Sunny Okukpolor Humphreys

Denecroft Residential Care Home

Inspection report

200 Newburn Road
Throckley
Newcastle Upon Tyne
Tyne and Wear
NE15 9AH

Tel: 01912676422

Date of inspection visit:
11 March 2016

Date of publication:
01 April 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 11 March 2016.

We last inspected Denecroft Residential Care home in March 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Denecroft provides accommodation and personal care for up to 13 people. Care is provided to older people, some of whom are living with dementia or dementia related conditions. Nursing care is not provided.

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

People said they were safe and staff were kind and approachable. There were sufficient staff to support people. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Systems were in place for people to receive their medicines in a safe way. People had access to health care professionals to make sure they received appropriate care and treatment.

Denecroft was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment. The environment was mostly well-maintained but some areas required attention to ensure they were designed to promote the orientation and independence of people who lived with dementia. We have made a recommendation with regard to this aspect of the environment.

Appropriate training, supervision and support were provided to staff to help them meet any specialist needs of people. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected by Denecroft staff.

People received a varied diet. There were activities and entertainment available for people. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the

running of the service.

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 and staffing levels were sufficient to ensure people were looked after in a safe and timely way.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

People received their medicines in a safe manner.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet to meet their nutritional needs.

The environment was well-maintained and comfortable but it was not all designed to help people who lived with dementia to be aware of their surroundings and to remain involved. We have made a recommendation with regard to the environment being more accessible for people who live with dementia to help them remain orientated.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of peoples' needs and met these in a sensitive way that respected peoples' privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. People received support in the way they needed because staff had detailed guidance about how to deliver their care.

There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was warm and welcoming.

The home had a quality assurance programme to check on the quality of care provided.

Denecroft Residential Care Home

Detailed findings

Background to this inspection

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

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams. We received no information of concern from these agencies.

This inspection took place on 11 March 2016 and was an unannounced inspection. It was carried out by an adult social care inspector.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We undertook general observations in communal areas and during a mealtime.

As part of the inspection we spoke with five people who were supported by Denecroft staff, the provider, the registered manager, three support workers, a cook and two relatives. We observed care and support in communal areas and checked the kitchen, bathroom and bedrooms after obtaining people's permission. We reviewed a range of records about people's care and checked to see how the home was managed. We looked at care records for four people, two peoples' medicine records, the recruitment, training and induction records for four staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits the registered manager and operational manager completed.

Good

Is the service safe?

Our findings

People told us they were safe and could speak to staff if they were worried. Their comments included, "I'm fine here, the staff keep me safe," and, "The staff are always around if I want them." A relative commented, "(Name) is well-looked after and staff are quick to help."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for pressure area care, moving and assisting and falls. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. We observed sensor equipment had been put in place, to alert staff when a person who may be disorientated at night, came out of their bedroom. This measure was to keep the person safe if they tried to come downstairs unescorted. Environmental risks were also regularly checked to ensure people were kept safe. For example, water temperature and window restrictor checks.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. A staff member commented, "I'd report any concerns to the registered manager or senior on duty."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place and one safeguarding concern had been raised with the local authority. It had been investigated and resolved.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. The staff member remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. Medicines were appropriately secured in a locked cabinet. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse.

Staff members who administered medicines told us they would be given outside of the normal medicines round time if the medicine was required. We saw written guidance was in place for the use of some "when required" medicines. The guidance included when and how these medicines should be administered to ensure a consistent approach to the use of such medicines, such as for pain relief. Care plans were also in

place for people who may have needed 'when required' medicine. For example, one stated, "'When required' medicine should always be offered to help (Name) to make the decision if they feel they need it."

