Alliance Care (Dales Homes) Limited

Woodbury House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 7 and 8 August 2017. The inspection was unannounced on day one and announced on day two. Woodbury House is a care home which is registered to provide care with nursing for up to 45 people, including people who live with dementia. At the time of our visit 37 people were using the services.

The home is a large detached Victorian building in a country location, not far from the shops and amenities of Wokingham, Reading and Camberley. People had their own bedrooms and use of communal areas that included enclosed private gardens. The people living in the home needed residential or nursing care and support from staff at all times and had a range of care needs. These included dementia care and palliative care.

The service has a registered manager. 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 received safe care. There were sufficient numbers of staff to keep people safe and meet their needs. However, we found that staff deployment at lunchtime on the memory unit had not provided the assurance that people were being checked and supported effectively regardless of staff numbers being of a good ratio. We had discussed this with the registered manager who had taken immediate and appropriate action to improve.

We have made a recommendation about the assessment of staff numbers to meet people's individual needs within the environment they live.

Staff were knowledgeable about how to keep people safe from harm. Risks to people's safety were assessed and plans were in place to manage and reduce risks. There had been a high turnover of staff in the 12 months prior to our visit. Staff were recruited safely using robust procedures. Medicines were managed safely by staff who had received appropriate training and had their skills monitored. The home had been refurbished. The kitchen and laundry were being reviewed for refurbishment and consideration of changing door closures to soft-closures.

People received effective care. Staff were trained and competent to carry out their roles effectively. Training updates were scheduled to cover staff induction and refresher training, which included dementia awareness, equality, diversity, and personal care. They were supported in their job roles through one to one meetings, appraisals and team meetings. People were supported to eat a choice of freshly prepared meals. They were supported with special diets if required and when necessary their dietary intake was monitored. Frequent snacks and drinks were available.

People were supported to maintain their health and wellbeing. Advice was sought from healthcare professionals when necessary. People were supported by staff to have maximum choice and control of their lives in the least restrictive way possible. The policies and systems in the service supported this practice.

The service was caring. Staff were kind, considerate and compassionate in the way they delivered support to people. They encouraged people to be as independent as they possibly could be. They addressed people in the way they liked and spoke respectfully to and about people.

The service was responsive. People's relatives and visitors were welcomed into the home and activities were designed to consider people's individual interests. One to one sessions were a regular feature for people who were at risk of being isolated. People received person centred care that focussed on their individual needs and recognised their preferred routines. People and their relatives were comfortable to raise concerns and speak with the registered manager and staff team if they wished.

The service was well-led. There were systems in place to assess, monitor and analyse the service in order to make improvements. The manager has a proven record of having made improvements in people's best interest since becoming the manager at Woodbury House. There was a high level of confidence in the registered and deputy manager amongst people, their relatives and professionals. They were complementary of the improvements made by the registered manager that protected people and promoted a respectful culture within the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to protect people from abuse.

People's families felt that their family members were safe living there.

The provider had robust emergency plans in place which staff understood and could put into practice.

There were sufficient staff who had the relevant skills and experience to keep people safe. Staff numbers were under review to take into consideration the environment on the memory unit.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's individual needs and preferences were met by staff who had received the training they needed to support people.

Staff met regularly with their line manager for support to identify their learning and development needs and to discuss any concerns.

People had their freedom and rights respected. Staff acted within the law and protected people when they could not make a decision independently.

People were supported to eat a healthy diet and were helped to see health professionals to make sure they kept as healthy as possible.

People lived in a comfortable environment. A review was underway to improve the kitchen, laundry and door closures.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity and promoted their independence as much as possible.

People responded to staff in a positive manner and there was a relaxed and comfortable atmosphere in the home.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and responded to their individual needs.

People's assessed needs were recorded in their care plans that provided information for staff to support people in the way they wished.

Activities within the home were provided for each individual.

There was a system to manage complaints and people were given regular opportunities to raise concerns.

Is the service well-led?

