they were able to request supervision if they needed to and they could always discuss issues with their line manager without waiting for their diarised supervisions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). One staff member told us that DoLS was, "For their [people's] protection around decision making. So, if they've [people] got dementia they may not be able to make safe decisions for activities of daily living, diet etcetera. You need something in place to ensure people are supported with appropriate decisions." Another staff member said that, "DoLS can take away their [people's] rights and can override their decisions. It is part of the Mental Capacity Act and DoLS helps provide support safely."

Where people required a DoLS, these were in place. There were dates noted for when the DoLS needed to be reviewed. The home had detailed MCA assessment forms that had been created following appropriate legal guidelines. Where people were unable to make decisions regarding their care there were records of best interest meetings. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. Where people were being deprived of their liberty by the use of bed rails, there were records of DoLS to support this as well as records of best interests meetings with relatives and healthcare professionals.

People were supported to have enough to eat and drink. There was a four week rotating menu in place which offered two choices at each meal. There was also a vegetarian option. People, staff and relatives, told us that snacks and drinks could be requested at any time. One person said, "The food is very good. I was involved in a relatives meeting and we talked about food. It is very good food. There is a menu in the dining room. We do get choices. Usually there are a couple of choices and if you dislike any of them you get something else. I don't like some stuff but you can ask for an alternative." Other people said, "I don't mind the food. I've got no complaints about that. If I asked for something else I'd get it" and "I don't go hungry here. That's for sure." Records showed that food choices were discussed during residents meetings. The service supported people that were diabetic. The deputy manager told us that the service ensured that they bought diabetic items such as diabetic ice cream, crisps and chocolate. The chef was aware of the types of food diabetic people could eat.

Where people required a specialist diet, such as thickened fluids or soft food, this was clearly recorded and staff were aware. This was also clearly noted in the kitchen to ensure that kitchen staff understood people's individual requirements. Assessments form Speech and Language Therapists (SALT) for people and advice had been included in care plans. We observed, at breakfast on the first day, staff using a person's prescribed thickener to thicken drinks and supporting people to eat that required a fork mashable diet.

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by professionals was included in peoples care plans. People were able to access healthcare with support from staff. Staff said that they knew about people's individual healthcare and how to refer people if necessary. This included dentists, doctors and opticians. Where people required referrals to specialist services such as SALT, there were records to show that this was done and followed up by staff.

We spoke with two visiting district nurses and a physiotherapy assistant during the inspection who told us, "Its lovely, always someone to help you out. I came to assess a person who was a bit scared as they didn't know me. Staff were available to assist" and "All the staff [at the home] are involved in the patients care and want to help and encourage. Communication is definitely great. I always see the patient in private."

Good

Is the service caring?

Our findings

We asked people if they thought that staff were kind and caring. One person told us, "Kind? Never thought of them in any other way. They're kind people" Another person said, "They're [staff] very nice. It's a lovely home. Very nice." Relatives commented, "When you come in they [staff] know us by name, so welcoming. This place is faultless. We have been coming here for two and a half years. We came in the door and we got the positive vibes. You could tell straight away what caring people they are" and "The people here have become my [relatives] extended family. They [staff] are fantastic. Ten out of ten in every aspect." There was a calm relaxed atmosphere throughout the home during the inspection. Singing and laughter was heard on a regular basis.

Staff sought people's consent to provide care and understood how this impacted on people's welfare. We observed staff knocking on bedroom doors and waiting for an answer before entering. People told us, "Oh, they always knock" and "They [staff] check if I am ready for a wash. If I say no, they'll wait for me to be ready."

Staff were aware of the importance of treating people with dignity and respect. One staff member told us, "If I am going into a resident's room, I knock and wait. Greet them. I explain why I am there. If they can make decisions I let them such as, what clothes they want to wear, how they want their hair. If I am giving personal care, I make sure that down below is covered. I always tell them and explain what I am going to do before I do it." One person commented, "[Caring] it's one of the jobs that they do beautifully."