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed regularly. Staff told us and their training records showed they were provided with the necessary training and they said they were sufficiently skilled to help people safely with their medicines.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We considered staffing levels were sufficient to meet the current needs of people who used the service. The registered manager told us staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs at all times. For example, an additional staff member had been introduced previously when a person had been assessed as being at risk of falling. At the time of our inspection there were 10 people who lived in the home and this included one person who was staying for a short term break. The home was staffed by two support workers from 8:00am until 8:00pm and two support workers from 8:00pm until 8:00am. These numbers did not include the registered manager who was also on duty during the day and was available 'on call' overnight to provide any support and guidance when required.

We spoke with the registered manager and other members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Criminal Records Bureau, now the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist bath.

Requires Improvement

Is the service effective?

Our findings

We looked around the building and saw it was mostly well-maintained and decorated for the comfort of people who lived in the home. We saw bedrooms were well-decorated and personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff respected people's belongings. One bedroom identified at the time of inspection showed the walls and carpet were marked as drinks had been spilt. This was discussed with the registered manager about the need to balance the person's privacy with the need to ensure their environment was clean and well-maintained. The kitchen cupboards were showing signs of wear and tear, as the coverings to some doors were peeling off and the sealant to some of the shelves was missing. The bath in the small bathroom was also damaged and scored from the bath hoist and the bath panel required attention as it was damaged. The registered manager and provider told us these issues would be addressed immediately. We received information immediately after the inspection of the plans to refurbish the kitchen.

We discussed with the registered manager the use of the small bathroom that was used as the main bathroom. It was small and there was not room for people to move around easily if they needed help with walking. The bath, although fitted with a bath hoist to help people into the bath, was not free standing for staff to move around if people required assistance as they bathed. The bathroom was cramped if people had other moving and assisting needs to help them mobilise. There was another larger bathroom equipped with a separate shower and a free standing bath, also with moving and assisting equipment to assist a person into the bath, where staff could position themselves at either side of the bath to assist the person more easily. As the room was larger it was easier to move around. The registered manager said they would consider the use of this bathroom as the main bathroom when people required assistance.

The building was bright and well-lit for people as they walked around. We observed the environment was not well-designed for the needs of people who lived with dementia to help maintain their independence. There was not appropriate signage around the building to help maintain people's orientation. Lavatories and bedroom doors did not have pictures and signs to identify the room to help maintain people's independence. We saw there were handmade signs written on pieces of paper that were attached to the walls to warn people in areas where the floor was sloped. Although it was positive to warn people we considered another means of alerting people was needed if they no longer understood the written word. The registered manager told us this would be addressed.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, a community nurse, a dietician and a nurse who provided information about Parkinson's disease, a psychiatrist, the behavioural team and General Practitioners (GPs). Records were kept of visits and any changes and advice was reflected in people's care plans.

Relatives were kept informed by the staff about their family member's health and the care they received. A relative commented, "I visit regularly and I'm kept informed."

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Staff said they received regular supervision from the registered manager every two months. Staff comments included, "The registered manager does my supervision," and, "I have regular supervision." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually and we talk about training and how I'm doing at work."

Some staff told us they had worked at the service for several years. Staff members were able to describe their role and responsibilities. Some staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. One staff member commented, "I've worked here for years but I do remember when I started I shadowed a more experienced member of staff as part of my induction." This ensured they had the basic knowledge needed to begin work. The registered manager told us new starters were to study for the Care Certificate as part of their induction to equip them with some of the required skills to work with people.

Staff told us and the staff training matrix showed staff were kept up-to-date with safe working practices. Staff members' comments included, "We do loads of training," "The manager is a good teacher," and, "I've just signed up to study for my National Vocational Qualification (now known as the diploma in health and social care) at level 3, the supervisor is coming next Tuesday." The registered manager told us and the staff training matrix showed there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Staff training courses included dementia care, Parkinson's disease, nutrition and hydration, mental capacity, dignity, care planning and deprivation of liberty safeguards.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Denecroft records showed six people were legally authorised by the local authority and one application was being considered by the local authority. Records showed assessments had been carried out where it was considered people did not have mental capacity to make decisions with regard to their care and welfare.

