

Four Seasons (Emmanuel Christian Care Home) Limited

Park House

Inspection report

93 Park Road South
Claughton
Wirral CH43 4UU
Tel: 0151 652 1021
Website: www.fshc.co.uk

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection was unannounced and took place on 20 January and 4 February 2016. At our last inspection in July and August 2016, we had found a number of breaches of legal requirements, relating to dignity and respect, consent to treatment, safeguarding, the numbers of staff provided and failure to follow safe recruitment processes. We made requirement actions for these areas to be improved. We also found further serious concerns and issued warning notices in respect of failure to provide

person centred care, safe care and treatment, nutrition and hydration and good governance. We rated the service 'inadequate' overall and in all domains and placed it in 'special measures'.

The provider sent us an action plan and updated us regularly on their progress with their planned improvements. We also received information from the local authority quality monitoring team. At this inspection

Summary of findings

we found that the service had made significant improvements to the care and support of people and had met the requirement actions and the warning notices. The home has now been taken out of special measures.

One visitor told us, “There has been a massive improvement since the last inspection” and another said, “There have been lots of improvements”.

Park House is a large modern building on three floors, located in a quiet residential area of Birkenhead. It is part of the Four Seasons group of health care services. The home is registered to provide accommodation and care for up to 111 people. The building is split into three units. The ground floor unit is for people who do not require nursing. The middle floor unit is for people with dementia who may require nursing and the top floor unit is for more frail elderly people who may require nursing. At the time of our inspection, there were 80 people living in the home.

The home requires 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.

Since our last inspection, the previous manager had left the service and the provider had recruited two managers, one who was the home manager and the other who was the clinical manager. The home manager had submitted their application to become a registered manager with CQC and was waiting for this to be processed. The clinical manager told us she would also be applying to be similarly registered. During this inspection, the home manager and the regional manager were present.

We found the service to be generally safer and that staff recruitment had been safely completed. The home had recruited more staff and people and visitors had noticed the improvement in care they were able to deliver. Staff knew about abuse and how to prevent and report it. However, we found that the medication recording was not adequate and have made a recommendation about this.

Staff were supervised regularly, but the training needed to be improved and more staff needed to attend key training, such as person centred care. The training records were difficult to follow. The staff followed the principles of the Mental Capacity Act 2005 and we saw that appropriate applications had been made for Deprivation of Liberty Safeguards to the local authority. The home was pleasanter in most areas and was in the process of some refurbishment and the outside areas were tidy.

We found that staff were caring and respected people and their right to privacy. The people living in the home were happy with the care they received. People’s religious and cultural needs were met and staff had been trained in end of life care.

Most people were cared for in a person centred way but records did not reflect that their assessment had considered this. People’s records were reviewed generally, well, but some review entries were sparse and not informative.

The home was benefitting from having two managers who had split the duties of running the home, between them. Records and auditing had improved but still required more work. The satisfaction with the home had improved and in January 2016, 100% of people who chose to complete a survey, recorded they would recommend it.

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?

The service was not always safe.

Staff were recruited using safe procedures and knew about abuse and how to report it.

There were sufficient staff on duty.

Medicines management had improved but required further improvement as records were not completed properly.

Requires improvement



Is the service effective?

The service was not always effective.

The home and the staff followed the Mental Capacity Act requirements.

Training was improving but more staff needed key training.

The dining experience had improved and the premises were cleaner and pleasanter, but still required some work

Requires improvement



Is the service caring?

The service was not always caring.

Staff were kind supportive and respectful and often had time to sit and chat with people.

Some work needed to be done to ensure people's independence was better promoted.

Requires improvement



Is the service responsive?

The service was not always responsive.

There was a complaints policy and procedure which was followed.

People were treated as individuals but their records needed to reflect a more person centred approach.

Activities in the home had improved but were still not to everyone's taste.

Requires improvement



Is the service well-led?

The service was not always well led.

The home had two managers who split the duties of running the home. They had developed a plan to improve the home.

The new processes and procedures still had to 'bed in' to ensure smooth running of the home.

There was currently no registered manager in post as required.

Requires improvement



Park 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 comprehensive inspection took place on 20 January and 4 February 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist advisor who was a registered nurse 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. This expert-by-experience had experience of elderly people with nursing needs and those living with dementia.

Before the inspection, the provider completed a 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 contacted both Wirral local authority quality assurance team and Wirral Healthwatch for their views on the service. Healthwatch is an independent consumer champion that

gathers and represents the views of the public about health and social care services in England. We also looked at our own records, to see if the service had submitted statutory notifications and to see if other people had made comments to us, about the service.

We talked with four people who lived in the home, six visitors including four relatives and with two health care professionals. We also talked with the registered manager and the provider's regional manager. We talked with five nursing and support staff, an activities co-ordinator and with the chef.

We looked at 15 care records and eight staff and training records. We pathway tracked three people's care. We also looked at other records related to the running of the home, such a medication and positional change records, policies, procedures and audits.

One inspector and the expert-by-experience took lunch with some of the people and the inspection team generally observed the care and support throughout the inspection. 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.

The provider sent us some information immediately after the inspection, such as the training plan and an update on progress.