People's waking and sleeping preferences were noted on their care plans. People told us that they were able to get up and go to bed when they wanted. One person commented, "I don't have a bedtime. I go when I'm tired. The staff never try to put me to bed." On the first day of the inspection, we observed a member of staff taking a person a cup of tea at 10:30 as they had just woken up.

People's faith was noted in their care files. The home had a visiting priest that conducted services for these that wanted to attend. The deputy manager told us that there were no people at the home that had a differing faith. We asked how the home would support people of a different faith if they moved in. The deputy manager told us that if someone with a differing faith moved in they would look at how that person wanted to be supported and put appropriate support in place.

There were appropriate arrangements in place for end of life care. There was detailed guidance for staff on dealing with individuals at the end of their life with dignity and respect and ensuring the person's wishes were carried out. Relatives had been involved in planning the care and one relative said that the care and attention to detail provided by the home had been, "faultless" and "caring."

Relatives said that they were able to visit when they wanted to and were always welcomed by the home. One relative told us that they could visit, "Twenty four seven" if they wanted to. Throughout the inspection we observed family and friends visiting and taking people out. Staff knew each visitor by name and stopped to chat with the, We saw that visitors were offered tea and coffee.

The home had a licenced bar in the dining room. People told us that they were able to use the bar for, "The odd tipple." Staff told us that whist this was not used regularly but that it helped people have a homely environment.

There were records of regular monthly residents meetings. These included discussions around food, people's opinions about the care they receive activities and any house news that needed to be shared. People were encouraged to bring issues up and discuss them. Two relatives told us that they were invited to resident's meetings and had found them useful and informative.

Good

Is the service responsive?

Our findings

Care plans were detailed and person centred. There were comprehensive records of people's backgrounds and personal histories which staff were aware of when we talked to them. One person's care plan noted, "I like to have a read of my kindle or browse through my IPad. I enjoy a hot drink before bed and some cheeky biscuits too." Another person care records noted that the person liked to have their handbag with them at all times and could become distressed if it was not with her. We observed this person with her handbag and staff checking that they had it with them. Care plans covered people's physical, mental and emotional wellbeing as well as the little things that were important to them and made a difference to their lives. One person said, "We are all special here."

People and their relatives were involved in planning their care. Relatives commented, "I'm involved in planning [relatives] care. We went through it, wrote it up and I read it and signed it" and "I reviewed it [the care plan] with [the deputy manager]. They discuss everything with us. I have complete confidence in them." People that we spoke with confirmed that they were fully involved in planning their care and were happy with the support that they were receiving.

Care records showed that people and their relatives had been involved in the initial assessments and on-going reviews of people's needs. As part of the initial assessment, people were able to spend time at the service on a trial basis so that staff could become familiar with their needs. This included day visits and overnight visits. This also allowed people to become familiar with the staff and the service.

The home completed yearly reviews of the care plans. The deputy manager told us that people and relatives were always involved in reviews. We asked a relative if there were regular reviews and they said, "All the time. I'm involved in everything." Another relative confirmed that the persons care plan had been changed following a review, "We have seen the care plan and it has been altered and brought up to date." Records confirmed that if there were any changes in people's needs, the care plans and risk assessments were updated immediately.

The home promoted people maintaining relationships with people that mattered to them. Relatives commented that they were welcome by the home to have meals with their relatives. One relative said, "I've had several meals. Anytime I can come and eat with [relative]. Never an issue. The standard is very good."

The home did not have an activities coordinator. However, the deputy manager told us that the home was in the process of employing one. A member of staff had taken on responsibility of organising activities. We observed a sing along on the first day of the inspection. There was a notice board that told people what activities were going on and when. For example, arts and crafts and music and movement classes. We observed people going out to the theatre on the second day of the inspection. People told us, "Oh, I'm never bored here" and "I don't join in as I can't but I like to go into the lounge and watch." The provider had purchased a new mini bus to facilitate day trips.