Care plans were in place which provided prompts and guidance, where necessary of people's capacity to make particular decisions. For example, they included details such as, "You must always give (Name) the opportunity to decide and choose what they want to do, never assume they are unable to," and, "You must always give (Name) time remembering to put their 'best interests' first."

Staff confirmed they had received training about mental capacity and DoLS. Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions and instructions were available for staff if people refused any care. For example, a care plan stated, "If (Name) refuses medicines on more than one occasion General Practitioner advice is to be sought."

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a communication book that provided information about people, as

well as the daily care entries in people's individual records. Staff members comments included, "Communication is good," and, "We are kept up-to-date about people's needs and if there have been any changes."

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. The cook told us they received information from the registered manager when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was stocked with fresh, frozen and tinned produce.

We saw food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received good food. However, we observed the menu did not offer an alternative to the main meal at lunch time. The cook told us people could request their own choice and we saw at tea time people were served their individual choices. For example, bacon sandwiches. This method although individual, relied upon people having the mental capacity to think of food they may wish to eat. We discussed this with the registered provider who said it would be addressed. People were offered a selection of hot and cold drinks throughout the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day.

We recommended the provider considered the Department of Health guidance about "Creating a more responsive environment in which people living with dementia can live safely and more independently." (Dementia-Friendly Health and Social Care Environments, March 2015- Department of Health).

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke with were positive about the care and support provided. Their comments included, "The staff are brilliant," "The staff are very caring," "The staff are excellent," "The staff are alright I'm getting by," and, "The staff are lovely. This is a lovely home." Relatives' comments included, "The staff are lovely to people." "They are all so welcoming and friendly," "The place is not large and its homely," "The staff are friendly and helpful," and,"(Name) was at another home where they were not happy, but they've really settled here and I see (Name) smiling more."

People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people were very relaxed. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, "Do you want to stay here to finish your cup of tea or shall I take it into the lounge for you,?" and, "Would you like some help to the lavatory before lunch?."

We saw that care was provided in a flexible way to meet people's individual preferences. For instance, we saw the registered manager had written notes to remind staff that care should be individual and not task centred. This meant staff provided support to people in the way they wanted and at times of their asking for support and not only at set times offered by staff.

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. People's privacy was respected. We saw staff ensured any personal care was discussed discreetly with the person. Staff treated people with dignity and respect. We saw staff observed and offered any prompts and words of encouragement to people at meal times to provide assistance. Staff knocked on people's doors before entering their rooms. People looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing two items of clothing so people could choose what they would like to wear. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Care plans were in place to record information about peoples' involvement in 'daily happenings'. For example, one care plan recorded, "(Name) is able to understand when you are talking to them. However, they are unable to retain the conversation you have had with them."

We observed the lunch time meal. The meal time was relaxed and unhurried. People sat at tables set with tablecloths and condiments. Specialist equipment such as cutlery and plate guards were available to help people. Tables were set for three or four and staff remained in the dining area to provide help and support to people. Some people remained in their bedroom or a quieter area to eat. Staff provided prompts to people

where needed to encourage them to eat, and they did this in a quiet, gentle way. Saying for example, "Can I help you," "Can you manage that," "Shall I move the table in a little nearer to you," and, "Let me help you." One person came in later for their lunch and they appeared unwell. A support worker observed the demeanour of the person and alerted the registered manager immediately. The staff acted swiftly and discreetly to obtain initial medical and then emergency medical assistance for the person. The person was reassured by staff as they waited for the paramedics and staff quietly explained to them what was happening. A member of staff then escorted the person to hospital.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told one person may require an advocate in the future to provide advice about their living situation.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. However, some people and relatives had commented to the local authority commissioner at a recent visit they would like more activities and outings. We observed a ball game took place with some people in the morning.
A weekly activities plan advertised the activities available. These included, ball games, baking, knitting, bingo, painting, arts and crafts, setting tables, dominoes, movies and sing-along. One person attended a day service. An activities person was not employed but staff told us after 10:00am drinks and in the afternoon they had time to provide activities with people. One member of staff told us, "A bird of prey is coming tomorrow. It was popular last time with a different bird." People told us they had opportunities to go out when the weather was fine. They had been to Blyth and the coast for fish and chips. On another occasion they had been for a pub meal. People also went out with their family. We were told fund raising took place through seasonal fayres to finance outings and entertainment for people. There were plans to purchase some more garden furniture for another part of the garden by the fishpond so people could sit out in the finer weather.

