Care Quality Commission

Tamaris Healthcare (England) Limited

The Mews Care Home

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

Overall summary

The Mews is a purpose built care home which provides nursing and personal care for older people, some of whom may be living with dementia. It is registered to provide up to 50 places, but two rooms are currently used as an office and a day room. All of the bedrooms are for single occupancy and are en-suite. At the time of this visit there were 41 people living at the home, including two people on short break placements.

The last inspection of this home was carried out on 20 August 2013. The service met the regulations we inspected against at that time.

This inspection took place over two days. The first visit on 24 February 2015 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 25 February 2015.

The home had a registered manager who had been in this role for two years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 told us they felt safe at the home and were happy with the staff. One person commented, "Yes, I am safe - everything is fine." Relatives also felt their family members were safe and comfortable with the staff who supported them. The health and social care professionals we spoke with during the inspection told us they had no concerns about the safety of people using the service. One visiting nurse told us, "I come at all different times of the day and have never had any concerns."

Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. The provider made sure only suitable staff were employed. People were assisted with their medicines in the right way.

All the people we spoke with felt their care needs were being met. One person felt they had to wait for assistance because staff had to bring hoist equipment. We told the registered manager to make sure staff and equipment were deployed as quickly as possible when people requested support. Staff told us there were enough staff on duty to meet people's physical and social needs. Visiting care professionals also felt there were enough staff to support people in the right way.

The people we spoke with confirmed that staff met their care needs. People's comments included, "They are very good and will give extra help if necessary" and "they couldn't do any more than what they do". All the people and relatives we spoke with felt staff had the right skills and competencies to provide the right support. Staff had the relevant training and support to care for people in the right way. Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision.

People said any changes in their health needs were referred to the relevant health care services. Health care professionals said the home responded appropriately to any changes in people's well-being.

People were supported to eat and drink enough and they had choices about their meals. People and relatives felt staff were caring and kind. People were encouraged to make their own decisions and choices about their lifestyle and daily routines. There was a warm sociable atmosphere in the home and there were friendly interactions between people and staff. People had opportunities to join in activities or go out with staff from time to time.

People had information about how to make a complaint or comment and said they would be confident that these would be acted upon. People, relatives and staff felt they could approach the registered manager at any time and said the home was "well managed".

Staff felt there was an open and supportive culture amongst the staff team. They said they liked working at the home. The provider had an effective system for checking the quality and safety of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People felt safe at the home and with the staff who supported them. Staff knew how to report any concerns about the safety and welfare of people who lived there.

Risks to people were managed in a safe way so that people could lead as independent a lifestyle as possible.

There were enough staff on duty to meet people's needs, but some people felt they had to wait. The provider made sure only suitable staff were recruited. People's medicines were managed in the right way.

Is the service effective?

Good

The service was effective. People and their relatives felt the service met their individual needs and that staff were well trained. Some people had complex nursing needs and staff had good opportunities for training in those specific health needs.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily, unless it was in their best interests.

People were assisted to have a good diet. People said the food was good quality and they had plenty of choices. People were helped to access other health care services whenever this was required, and the home staff worked well with those services.

Is the service caring?

Good

The service was caring. People and visitors said staff had a "caring" and "compassionate" attitude.

Staff asked people for permission before carrying out care tasks, such as support with mobility or assistance with meals. People felt they were supported with their personal care and appearance.

People and relatives said staff were respectful. Staff assisted people in a way that upheld their dignity and privacy.

Is the service responsive?

Good

The service was responsive. People and relatives said staff understood what was important to each person as an individual and how they liked to be assisted.

There were in-house activities, social events and some opportunities to go out into the local community.

People and their relatives said they would be comfortable about making a complaint if necessary. They had confidence in the registered manager to look into any concerns.

Is the service well-led?

Good

The service was well led. People, staff and visitors said the home was well managed. The registered manager had been in post for two years and staff felt she was approachable and supportive.