The home had several adapted bathrooms to accommodate people who needed support when bathing.

Taps on sinks in all bathrooms were adapted to ensure that people with dementia or problems with mobility could use them and had an automatic shut off. The deputy manager told us that this helped people maintain their independence and also their safety as there was no risk of flooding. Water temperature was thermostatically controlled to ensure people's safety and prevent scalding.

The home was dementia friendly. People's bedroom doors were different colours with numbers and letterboxes. Where people had dementia or memory problems this allowed people to identify their bedrooms easily. The corridors where the bedrooms were located were decorated like a street to look like people were entering their own homes. This gave a homely feel and people commented, "It feels like home here" and "It is cosy and well decorated."

Rooms were decorated when a person moved out including replacement of carpets. When new people moved in, as part of their assessment, they were asked if they had any preferences in relation to the decoration of the room. Rooms were personalised with pictures, photos and ornaments. The deputy manager told us that when people moved in, they were able to bring items of furniture from home with them to make sure that they felt comfortable. We observed several rooms where people had brought in their arm chairs, dressers and other homely items.

The home had a complaints procedure that was available for staff and people to read. People and relatives said that they had been given information by the home on how to complain but that they would talk to the registered manager or deputy manager if they needed to. Resident meeting minutes showed that people were encouraged to complain. "I've got all the information [on how to complain] in the information pack but my first port of call would be [the registered manager]." The home had not received any formal complaints in the past year. However, the deputy manager told us that any complaints were taken seriously. We saw that where people had raised issues the home had treated these like complaints, investigated and fed back to the person. This included complaints about food, 'there was no vanilla ice cream' and 'the carer did not put sugar in my tea'.

Good

Is the service well-led?

Our findings

There was a positive open culture within the service. The manager knew people using the service well and both people and staff were encouraged to voice their views and opinions. Staff were positive about working at the home. One staff member told us, "I love it here. It's a smaller home and I love it. It's more like a family environment." People were confident that they were able to ask questions. One person said, "I asked staff about what you [the inspection] are doing and this was explained to me without any problem."

Management had a consistent clear vision and strong values which was reflected when talking to staff and healthcare professionals. Staff were aware of the values of the home and had been trained in this during induction. We asked relatives and people about the registered manager, relatives said, "We are able to approach [name of manager] the manager. She is a hand's on manager. Absolutely on the ball" and "[Name of manager] is amazing, always there to help and so is the deputy. They are so responsive to anything we need." We asked about communication between them and the home. Their response was, "Fantastic, absolutely faultless." People, where able, knew who the manager was. One person commented, "Aw, she's a sweetheart. Really kind and helpful."

Healthcare professionals that we spoke with were positive about the management of the home and guidance that staff received regarding referrals and care and treatment provided by them. One healthcare professional commented, "Its top down management."

We reviewed accident and incident logs. It showed that the manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report and record accidents and incidents.

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training. We saw that where a staff member identified training that would improve their care practices, this was provided. There were quarterly team meetings which allowed staff to discuss any issues and concerns. It was also an opportunity for the manager to update the team on any management issues or changes within the home.

There were regular audits of various aspects of the service. The registered manager and deputy manager completed quarterly care plan and risk assessment audits. A 'resident's file audit' which looked at all information held about people and ensured it was up to date. There were six monthly staff file audits which checked supervision, appraisal and recruitment information, Bedroom audits to ensure maintenance, infection control, training and medicines audits. Where any issues had been identified, all audits had an action plan and follow up information noting how things had been addressed. The deputy manager told us that audits were a way of quality assuring the home and the care that was provided to ensure best practice.

The home completed an annual survey with relatives and people that used the service. The most recent

survey from the end of 2015 was available for people and relatives to read. Questionnaires were sent out and results collated into a short report. The survey was positive and noted any leaning for the home. The home was in the process of staring the 2016 survey.

All policies and procedures held by the service were up to date and included date for review. The provider updated policies as and when necessary according to legislation changes and reviewing care practices within the service.