Good

The service was well-led

People, their relatives and staff said the registered manager was open and approachable. They had confidence that they would be listened to and that action would be taken if they had a concern about the services provided.

The registered manager and provider had carried out formal audits to identify where improvements may be needed and acted on these.

Woodbury House

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 was a comprehensive inspection which took place on 7 and 8 August 2017. It was unannounced on the first day and announced on the second. The inspection was carried out by one inspector and an expert by experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert who attended this inspection was experienced in caring for older people and people who live with dementia. Two inspectors completed the inspection on the second day.

Before the inspection we reviewed the information we held about the service, which included notifications they had sent us. Notifications are sent to the Care Quality Commission (CQC) to inform us of events relating to the service which they must inform us of by law. We looked at previous inspection reports of the service and contacted commissioners and health and social care professionals for feedback. We received feedback from three social workers, a local authority commissioner, chiropodist, pharmacist and Rapid Response and Assessment Team (RRAT).

We reviewed the Provider Information Return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection, we spoke with a visiting GP and two specialist nurses from the NHS Care Home Support Team. We spoke with nine people who live at the service and five relatives/visitors. We also spoke with the registered manager, deputy manager, regional manager, training manager, two registered nurses, one senior care worker, three care workers, an activity coordinator and the housekeeper.

We looked at records relating to the management of the service including eight people's care plans and

associated care records. We looked at six staff files including staff training and recruitment records. We reviewed quality audits relating to compliments, concerns and complaints, accident/incidents as well as a selection of documentation relating to the maintenance and safety of the premises.

Good

Is the service safe?

Our findings

People told us they felt safe living at Woodbury House. They felt confident that they would be listened to by the management team and staff if they were worried or had concerns about their safety. They told us that staff were always around and if not, their call bells were answered quickly. One person said, the response to call bells were, "so so" and remarked "they (the service) were always short staffed." Another person commented on the number of staff who had left the service, adding, "there are a few people (staff) leaving. Additionally another stated that their partner (a resident) liked to walk in the garden declaring, "I like how staff make sure he is safe."

There were adequate staff numbers to ensure people received safe care. There were a minimum of nine staff during the daytime and three staff at night to meet the needs of 37 people. The nurses and care staff were supported by the registered manager, deputy manager, administrative staff, domestic and kitchen staff. Staff shortfalls were covered by staff working additional shifts and by agency staff if necessary.

The environment, with particular reference to the memory unit, did not lend itself to people being easily seen by staff if they choose to walk towards the lower end of the corridor. We observed that measures were in place to protect people who remained in their room through choice, frailty and/or receiving end of life care. This included risk assessments that determined reasonable risk from harm and detailed actions to be taken. For example, sensor matts were placed on the floor by the bed of a person receiving end of life care to alert staff should someone uninvited enter their room. A staff forum held on 3 July 2017, had reviewed a nationally recognised staff ratio assessment tool used by the provider to dictate staff levels. Staff commented that the tool "did not consider the environment of the home."

We recommend that the service consider current guidance or seeks advice from a reputable source on staff levels that includes consideration of the environment.

People were supported by staff that had been recruited as safely as possible. The service had a high turnover of staff. During the previous year 41 had left with 40 staff currently employed to deliver the regulated activities; there were five staff vacancies. The rural location contributed to difficulties recruiting and retaining staff. The registered manager told us she was conducting an in-depth review of why staff were so difficult to recruit and retain, and of action so far taken to improve the situation. Action included use of the home's minibus to pick up scheduled staff on the roster at set location points, which had improved retention of staff. Staff files contained relevant documentation to check identity, previous employment, confidence and character, together with criminal record checks. Application forms were complete and records of interviews were maintained.

Staff were able to provide a robust response in relation to their understanding of safeguarding. They referred to the organisation's whistleblowing policy and stated that if they were not listened to by the registered manager or within the organisation that they would report their concerns to the local safeguarding authority and/or Care Quality Commission. Two staff were unsure whom they could report to outside of the organisation. There was a whistleblowing policy readily available for staff to refer to within the home. Sixty

percent of staff had received safeguarding training and further training was scheduled for the remaining staff in August 2017.