People were encouraged to make comments and suggestions about the running of the home, and these were acted upon.

Summary of findings

People's safety was monitored and the provider had effective systems for checking the quality of the care service.

The Mews 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.

This inspection started on 24 February 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist adviser and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second visit, which was announced, was carried out on 25 February 2015 by an adult social care inspector.

Before our inspection we reviewed the information we held about the service, including the notifications of incidents that the provider had sent us since the last inspection. We contacted the commissioners of the service, dietitian services and the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with nine people living at the home, nine relatives and four visiting care professionals. We also spoke with the registered manager, deputy manager, a nurse, four care workers, an activity staff member and a member of catering staff. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of six people, the recruitment records of four staff members, training records and quality monitoring reports.

We used 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 talk with us. We also joined people for a lunchtime meal to help us understand how well people were cared for.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and were happy with the staff. One person commented, "Yes, I am safe - everything is fine." Other people commented, “They are definitely good and I am well looked after" and "they are certainly alright to me”. Relatives also felt their family members were safe and comfortable with the staff who supported them. One relative commented, "All the staff are lovely, every one of them. They are excellent.”

Staff also felt people were safe at the home. One staff told us, “Yes, it’s safe. I even had my mam and dad staying here.” The four health and social care professionals we spoke with during the inspection told us they had no concerns about the safety of people using the service. One visiting nurse told us, “I come at all different times of the day and have never had any concerns.”

Staff had a good understanding of safeguarding and knew how to report concerns. They could describe various types of abuse and said if they had any concerns they would go straight to the registered manager. Staff told us, and records confirmed, that they had completed training in safeguarding and whistleblowing so they knew how to report poor practices. All of the staff we spoke with said they did not have any concerns about the care provided or the safety of the people living in the home. They told us they felt able to raise any issues and were confident the registered manager would deal with their concerns straightaway.

There was written information in the reception area and the staff office about how to report any safeguarding concerns including the contact details of the local authority which takes the lead on any safeguarding matters. There had been two potential safeguarding issues raised over the past year. The registered manager had taken appropriate action and had worked collaboratively with the local authority to address these matters. This meant the registered manager and staff at the home were aware of their responsibilities to safeguard the people who used this service.

Risks to people’s safety and health were appropriately assessed, managed and reviewed. These included, for example, risks to individual people in relation to falls, mobility equipment, nutrition and skin care. This meant risks were identified and minimised to keep people safe.

People told us, and records showed, they had been involved in making decisions about acceptable risks to their safety, wherever their capabilities allowed, such as managing their own medicines.

The provider also had a computer-based reporting system in place to analyse incident and accident reports in the home. This was to make sure any risks or trends, such as falls, were identified and managed. Reports of any falls were collated monthly and we saw this included the details of any actions taken, such as referral to the falls clinic or the provision of a sensor mat.

Staff told us, and records confirmed that the home’s maintenance member of staff carried out health and safety checks around the premises, including fire safety and hot water temperature checks. It was good practice that the home had a ‘grab file’ for any staff member to use in the event of an emergency in the home. The grab file included details of what to do and who to contact in the event of a flood, fire or staff absence. It also included the personal evacuation plans for each person who lived there.

All the people we spoke with felt their care needs were being met, but there were mixed views about staffing levels. Some people felt there were sufficient staff and their comments included, “There are enough [staff] – they’re always popping in and out" and “there are enough, they don't leave me waiting". However, one person commented, “Not enough. When I ring for the toilet, as I need a hoist I have to wait.” We told the registered manager about this person’s comments to make sure staff and equipment were deployed as quickly as possible when people requested support.

Staff told us there were enough staff on duty to meet people’s physical and social needs. Although the home was busy there was a relaxed atmosphere and staff were calm and productive. Visiting care professionals also felt there were enough staff to support people in the right way. For example a social worker told us, “Whenever I come there are always plenty of staff around, and it’s got a really, relaxed atmosphere.” A community matron told us, “There always seems to be plenty of staff on duty.”

