Hampshire County Council

Forest Court Nursing Home

Inspection report

Forest Way
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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

About the service
Forest Court Nursing Home is a care home which currently provides personal and nursing care to 71 people aged 65 and over. The service can support up to 80 people, including people admitted for short stay and reablement and those living with dementia.

People's experience of using this service and what we found
Staff and managers were committed to continually improving the service and what they could offer people living there. There was a strong person-centred culture which reflected the provider's values.

Clinical audit systems were given a high profile and were in place for monitoring service provision. These showed management had a robust oversight of service quality and everyone's safety.

The provider had a programme of ongoing investment to improve the environment. This included investing in technology and systems to improve both the environment and people's experiences of care.

People felt safe. Staff had received training in safeguarding and understood the actions they needed to take if they identified any concerns.

Systems were in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. A range of healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

People received personalised care in line with their assessed needs and their care plans. Risks were assessed and actions taken to minimise these while promoting independence as far as possible.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

People were supported to have enough to eat and drink. Attention was paid to people's hydration needs and a breakfast club had been developed and was also used as a social occasion.

The service was responsive to people's needs and staff listened to what people said. People were confident they could raise concerns or complaints and that these would be dealt with.

People and their families or other representatives were involved in discussions about their care planning. The provider sought feedback through the use of questionnaires and surveys.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 26 October 2016).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below

Is the service effective?

Good

The service was effective.

Details are in our effective findings below

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Forest Court Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector accompanied by a Specialist Advisor and an Expert by Experience. The Specialist Advisor had clinical and practical experience and knowledge of best practice relating to the care of older people and those living with dementia. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Forest Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with nine people who used the service and two relatives about their experience of the care provided. We spoke with ten members of staff including the registered manager, deputy managers, registered nurses, assistant practitioners, and care assistants. We also spoke with a visiting social care professional.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People felt safe and well treated living at the home. One person, when asked if they felt safe said "Yes I do. Nobody can get in."
- Policies and procedures in relation to safeguarding and whistleblowing were in place and information on the importance of speaking up about poor practice was accessible to all staff.
- Staff confirmed and records demonstrated they had received training in safeguarding adults and this was regularly updated. Staff were aware of the possible signs that could indicate abuse and told us they were confident that any issues they reported would be responded to appropriately by the provider and registered manager.
- Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns.

Assessing risk, safety monitoring and management

- The care plans reviewed contained risk assessments. These were reviewed monthly and updated when people's needs changed.
- People had been risk assessed for areas such as not being able to use the call bell, for falls, moving and handling, tissue viability and choking. When risks had been identified, care plans contained clear guidance for staff on how to manage these.
- There were clear systems in place to monitor people following any falls and assessing where people may be at risk of becoming malnourished and losing weight.
- One relative told us when staff used the hoist for their loved one, "There is always two (staff) and sometimes three."
- The registered manager had undertaken training in pressure care and worked with social workers to ensure a shared understanding about pressure area risks and assessment.

Staffing and recruitment

- We received mixed views from people and their relatives on whether there were sufficient staff. One relative told us "If I want to take (person) in the wheelchair somewhere I have to wait a long time for two staff to hoist (person)". One person said, "I rang one morning and waited and waited. Eventually someone came and said 'they are doing breakfast, you will have to wait.' Other people told us, "If I need help I just ask"; and "I use my buzzer and they come quite quickly".
- We observed sufficient staff on duty and different roles all worked together at busy times such as meal times to provide a good service.
- Staffing had clearly defined roles, for example there was a designated member of staff on the reablement

unit with a lead role to ensure liaison happened with other agencies so that admissions, discharges and referrals did not impact on the staffing in the unit or across the home.
● A dependency tool was used to assess people's changing needs and staffing rotas were regularly monitored to ensure that there were sufficient numbers of staff on duty.
● Robust recruitment procedures were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.

Using medicines safely
● Medicines were managed and stored safely. People received their medicines from staff that were trained to do so and who had regular assessments to ensure they remained competent to administer medicines.
● Medicine administration records (MARs) had been completed accurately. Two staff members had signed they had checked medicines into the home. This helped staff check the numbers of medicines people had.
● People's medicines records included important information such as allergies and an up to date photograph of each person.
● We observed the registered nurse and assistant practitioner administering medications in the morning and at lunchtime. They were friendly and patient, giving people the time they needed to take their medicines.
● Controlled drugs were stored and managed safely and in line with current practice. This included having a second member of staff check and sign when these drugs were administered.
● There were clear instructions for 'when required' (PRN) medicines. The instructions gave staff details, which included the name and strength of the medicine, the dose to be given, and the maximum dose in a 24-hour period, the route it should be given and what it was for. This helped prevent errors.