A local authority commissioner reported that the registered manager had taken appropriate action to report safeguarding concerns. Health and social care professionals stated, "I have never seen anything that I was not comfortable with that gave me concern. They (staff) all engage fully in reviews of customers and safeguarding enquiries." "I believe that residents are safe and well treated with respect and dignity. I have never seen anything to give me cause for concern as to their well-being."

People's safety was enhanced by detailed risk assessments relating to areas of care relevant to their individual needs. Examples included falls, equipment, isolation, nutrition and skin integrity. We saw that regular assessments were completed and action taken to minimise any risks. For example, it was noted that an air mattress had malfunctioned. More regular checks were put in place to reduce the risk of pressure sores until the mattress had been repaired/replaced.

People's medicine was administered safely. They told us that they received their medicine correctly and on time. Registered nurses gave medicine and their competency was assessed by the registered manager every year. People's individual care plans included side effects of medicines, how to give the medicine and how to position the person to enable them to swallow their medicine safely. Additionally, care plans described how people displayed pain. A recognised observational pain assessment tool was used in the care of people with dementia who may not be able to communicate that they were experiencing pain.

Good

Is the service effective?

Our findings

People were supported to maintain their health and well-being. We asked health care professionals if people's health needs were addressed by staff in a timely manner. They said, "Yes I believe this to be true, I have seen no evidence to the contrary." another said, "Any health issues are dealt with in a caring and timely manner." People's health and medical needs were clearly described in their care plans and records indicated medical advice had been sought promptly when people had become ill. Appropriate referrals were made to health professionals such as dieticians, mental health professionals and specialist nurses. Regular visits from health professionals such as chiropodists and opticians were also organised.

People benefited from being cared for by staff who had received training and had /or were developing the necessary skills through further training and experience for the job role. A relative of a person stated, "On the whole the staff are well trained and know what they are doing, they are wonderful, without exception". Another stated, "They show you courtesy, respect and enormous kindness". Another relative told us the "care varies" but it is "quite satisfactory" and that the staff appeared well trained.

People were provided with adequate amounts of nutritious food and supported to drink enough fluids to keep them healthy. People's care plans included eating and drinking assessments, as necessary. Action was taken if people's weight fluctuated or decreased significantly. People were complimentary about the food stating that "the food was good," and "there was plenty of it." People were offered drinks and snacks throughout the day and could choose where to eat their meals.

There was a formal dining area on the ground floor and the memory unit. On the ground floor, menus were placed on the tables and people were asked which option they wanted. The dining area was free of noise and was very calm and relaxed where people could chat while eating. People eating in their rooms did so from over-bed tables and were given extra help, where required from staff. On the memory unit, some people had their meals in the dining area and/or chose or needed support to eat in their rooms. Staff did not always converse and interact with people during the lunch period on the memory unit to encourage them to eat. For example, we observed on day two of our visit that one person had discouraged another person from fully eating their meal. By three pm they had still not eaten. We had seen no attempts by staff to encourage or offer food. The registered manager undertook to investigate this incident and take appropriate action.

New staff received an initial three-day induction to the service, which included training sessions in areas such as moving and handling, infection control and fire safety. After this, they spent time shadowing experienced staff in order to meet and get to know the people they would be supporting. The provider was in the process of implementing an induction that complies with the care certificate. All new staff are required to complete the care certificate, which is a set of 15 standards that health and social care workers adhere to in their daily working life. At the time of our visit, not all staff had completed their induction training or refresher training. This was due to a significant staff turnaround that the home had experienced. There was also a new face-to-face training programme that had been rolled out that replaced on-line training. The in-house trainers received training and support from the providers training coordinator to facilitate staff training.