The staff who were providing care on the day of this inspection were the deputy manager, a nurse, a senior care worker and five care workers. There were also an activities staff, three housekeeping staff, two catering staff a, a

Good

Is the service safe?

maintenance staff and an administrative officer. The night time staffing was one nurse and four care workers. Staff rotas showed that these were typical staffing levels for this home.

The provider had recently introduced a new staffing tool, called CHESS, to determine the staffing levels. The new tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nursing staffing hours required throughout the day and night. The new staffing tool indicated that the staffing levels provided were sufficient at this home. The registered manager also described the flexibility to bring in additional staff if necessary, for example to accompany people to hospital appointments if their family were not able to do this.

The registered manager described staff turnover as low, and there had been few changes to staff in the past year. It was good practice that people who used the service had recently been included in the interviews for new staff members. There was only one vacant nurse post at this time which was being covered by existing or relief staff. The registered manager said she preferred not to use agency staff, unless critically essential, as they would not be familiar with people's needs or the homes' systems.

The recruitment records for four staff members showed that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

The provider carried out monthly checks to make sure that nursing staff were registered with the Nursing and Midwifery Council (NMC). This helped to make sure people received care and treatment from nursing staff who were required to meet national standards and abide by professional code of conduct.

People said they got their correct medicines and at the right time. Their comments included, "They bring them on time" and "yes, they are all seen to correctly". A relative told us, "His medication is spot on now – it wasn't at the hospital."

Medicines were managed safely and recorded properly. As soon as people moved to the home staff contacted their GP to confirm their medicines and set up arrangements for getting their prescriptions to the home. People's care records also showed their medicines were regularly reviewed with their GP.

People's medication administration records (MARs) were well maintained. A current photograph of each person was attached to their MARs to ensure there were no mistakes of identity when administering medicines. There were clear protocols in place for the administration of 'as required' and homely medicines. For medicines with a choice of dose, the records showed how much medicine the person had been given at each dose. The medicines records were completed in the right way which meant the home staff could confirm that people's medicines were being given as prescribed.

Good

Is the service effective?

Our findings

The people we spoke with confirmed that staff met their care needs. One person told us, “They do as much as I need, and I need a lot of help." Another person commented, “They do what I can't do for myself.” Other people’s comments included, “They are very good and will give extra help if necessary” and “they couldn’t do any more than what they do”.

All the people and relatives spoke with felt staff had the right skills and competencies to provide the right support. One person told us, “They are well trained.” Another visitor told us, “When I came to look round I was very impressed. The nurses are very good.”

Staff told us, and records confirmed, they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer based training system for each staff member to complete annual training courses, called e-learning. Care staff had achieved, or were working towards, a care qualification such as a diploma in health and social care. The activities co-ordinator had recently achieved a qualification in activities for people living with dementia.

Nurses had training in relevant nursing areas such as infection prevention, tissue viability and catheterisation. Nurses and care staff also had training in people’s specific needs, such as Huntingdon’s disease and dysphagia (swallowing problems). Nurses also told us they had good opportunities for relevant training, for example one nurse described ‘end of life’ training they were going to undertake at the local hospice. Three members of staff were trained as moving and assisting trainers. This meant they could make sure all members of staff were up to date with the correct moving and assisting techniques. This was good practice because 12 people living at the home needed support with hoisting.

Staff told us, and records confirmed, they had two-monthly supervision sessions with either the registered manager, deputy manager or a nurse. All staff also had an annual appraisal with their supervisor. The staff we spoke with said they felt supported to carry out their role. This meant the registered manager made sure that the professional development of staff was supported and assessed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager was aware of the supreme court decision about DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. She had made DoLS applications to the local authority in respect of people who needed supervision and support at all times. At the time of this inspection 12 DoLS applications had been sent to local authority for authorisation. This meant the home was working collaboratively with the local authority to ensure people’s best interests were protected without compromising their rights.