Preventing and controlling infection
● The provider had infection prevention and control (IPC) policies and procedures.
● Staff were trained in IPC and were equipped with protective clothing, such as aprons and gloves.
● Cleaning records were in place and there was a range of audits carried out and signed off by senior staff.
● People said the service was clean. For example one said , "It's clean and no smells."

Learning lessons when things go wrong
● Incidents and accidents were recorded electronically from written incident forms. The records showed appropriate action was taken. Protocols were in place to ensure staff monitored people for any health concerns for 24 hours following any accidents or incidents.
● The system in place for recording incidents would raise a flag, for instance if someone had a fall more than three times in three months, they would then be monitored more closely. The incidents were also reviewed by the providers' care governance team on a monthly basis.
● Following an incident around a person's discharge from the reablement part of the service, the procedures had been reviewed. When a person comes to stay on a short term basis, the person now must have an allocated social worker and exit strategy. This prevented people having to stay longer than necessary and ensured the reablement part of the service could operate as such.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had individual care plans in place based on initial and on-going assessments. These had been updated regularly with clear review dates set after each care plan had been agreed. Changes in people's health and well being that required different levels of support or assistance were recorded and shared with staff.
- From the daily notes it was evident that people were provided with good quality care and support, which was individual and personalised. From the initial assessments, through to the delivery of care, steps had been taken to ensure that each person's preferences and needs were understood.
- People with physical health needs, for example, catheters, epilepsy, diabetes type 1 and 2, had care plans to guide staff on how to care for them. For diabetes management there was a good resource book with relevant information for staff to refer to.
- Wound care assessments were up to date and detailed with photographs and body maps for staff to monitor progress.
- Where people were not able to express that they were in pain, a pain assessment tool was used.

Staff support: induction, training, skills and experience

- The provider's induction programme for new staff involved eight days of essential training during the first four weeks, complemented by shadowing experienced staff to help ensure that the training could be applied in practice. There was also an onsite induction which introduced staff to their role and responsibilities, which included health and safety and fire safety training.
- The provider required staff to complete further mandatory training in dementia care, emergency first aid, safeguarding, moving and handling, infection control, the safe use of medicines and food safety. Staff could also complete additional training including, for example, training in positive behaviour support. An online system was in place to track the training that each member of staff attended.
- Refresher training in various subjects was provided using alternate online and 'classroom' based approaches. A training room was available within the home.
- A staff supervision structure was in place that included observation and monitoring of care practices and annual appraisals.
- Staff spoke positively about the training and support they received and told us they could request additional training if they felt the need. They demonstrated clarity regarding their role and a person-centred approach to caring for people.
- Nurses spoken with had received appropriate training and had the skills they required in order to meet

people's needs. They knew when their revalidations were due and said the deputy managers and registered manager were always available to support them when revalidating.

Supporting people to eat and drink enough to maintain a balanced diet

● Each unit within the home had a member of care staff trained and assigned as hydration champion. The sole focus of this role was to ensure people drank sufficient amounts to stay hydrated, prioritising those people assessed as needing support, for example with fortified drinks and shakes. Hydration champions were also involved in referring people to a dietician if needed.

● There was also a member of care staff on each wing assigned as 'nutritionist' and on duty during breakfast and lunchtime. A nutritionist we spoke with had a good knowledge of people's dietary needs, likes and dislikes. They also showed us where such information was recorded and available to all staff during meal times.

● Each person had a nutritional assessment and support plan that was kept under review. This included their individual preferences, for example having small portions of food if large meals put them off eating. A risk assessment tool was used to help identify anyone who might be at risk of malnutrition and specific care plans were in place to minimise the risk. Food and fluid charts were used to monitor people's intakes. We observed jugs of squash with beakers and glasses were available at points around the home.