Staff said they had received training and were provided with development opportunities. They told us that the new face-to-face training was, "Adequate and of good quality." Another described the training as, "Interesting and very good." They added, "It keeps you refreshed and is better than e-learning because you are learning in a group and you have someone talking to you." Some staff felt that the only issue with the face-to-face training was that staff were left with low staffing levels to support people. Other staff, the registered manager and deputy told us this was not the case as the care rota was always covered. Training scheduled in August 2017, included dementia awareness, equality and diversity and personal care. Staff told us that they received supervision regularly. They told us they felt well-supported by the management team and their colleagues.

People's rights were upheld by the management team who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). 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 so that they can 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 and hospitals are called the DoLS. The service had made appropriate DoLS applications.

People were encouraged to make as many decisions and choices as they could. Best interests meetings were held and the content recorded, as necessary. These included the use of covert medicine and health treatments. Care plans included detail of the day to day decisions people were able to make and how staff should assist them to make them. During the inspection staff asked people's permission before undertaking any personal care or other tasks. For example, what activity they would like to do.

People who had behaviours that could cause distress to themselves or others were not admitted to the service. However, some people developed anxiety or distress due to their deteriorating mental health or because of being admitted to a strange environment. The service made appropriate referrals to other professionals to enable them to support people with these particular needs. A mental health nurse told us that she planned to complete a review of a person's behaviour and that "staff always call for advice, but also used their own initiative." Behavioural support plans were in place, as necessary but would benefit from more detail. For example, one behavioural support plan noted staff should use de-escalation techniques but it was not clear what these were, for the individual. One person had a detailed but simple and easy to follow flow chart to inform staff how to support an individual with their distressing behaviour. The registered manager and staff told us they did not use any form of restraint. However, medicine to support people with their behaviour was given as a last resort. Guidelines for their use were in place.

Woodbury house had recently been refurbished throughout with the exception of the kitchen and laundry facilities. These were under review to bring them to the same standard as the rest of the home. There were some concerns expressed by people over noise, particularly early morning and late at night. Two people said that they are disturbed in their room by doors banging where soft-closures were not working and that staff let the doors bang when they go in and out of rooms. Over the course of our visit, we noted that some doors did not close quietly. The registered manager has undertaken to review the door closures throughout the home. A social worker who visits the home regularly said, "The home always has a feeling of being clean and hygienic. The furniture is of a good standard, in particular the seating. The environment is very homely and stylish".

Good

Is the service caring?

Our findings

People were provided with care by caring and committed staff. Comments from relatives included, "The care in general is excellent, and I can't fault it." "They're wonderful people; I wouldn't fault them for care." "They are wonderfully kind, patient and they put themselves out for you; they have a sense of humour too." A social care professional stated, "People are treated with respect and dignity. I would readily place my customers / family there."

People received compassionate end of life care. Some staff were provided with training on end of life care and further training was scheduled. A relative told us, "I haven't got a bad word to say…They (the service) bent over backwards to help my (relative)…The care is absolutely amazing. My (relative's) pain is well-managed …They try all sorts of things to keep (relative) comfortable." Another relative of a person wanted to make us aware that they could not fault the care their (relative) received within the home particularly at end of life stage.

Relatives of people spoke appreciatively about a meeting that was held within the home, which gave people and their relatives an opportunity to discuss end of life care. They stated that this had been a "very interesting and helpful evening." Other comments included, "very informative, and the talk the doctor gave was fantastic, and that made the meeting (planned care review) with the deputy manager a lot easier." They told us "it was good to hear what healthcare professionals had to say about what to expect of the services people received to ensure a dignified and comfortable death." People were able to chose to have 'do not attempt cardio-pulmonary resuscitation forms' (DNACPR), in place. DNACPR's had been signed by the appropriate health care professional.

People were predominantly helped to maintain their dignity and staff mostly ensured people's privacy was respected. Staff interacted with people positively and reacted to them in a warm and friendly way. Throughout the day we saw excellent examples of staff relating to people using soft and measured voice tones and appropriate humour. We saw that people were comfortable, happy and encouraged to join in with activities and interact with staff and others. People were helped to sit in easy chairs while others who wished to wander were supported and reassured by staff. However, on day one of our visit we did witness one member of staff being indiscrete and loud about a resident requiring the toilet. On day two of our visit, we saw three staff who mostly interacted with each other rather than with people, and did not preserve their privacy. For example, we saw one staff member who entered two individual's room without knocking or announcing themselves and did not discourage another person from wandering in and out of the individual's private space. This had included a person who was at the last stage of end of life care. This did not demonstrate respect for the person's privacy.