People’s care records identified where they could make decisions, or where they needed support from other people, including advocates, for more complex decisions. We saw records of a ‘best interest’ assessment that involved relevant care professionals as well as home staff for one person who had chosen to move back to their own house. In this way the registered manager was clear about the principles of the Mental Capacity Act 2005, and staff also had training in this.

The accommodation for people was clean and comfortable. However there were some decorative shortfalls to bathrooms and toilets which were in need of attention. Although these shortfalls did not present a health and safety risk to people or staff, they did not promote the dignity of the people who used the service. For example, one shower room had two cracked tiles, the shower fittings were broken and wall surfaces were scuffed. At the time of this inspection the assisted bath on the first floor was broken so was out of use. However the assisted bath on the ground floor was not accessible as this bathroom was being used for storage. This meant people only had access to showers, so were unable to choose to have a bath. We spoke to the registered manager about this who agreed to remove the storage from the ground floor bathroom so that people could have a choice of a bath or shower.

People were very complimentary about the quality and choices of meals. Their comments included, “The food is canny”, “The food is very nice, they are lovely meals” and “The food is excellent. I’m even putting on weight”. Relatives told us they felt the quality of meals was good and said they had been invited to join people for meals.

Good

Is the service effective?

People said they were always given a choice of meals and portion size. One person commented, “They come with the menu in the morning. There is enough choice.” People said they felt comfortable about asking for alternative dishes. For example, one person told us, “If I did not like what was on offer they would get something else for me.” Another person told us, “I like what I get, and if there was not enough I would ask for more.”

Some people needed physical support at mealtimes and they told us they got help if they needed it. For example, one person commented, “They cut things up for me if necessary. There are enough staff to do this for me. I get plenty to eat and drink.” A relative told us, “My family member cannot see so they put her food on a black plate which helps her.” During the lunchtime meal we saw staff were supportive and engaged with people, encouraging them to enjoy their meal.

Catering staff were knowledgeable about people’s individual dietary needs and their individual preferences. They kept records in the kitchen of each person’s dietary type, portion sizes, frequency of meals, any allergies and fluid requirements. The cook told us, “We go into the dining room and see if people have enjoyed their meal or not. Staff let us know if people are losing weight or if they’re poorly and need building up.” This meant there was good communication between the care and catering staff to support people nutritional well-being.

Food intake and fluid balance charts were recorded for people, where required. Several staff had recently attended training in dysphagia (swallowing difficulties) and felt confident about supporting people in the right way with drinks and foods. Staff showed us assessments by the speech and language therapist (SALT) were in place about people’s risk of choking during meals and how they should manage this. The assessments were readily at hand in the dining area. This was important because it showed staff knew how to keep someone safe from choking by following guidance given them by the SALT team.

The home was part of a local community health care scheme, called the Coalfield Initiative. The initiative aimed to improve primary care and nursing care in care homes and to reduce admissions and readmissions to urgent care. As part of the pilot a local GP and community nurse visited the home every week to check people's health care needs. This helped to ensure people received timely support with any changes in their health, which could also help to prevent some admissions to hospital. A GP told us, “Staff here know how to manage people’s health needs without them having to go into hospital unnecessarily.”

We saw people records included details of visits by and guidance from a range of health and social care professionals including a tissue viability nurses, dietitians, a percutaneous endoscopic gastroscopy (PEG) nurse, speech and language therapist, social workers, continuing healthcare assessors, physiotherapists, palliative care team, occupational therapist, podiatrist and chiropodist. A community nurse told us, “Staff recognise changes in people’s well-being and act on it quickly.” This meant that people received on-going healthcare when they needed it and were supported to maintain their health.

Good

Is the service caring?