● We observed the lunchtime meal being served. Staff with a variety of roles assisted with the delivery of food and support people required. People received meals that were appropriate for their assessed needs, for example soft diets. A person asked for a plate guard and a member of staff got this for them and asked if the person wanted any help with their meal, addressing the person by their preferred name. A member of staff sat at the bedside of a person who ate in their room, providing patient, friendly support and telling the person what food was on the plate.

● On the second day of the inspection, a person told us they were going to 'breakfast club'. They said "It's very social" and commented on the nice smell of cooked breakfast coming from the kitchen. Another person said the food was "Very nice, it's lovely." Other people we spoke with commented that the food was good.

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support

● In nutritional assessments, where necessary, people had access to specialists such as dieticians or speech and language therapists (SALT). The service has introduced a Skype assessment system, which is connected to the NHS. This means people with swallowing problems were being assessed quicker by the SALT team and safe swallowing care plans were being discussed on Skype with the dysphagia specialist.

● People had access to other specialist services, for example physiotherapists, opticians, podiatrist, dentists, and the community mental health team.

● The GP attended the service regularly and people were able to access the GP outside of these times when needed. People confirmed that they were able to see the GP when they needed to.

Adapting service, design, decoration to meet people's needs

● The home was a purpose built nursing home. Each person had their own room they could personalise as they wished.

●Communal areas of the home were bright and well lit. Care had been taken over the design for example, walls in some corridors had tree designs painted on them, which created a brighter and less clinical appearance. These had been created with the participation of people living in the home. In other units, people had chosen different colours and designs, for example a blue theme with paintings of views through portholes on the walls.

● The bedroom doors in the reablement unit were decorated to resemble individually coloured front doors.

●There was a programme of ongoing improvements to the environment. The call bell system had been

upgraded and could now show on small screens where staff were and when people were being attended to. New furniture had also been purchased.
● A small 'self-service café' had been created, containing tea and coffee making facilities and fresh cakes were supplied daily by the kitchen staff. This provided an alternative place for people to meet with friends and relatives.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Consent forms had been completed with people confirming they had agreed with the support provided. However, in one person's care plan their daughter was involved as next of kin but was also involved in making decisions about their health but there was no evidence of LPA documents available. This person used bed rails when in bed and also used a sensor mat to manage falls. There was no DOLS in place. This was brought to the attention of the managers and they acted on this immediately.
● Staff had received training in MCA and we observed staff asking people's consent before providing care and support. Staff understood the importance of seeking peoples' consent and supporting them in the least restrictive ways. They spoke of engaging with people and said, "Give the time, give the choice".

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- It was clear that staff knew people well. We observed many examples of staff being aware of what people needed and did not need. Staff were always cheerful when speaking to people and called people by their preferred names as recorded in their care plans.
- The deputy clinical manager was trained in a technique called dementia care mapping. They were using this to help staff understand people's behaviours and devise care plans to meet these needs. They were able to demonstrate that this had led to increased engagement with staff and had improved people's moods and behaviour. Staff engaged people with everyday tasks such as laying tables. Staff were also more aware of the language they used when talking to people.
- People walked freely around the home and sit anywhere they liked, for example, one person was in another unit at lunchtime and staff said they communicated with the unit and the chef so that the person's meal was delivered there rather than them having to go back to the other unit.

Supporting people to express their views and be involved in making decisions about their care

- One person told us "They take care of me well. They are very kind. They are here when you want them."
- People's care was reviewed by staff who knew them well and involved their friends and relatives if they wished. Records indicated people's decisions were respected, for example whether or not to have a flu vaccination.
- Staff knew what was important to people and enabled them to do as much for themselves as possible. For example, one person had their pet birds in a cage in their room and another person enjoyed being able to make their own coffee.
- Staff spoke respectfully about the people they supported. A member of staff spoke about their approach to involving people and respecting their choices, saying, "Be gentle, listen, don't rush". Another member of staff said, "Give the time, give the choice" and "We are not living in our home, we are working in theirs".
- A member of staff said they sometimes did a person's makeup for them, with their permission. They told us, "I love to spend some time with them talking about what they did before. We learn every day from each and every person". They said "We know the care plan and how they want us to do their care". They told us about supporting a person with an essential aspect of their personal care that could occasionally be challenging if the person was not cooperating: "We take our time, sometimes come back later".