After discussion, the registered manager undertook to investigate these occurrences and reported to us detailing the action they had taken. This had included end of life care training that also looked at dignity. This would be delivered by the care home support team specialist nurse on the 4 September 2017, together with end of life training by an external recognised training provider. Senior leaders that included registered nurses were given a copy of the palliative and end of life care manual. This sets out the framework and

guidance to enable the staff to deliver a safe, dignified and holistic approach to the care of the dying within the home. In addition, the registered manager had linked the registered nurses part of their development/revalidation by discussing end of life care. They had also commenced an audit on dignity and respect within the home.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the service. This information was used to create a care plan for each person. People were able to view the home before they made a decision to live there. A person's relative said, "We viewed three places with (name of the person) who made the final choice." Adding, "(name) made up his mind straightaway, but has never been one for snap decisions". "It was the ambience of the home… that inclusion, friendliness and openness that swung it for (name) and he is still so happy."

Peoples care plans' were divided into 15 sections. For example, section eight addressed social interactions and mood, choices, preferences and life history. With the involvement of people and when appropriate relatives, each care plan was designed to meet people's individual needs. Care plans were updated on a regular basis that meant staff had up-to-date information about the individualised support needed for each person.

People also had a room file, which incorporated a summary of their needs, and what was important to them. Monitoring records were held within this file to enable staff to update records, such as repositioning and visual checks. One of our observations was of a person who remained in bed and who required 30 minute visual checks. We saw on one occasion 50 minutes had elapsed before this person was checked. The registered nurse stated that the "timing of the visual check had been changed that morning." Records showed that where there was a concern or a change in someone's needs, the care plan was reviewed and updated. However in this instance this was not followed through. We discussed this with the registered manager who took immediate action to address the matter.

The service was responsive to people's diverse and changing needs. We saw staff largely responded to people's body language and facial expressions in a positive and caring manner. This was with the exception of two staff and one nurse during lunch on the memory unit on the second day of our visit, who did not interact with people. For example during a half hour observation three staff were not fully responsive to people's emotional well-being, whilst three staff were focussed on giving people an enjoyable dining experience. Professionals who visit the services regularly and staff told us this was not typical staff behaviour and could not explain why it had occurred. We discussed this with the registered manager who took immediate action. Staff training was scheduled to take place in August 2017, that included equality and diversity and dementia awareness. The activity coordinator told us that they had recently completed a training course called pacesetters. Adding that this was, "to provide training to staff in stages, about the organisations values, to make life better for all and "to create a culture of positive thinking for everyone."

A relative informed us that they were involved in planning and reviewing their family member's care but had been unaware that the person themselves had been invited to the review. The registered manager told us that the person had declined to attend, however, this information was not recorded. People who had the capacity to make a decision about their care had signed care plans in agreement of their content. A person's relative said, "Yes, there have been care plan reviews. My sister and I both get an invite and you're always given good notice..." Records of invites confirmed that in May 2017 letters were sent to people's

families/friends and/or advocate to invite them to attend care plan reviews. A social care professional stated, "I have found care plans and risk assessments are up to date. Woodbury House work in an open way - working in partnership is at their core, learning together to develop best practise."

People's changing needs were communicated to care staff by a number of methods. For example, registered nurses gave a verbal handover at each shift and the registered manager held a, "flash" meeting during the day to discuss any issues or information with staff. Staff could also consult the daily notes written by the registered nurses in the care plans.

People and their relatives were encouraged to provide feedback on the service. The manager held resident and relatives meetings to gather views and discuss plans for the service. The minutes of the most recent meeting in June 2017, showed information was shared to keep people informed of changes and future plans. Time was also given to allow people and relatives opportunity to express their views.