Our findings

All the people and visitors we spoke with made positive comments about the "caring" and "compassionate" attitude of staff. For example, one person told us, "They are definitely caring. They are very patient. I had a second stroke which took my voice away but they understand me." Another person commented, "They are very nice. It is mutual - I am nice to them they are nice to me." Relatives' comments included, "They are very good to my [family member]" and "All the staff are lovely - every one of them. They are excellent."

People told us they had good relationships with staff. There was a convivial, sociable atmosphere in the home. Several people enjoyed sitting in the reception area so they could watch the "comings and goings", and chat to staff as they passed by. People were visibly relaxed and comfortable with all the staff.

The four visiting care professionals we spoke with all commented positively on the caring attitude of staff in the home. For example, a GP who had frequent involvement with the home told us, "Staff genuinely seem to care. They have managed some very difficult situations with professionalism and tact." A visiting nurse told us, "Staff are compassionate and treat people well." A visiting social care professional told us, "The staff communicate very well with relatives. The family of the person I'm involved with are delighted with the service."

All the people we spoke with said that staff asked their permission before carrying out care tasks, such as support with mobility or assistance with meals. One person commented, "Oh yes, they always ask first." People felt they were supported with their personal care and appearance. One relative commented, "My [family member] is always clean and nicely dressed with his own clothes."

People told us they were treated with respect and dignity. One person commented, "They show me respect. They shut the door when doing anything private." Another person said, "They really listen to me - everybody is just nice." People told us staff respected their privacy, for example one person said, "If I have company they don't come in [to my room]."

Staff had training in equality and diversity. The staff members we spoke with talked about people in a respectful way that valued their diverse needs. Staff had a good understanding of the importance of treating people with dignity. They gave us practical examples of how they delivered care to achieve this. For example, making sure people could choose what they wanted to wear, making sure doors and curtains were closed when helping with personal care, keeping people covered up and respecting people's rights and choices.

People were encouraged to make their own daily decisions wherever possible. One person told us, "I can get up when I like and have breakfast when I want it and go to bed when I want." Care records showed that people were encouraged to make their own choices about when to get up and go to bed, what to wear and what to have for meal.

Staff also told us how they promoted people's independence by encouraging them to do things for themselves if they were able. One staff member said, "I personally try to let people do what they would like to do and support them in that."

The registered manager and deputy had completed training in designing individual profiles and were planning to develop these for each person. These would be particularly useful for when people go to hospital or to other services as they provide helpful information about the person's communication skills, how they make choices and their preferred way of being supported.

Good

Is the service responsive?

Our findings

People told us they were involved in decisions about their care, if they wanted to be. Some people would not be able to be involved due to their limited capacity, but care records showed they were encouraged to make choices about their daily routines. Relatives also felt informed and involved in people's care. One relative commented, "We were involved in the review." Another relative commented, "When my family member came in they wrote down all their history."

People had care plans that set out their individual needs and how they required assistance. In the six care records we looked at it was clear that people's individual needs had been assessed before they moved to the home. The assessments were used to design plans of care for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs. The care plans were detailed and provided guidance for staff about how to support each person with their specific needs. A visiting healthcare professional commented, "When I visit, staff are always informative about how a person has been. Care records always seem to be in good order."

People's care records were personalised to reflect their individual preferences, support and what they could manage for themselves. For example, one person's care plan included, "enjoys wearing her make-up" and another stated, "encourage to do as much as [they] can for themselves, needs a lot of encouragement but washes their hands/face themselves".

It was clear from discussions with nursing and care staff that they had a good understanding of the needs of people who used the service. They were aware of people's individual needs, choices and preferences. One staff member told us, "We talk to people and their relatives. We have a relationship with them and ask what they like and don't like."

A visiting nurse told us, "Staff know people's needs and are familiar with them. They identify when people are not their 'normal' selves. They are good at picking up clues like if people are slightly more confused or off their food."