Respecting and promoting people's privacy, dignity and independence

● People's privacy and dignity was respected. Staff were careful to be discreet when supporting people. Personal care was provided behind closed doors.
● Privacy had been further enhanced by the introduction of technology. When a person was receiving personal care, a green light on their door indicated this was happening so other staff knew not to intrude.
● We observed staff talking respectfully about people.
● Confidential records were kept secure.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People had personalised care plans that detailed the care and support they needed. Staff had the information they needed to provide consistent support for people. Information included people's backgrounds, spiritual needs, hobbies and interests and helped staff know what was important to people and engage with them in a meaningful way.

● A full assessment of people's needs had been completed before they moved into the home. Following the assessment the service, in consultation with the person, had produced a plan of care for staff to follow. These had been kept under review to ensure the information was up to date and appropriate to meet the person's needs.

● Handover meetings were conducted daily and documented. This allowed staff to effectively share information about any new risks or concerns about a person's health.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Everyone had a communication care support plan with details about their preferred means of communication and the support they needed. This supported people to make decisions and choices. For example, one person had information about how they would like staff to talk to them as they had a hearing impairment.

● Different formats were available to provide people with information about the service, such as large print or pictorial format.

● We observed staff talking to people in ways that supported them to take their time to make choices and decisions.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People mainly told us there was enough to do. One person said, "There is all sorts going on if you want to join in"; and "Last week six of us went with six staff to the pub. It was lovely". One person commented about activities, "Not as many as I would have hoped. When I first came there was lots going on".

● The service had implemented an action plan to increase the activities on offer. Activities were provided to

people in their own rooms when they were not able or interested in joining in with the group
● A programme of activities was available for people to join in if they wished. This was led by activity coordinators and included internal activities, entertainment and plans to increase activities outside of the home.
● The service had developed different programmes to support people. These included using a 'magic table' which was used to engage people living with dementia with 3D games.
● Staff had developed 'sensory boxes', for example with sand to stimulate memories of the beach, to complement the Namaste practice. Namaste is an approach used to support people with end stage dementia. Staff showed a lot of passion in how to engage in various ways with people living with dementia to avoid isolation.
● Relatives were involved in their loved ones care where they wished to be and we observed relatives supporting their loved ones at lunchtime. Relatives confirmed they were kept informed of people's changing needs by the service.
● Peoples' religious beliefs were respected. One person told us, "The vicar comes and sees me every week. I have communion in my room every week". Another person said, "We have a church service and communion as well. I think it's every month".

Improving care quality in response to complaints or concerns
● People told us they would feel comfortable raising any concerns or complaints. Information about how to make a complaint was displayed within the home and a copy given to each person on admission. There were three complaints recorded for the year up until this inspection. The provider and registered manager kept records of actions taken in response to complaints and the feedback given to complainants, in line with the complaints procedure.
● A residents survey carried out in September 2018 included questions about the quality, quantity and choice of food, care and support, staff responsiveness, dignity and respect. An action plan had been developed based on responses to the survey, for example requests for more trips outside the home. As a result of the survey, the role of nutritionist staff had been extended to include activities on Tuesdays, such as trips out and a 'beach day' at the home's 'café' with fish and chips and ice cream. Another survey was planned for September 2019.
● The service development plan for the previous year had included updating end of life care plans and this had been completed.

End of life care and support
● People were supported at the end of their life to have a comfortable, dignified and pain-free death and where possible people were able to remain at the home and not be admitted to hospital.
● There was relevant guidance, for example, on following six steps to end of life (EOL) care which included the protocols to be followed by staff. The service had a registered nurse trained as champion for EOL care, who trained nurses on the six steps. A deputy clinical manager had specialised in palliative care and all nurses had also received training on EOL care at a local hospice.
● People's end of life care wishes, where they or their families had agreed to discuss these, and any advance decisions were documented in their care plans
● Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate.
● Anticipatory medications were put in place following a nurses meeting where symptoms were discussed and decisions made.
● Families were supported, for example, a room was offered if they wanted to stay overnight and they were shown how to massage their loved ones hands if they wished to do so.
● Staff were debriefed and supported following a death and some families held their wakes at the home where staff were invited. Staff also attended people's funerals and families appreciated their support, for

example, there were several thank you cards from families, which were on the noticeboard.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●The registered manager managed the service well and had nurtured a positive person-centred culture within the home. They knew people well and displayed a commitment to putting person-centred care first, of trying new ways of meeting people's needs and to improve their quality of life

●There was a strong person-centred culture which kept people at the heart of the service. This reflected the provider's values of person-centred, accountability, resilience and working together.