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Up-to-date written information was available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs took place with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, mobility and falls and personal hygiene.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition and a specialist nurse for Parkinson's disease. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when a person was assisted with a bath and personal care. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

The care plans gave staff specific information about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They detailed what the person was able to do to take part in their care and to maintain some independence. For example, a care plan for personal hygiene stated, "Assist (Name) to wash parts of the body they cannot manage for example, back and hair. Encourage (Name) to wash the rest of themselves to promote their independence," and, "Each morning and night (Name) will wash their hands, staff to assist to clean their dentures." Care plans were up-to-date and they were reviewed monthly and on a more regular basis, if a person's needs changed.

Care plans were in place for peoples' healthcare and nutritional needs. The PIR stated care plans were also in place for, "Short term recurring infections such as urinary tract and chest infections." We saw a care plan for Parkinson's disease that described the effects of the illness on a person's ability to be involved in their personal care. For example, "(Name) relies on support staff. They have good days and days where they need more support. Some days (Name) can brush their own hair and put their slippers on," and, "Parkinson's is a very complex illness and if you suspect any changes to (Name)'s daily support you must inform the person-in-charge."

Information was available to help staff provide care and support for when a person was no longer able to tell staff themselves how they wanted to be cared for. The PIR showed the registered manager planned to send out 'All about Me' questionnaires to collect additional information from people and their families about peoples' life history and likes and dislikes. This would give staff more insight into people's previous interests and hobbies when people could no longer communicate this themselves. Information was available with regard to peoples' wishes for care when they were physically ill and recorded their spiritual wishes or funeral requirements.

Regular meetings were held with people who used the service and their relatives. Meeting minutes showed topics discussed included fund raising for social outings, menus, activities and entertainment. The registered manager said meetings provided feedback from people about the running of the home. We saw the meetings were an opportunity for people to give feedback about the care they received.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw no complaints had been received since the last inspection.

Good

Is the service well-led?

Our findings

A registered manager was in post and they were registered with CQC in 2012.The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

Regular monthly analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. Records showed that where a person had fallen more than twice they were referred to the falls clinic. The registered manager told us if an incident occurred it was discussed at a staff meeting to look at 'lessons learned' to reduce the likelihood of the same incident being repeated.

People told us the atmosphere in the home was warm and friendly and relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. Comments included, "The manager is very approachable," "The manager is very welcoming and friendly," and, "You can speak to the manager at any time."

Staff told us staff meetings took place three monthly. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed good practice, health and safety, training and development and the needs of people who used the service. Meeting minutes were made available for staff who were unable to attend meetings

Records showed audits were carried out regularly and updated as required. Monthly audits were carried out and they included health and safety, fire safety, medicines management, accident and incidents, falls, finances and documentation. Weekly menu checks took place to survey if people were satisfied with the meal selection. The registered manager told us a separate audit was carried out by the provider. Their office was located on the premises and they were at the home every day but they carried out a formal documented visit monthly to check upon the quality of care provided. The provider's visit included speaking to people and staff regarding the standards in the service. They also checked the environment and audited a sample of records, such as care plans and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and visiting professionals. We saw surveys had been completed by people who used the service and relatives in 2015. We were told the results were analysed so that action could be taken as a result of people's comments, to improve the quality of the service. Relatives' comments included, "The staff are the real strength at Denecroft. It is always evident that they are both caring and committed to their residents. They are very understanding people."