People and relatives told us there was a range of social activities at the home. The home had an enthusiastic activities co-ordinator who arranged group activities such as bingo, dominoes, balloon games, film and reminiscence sessions. The activities co-ordinator also spent time with people who were bedfast in individual activities such as reading newspapers and manicures. One person felt that there were limited activities that were suitable for people with poor vision. We told the activities co-ordinator about this for their attention.

The activities co-ordinator tried to encourage community involvement in events in the home such as local historian talks, entertainers and church services. The local library also had a book-lending scheme at the home. She arranged for people to go out to community resources such shops and church, and the local park in better weather. Age UK used an area of the home to provide a social day care service for older people from the local community. Although this was not for the use by people who lived here, the two services did share some entertainment and social events.

People had written information about how to make a complaint and this was also displayed in the reception area for visitors. The registered manager told us that any complaints would be recorded on the provider's 'datix' (management reporting tool) so that the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

People and their relatives said they would be comfortable about raising any complaints with the registered manager. One person commented, "If it was necessary to complain I would go to the manager, but I don't think It would happen here - they've got their finger on the pulse." Another person commented, "I would speak first to the home, then social services or head office. I had to sort out a financial rebate so I rang head office and it was sorted immediately."

Good

Is the service well-led?

Our findings

All the people and visitors we spoke with felt the home was well-managed. One person told us, “Definitely. That’s where it starts - if the management is not right nor is everything else.”

People who could express their views and relatives felt they had the chance to contribute their comments and suggestions about the running of the service. There were occasional resident/relatives’ meetings; the last one was held in December 2014. The minutes showed that people had discussed changes to the provider’s organisation, Christmas, activities and any issues or concerns. Everyone attending the meeting had expressed satisfaction.

The provider also used an annual customer satisfaction survey to gain people's views. The last one was collated in December 2014. There had been a fair response to the survey and many positive outcomes. The results of people’s comments were displayed in the reception area for people and visitors to see. There had been only one critical comment about a dark coloured carpet in the foyer. As a consequence, the carpet had been replaced with modern, light wood flooring which was brighter and easier for people who used wheelchairs. In this way the registered manager and provider had acted on people’s suggestions.

People, relatives and other visitors told us the culture in the home was warm, friendly and sociable. Staff felt there was an open and supportive culture amongst the staff team. They said they liked working at the home because they enjoyed supporting with the people who lived there and enjoyed working alongside their colleagues. One staff told us, “I’m proud to be part of it. I think it’s one of the best homes.”

Staff told us the registered manager was approachable and supportive. Their comments included, “Her door is always open” and “if I have any issues I can go and see her”. Staff described the service as “well managed”. They told us they would feel comfortable about questioning practice, raising concerns and putting forward views for making improvements. Full staff meetings were held around four times a year. The last one, held in December 2014, included a discussion with staff about the standards expected in relation to care records. The minutes of the meetings were displayed in the staff room for those staff who had not been able to attend. The registered manager also held clinical governance meetings and health and safety meetings with relevant staff members.

Staff had a good understanding of their role, responsibilities and expected standards of practice. Some staff had additional roles such as nominated lead person for infection control, end of life, pressure care, falls, nutrition and dementia care champion. These staff took responsibility for keeping up to date in relation to current best practice or initiatives relating to those areas and sharing them with other staff.

The provider had a quality assurance programme which included monthly visits by the regional manager to check the quality of the service. We saw detailed reports of these visits and action plans and timescales for any areas for improvements. For example, we saw the shortfalls in bathrooms had been identified for action.

There were also regular in-house audits, for example of health and safety, food safety, the dining experience, nutrition and moving and assisting equipment. It was good practice that medication audits meant each person’s medicines were checked on a monthly basis. There were monthly checks of a sample of care records. For example, the records checked in February 2015 included risk assessments for bed rails, choking and pressure care, and activities and care records.

The home was subject to monitoring by other agencies, including commissioners. At the most recent audit by the Clinical Commissioning Group (CCG) in August 2014 the home had achieved an overall score of 85%. The audit was based on standards that included care records, staff training and infection control.