● Staff were strongly collaborative and expressed high levels of job satisfaction across all roles. They were proud of the service. The registered manager said, "I feel very privileged to be here. There is not one member of staff I would not have chosen. I have worked hard at making a no blame culture". Staff confirmed this saying, for example, "I love my job. The team works hard. There is an open culture, no blame".

● All staff we spoke with were enthusiastic about their work and felt well supported by the staff team and managers. A member of staff commented, "I appreciate them, and they appreciate me" and, "We are one team all together". Other staff comments included, "There have been many improvements" and, "We are very happy". The provider held a well being event for nursing staff to provide an opportunity for nurses to get together with colleagues and discuss practice.

● Managers developed their leadership skills and those of others. A deputy clinical manager had received training to carry out 'dementia care mapping' and was using this technique to review staff approaches to and engagement with people; and to support care planning. Observations were recorded and analysed and followed by a staff group discussion to promote learning and improve care. The deputy clinical manager spoke enthusiastically about "A culture of helping and learning" within the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The registered manager and provider were clear about their legal responsibilities and notified the commission appropriately.

● Where issues were brought to their attention, the registered manager and provider investigated these and informed relevant parties as needed.

● The registered manager had recently spoken openly with a relative following an incident involving agency staff. As a result of this, the registered manager had introduced supervision sessions for agency staff.

Managers and staff being clear about their roles, and understanding quality performance, risks and

regulatory requirements

● Clinical audit systems were given a high profile and were in place for monitoring service provision. There were systems in place for reviewing, for example, care plans, infection control, falls, risk assessments, safe swallowing plans and physical health conditions. The use of daily, weekly, monthly regular completion of clinical auditing systems and acting swiftly to address any identified issues showed management had a robust oversight of care provision, service quality and everyone's safety.

● The registered manager had recently involved staff in carrying out a full audit based on the CQC key lines of enquiry (KLOE) to help ensure the service was safe, effective, caring, responsive to people's needs and well led. There were plans to do these audits every three months.

● The service had a registered manager. The registered manager had previously worked as a deputy clinical manager in the service and knew the systems and improvement needs of the service well.

Continuous learning and improving care

● Staff and managers were committed to continually improving the service and what they could offer people living there. They had raised funds through, for example, car washing, leg waxing, making cakes, and donations from relatives, to purchase a 'Magic Table'. This is a small ceiling mounted projector with infrared sensors and speaker that work to project games onto a table. The projected colourful objects respond to hand and arm movements, so that people can play with the light itself. This innovative technology can be used to help stimulate movement and to connect people, particularly those living with dementia, with each other and with their surroundings.

● An extension of the cafe was planned for the summer, when a little-used lounge was to be converted into a 'high street café' with more space and facilities. The provider had agreed to fund this, in recognition of the previous fund-raising efforts by the staff.

● The service had introduced a Namaste programme, which benefitted people, particularly those with end stage dementia, as it increases stimulation through various 'spa' type treatments. There was a staff rota organised to implement this programme. The registered manager spoke passionately about the benefits of this for people. These included people being more relaxed, a reduction in agitation and helping to recognise and help with aches and pains people may be experiencing. Overall the well being of people in the service had benefited from this approach. The registered manager also did presentations promoting the programme to other services. The home had been shortlisted for the provider's 'making a difference' award.

● The provider had invested in new IT and upgrading WIFI throughout the building, as part of a move toward electronic care planning, which would be a more efficient and secure way of managing people's personal information and care.

● In-house clinical governance meetings took place to discuss clinical issues and agree any actions and learning. This had led, for example, to improved record keeping in relation to people's food and drink intake.

● Registered managers' meetings were held regularly and were used as an opportunity to share good practice.

Working in partnership with others

● The registered manager reported good working relationships with community care professionals including the tissue viability nurse and care managers. For example, working with the SALT and dietician, the catering team had undertaken further training to understand and provide improved diets.

● Staff on the reablement unit worked closely with care managers, occupational and physiotherapists to enable people to return home and, if needed, to receive care in the community. This also assisted the general management of health services overall.

● A visiting professional said staff are "really good, helpful" and that they do not shy away and there is always good communication and the people she sees "are happy".