People knew the registered and deputy manager and said that they would approach either if they needed to make a complaint. They said they felt confident that their complaint would be acted upon. The service had received 32 compliments in the last 12 months. They also received three complaints that related to an increase in fees and labelling of laundry items. These were investigated to a satisfactorily resolve.

There was a full-time activity coordinator and a vacant part-time post had been advertised. Daily activities were provided and a programme of activities was posted on the notice board. A newsletter was available to keep people informed. A relative said, "The residents are encouraged to join in and make new friends but they are not forced in any way." Adding, "There is always something going on, and local churches support the home with services." Staff were using jigsaws in the memory lounge with people and playing various games with them. People reported that they were supported on trips and enjoyed entertainers who regularly came to the home. One person told us there favourite was, "The Owl Man". Another said, "Although outside entertainers were very good, there were not a lot of other activities." Two people said, "Staff would call in for a chat when they have time" and one person said they "occasionally got a visit from the manager for a chat." A social care professional stated, "I have one client residing there who has advanced dementia. I am happy with the service (name) receives … and the opportunity to take part in lots of activities…"

Various activities were offered that included one to ones for people who remained in their room through choice or frailty. These included music, reading and sensory pursuits such as head massage. The activity coordinator said, "We talk to people and/or their relatives about their life to support resident's choice through for example, the wishing well. This was completed in conjunction with people and their families and had for example, promoted a person's wish to have a guest speaker on "Victorian crime" and a person to share a meal with their whole family.

Good

Is the service well-led?

Our findings

At the time of this inspection the service had a registered manager who was present and assisted us throughout this inspection. There was an open and honest culture within Woodbury House. Throughout the inspection we noted a warm and friendly atmosphere between everyone at the service. The registered manager and deputy manager regularly walked about the home and their presence was clearly visible for people and their visitors to approach them.

People and their relatives felt listened to and felt confident that the registered manager and staff would act in their best interest should they have a concern or complaint. They all spoke highly of the registered manager and her deputy and of staff, who were reported to be "very approachable", "reliable" and "efficient". They said, "The service always calls you to notify you of change." "There's always been good communication lines" and "The level of communication has been wonderful."

Staff told us that the registered and deputy manager were, "very supportive". They were confident that the registered and deputy manager would continue to promote their personal development in the best interest of people who used the service.

Health and social care professionals were confident that the registered manager and staff would act in people's best interest to provide a safe, effective, caring and responsive service. Comments from a number of professionals included, "The manager and her team have always given their total co-operation…" "They always work in the best interests of their residents, working hard to manage the dynamics of the mix of residents in a unit, which I recognise is not always easy." "I am most grateful to Woodbury House for the great care that they have provided for my customers - moving people into residential care is never an easy decision, but Woodbury House endeavour to make it a positive outcome." "In my opinion from my professional experience, Woodbury House is a well-managed care home looking after each resident's every need in a professional, attentive, safe and caring manner." "I'm very positive about the home culture; they are very friendly and wouldn't hesitate to get in touch." "They are open to advice and readily consult the rapid response and assessment team. We have worked well with this home since our service started two years ago. They are also well supported by their GP. We are always very welcome when we go there and there is always a visible staff presence."

A system of audits and checks to monitor the quality of the service was in place. This included a whole home audit that covered set assessments each month on matters as directed by the provider. For example, July 2017, covered safeguarding, end of life care, recreation and activities and health and safety. The audit was completed using observational checks and a series of questions that were put to five people and five staff, who were randomly chosen to seek their view. A regional manager monthly visit looked at the overall compliance of the home and addressed areas such as health and safety and resident involvement. We saw that where they had identified any areas of concern, action had been taken to address and improve them. Other audits undertaken by the senior team included dignity and care and clinical assessments. An assessment tool to determine staff levels to meet people's needs was also used each month. We have made a recommendation within 'safe' for the service to consider staff levels that includes consideration of the

environment.