Is the service safe?

Our findings

One visitor told us, “We have peace of mind; we know she’s safe” and another commented, “I think it’s improved in the last year”.

Visitors generally seemed happy with the staffing levels, but one visitor commented “I think they could be better especially at weekends; she needs to ‘go’ when she needs to go”.

A staff member told us that the, “Safety of the residents was paramount”.

At our last inspection we identified concerns with medication procedures, staffing and infection control. At this inspection we saw that improvements had been made in these areas. Further improvement was still required. Further improvement was still required.

We observed a medication round and the administration of medicines to people in the home. We noted that a registered nurse and a senior health care assistant shared the duty and noted that they had been trained to administer medication safely. ‘Controlled drugs’ (CD) that needed to have two people verify the administration, we saw were checked by both members of staff. The staff administering the medicines wore a tabard top which demonstrated to everyone that medication administration was being undertaken and the staff member should not be disturbed.

We noted that medications were administered to people in a calm, sensitive and confidential way. The medication was explained to the person and agreement obtained from them before its administration. There was a policy relating to covert medication, which is when medication is given masked with something, or given without obtaining consent. The correct procedures had been undertaken for a person requiring this process.

The lockable medication trollies were kept in the locked medication room along with the medication administration record (MAR) sheets. We saw that the medicines stocks stored in the cabinet and the MAR sheets, tallied. All the drugs were ‘in date’ and new stock had been checked in properly, stored correctly, and administered appropriately. We saw the records which showed that the temperatures of the medication room and the lockable medication fridge were checked twice a day and were all within the

recommended levels. PRN (as required) medication and homely remedies were recorded in a similar way. Again the stocks tallied with the record. All medications were labelled clearly and appropriately stored within a locked cupboard or trolley.

Most of the medications administered were signed for in the correct place at the correct time on the MAR sheet by the registered nurse. The CD cupboard was a locked cupboard within the locked clinical room and was fixed to the wall. The drugs in the cupboard correlated with the amount written in the CD Book. However, we saw that there had been some entries in the CD register which appeared to have been altered and that some of the quantities recorded did not add up properly. We also saw that staff had written over a GP’s note about a medicine and had altered the dose the GP had prescribed and there were a number of illegible entries and the use of non-standard codes on some MAR sheets.

We noted that several of the communal toilets did not have soap and that one of the hand sanitizers on the corridor was empty which meant that it was difficult to ensure good infection control. We discussed these concerns with the managers who assured us this would be addressed with staff.

One person’s medication and their liquid diet was administered to through a percutaneous endoscopic gastrostomy (PEG) and records showed us the PEG site had been correctly cleansed and managed each day. A PEG tube is inserted into the stomach wall in order to provide an alternative way of feeding people who have difficulties swallowing. We saw that this person also received mouth care. During the whole process, the person was given an explanation of what the process was and why it was being done.

Most staff had been trained in safeguarding and were able to tell us what abuse was and how and to whom they would report it. They told us they knew how to get the contact numbers to report an issue. One staff member said, “It is not allowing physical, financial or mental abuse and I would tell my senior or unit manager; sometimes we write the report”.

We saw notices in the home which gave the telephone numbers to contact, if there were any concerns. We saw that further training had been planned for February 2016.

Is the service safe?

We saw staff rotas for the previous four weeks and the following two weeks which showed that there were always sufficient staff on duty. We were told by the manager that an additional 39 staff had been recruited since the last inspection. The providers' dependency tool had been updated. This dependency tool was a tool which assessed peoples' needs and gauged the number and type of staff needed in the home.

We noted that the staff had been recruited according to the legal requirements. All staff had been checked for criminal records, qualifications, their right to work in the UK and all had at least two references. Staff had not been allowed to work until these requirements had been met and a satisfactory interview had taken place. We saw records of application forms, interview notes and other documents in the staff recruitment files. The provider had various policies relating to employment, such as disciplinary and grievance procedures. This showed that there was clear guidance about the relationship, expectations and requirements between the employer and employees.

In the care files we saw that risk assessments had been completed on the various aspects of each individual's person's life, such as using bed rails, hoists, mobilising and nutrition. We saw that weights and fluid and nutrition

intakes were recorded and that concerns were acted upon. We noted however that there was a discrepancy in some care files which did not have a MUST (malnutrition universal screening tool) when there was an entry onto a matrix kept in the office. The managers assured us that a record would be inserted into the persons care file.

There were smoke and fire detectors throughout the building, with the necessary firefighting equipment placed around the home. This equipment had been checked and serviced regularly as had the hoists and other equipment.

Window openings and patio door openings had restrictors and these were checked routinely by the maintenance person, who also checked such things as the hot and cold water temperatures and some of the equipment in the home. We were shown various test certificates for the gas, electrical and lift installations as well as the legionella certificate, which were all in date.

We saw there were appropriate fire evacuation plans, should there be an emergency. We saw that individual personal emergency evacuation plans (PEEPs) had been written for staff to use in an emergency.

We recommend that the service considers the latest guidance about managing medicines in care homes.

Is the service effective?

Our findings

One relative we spoke with told us, “We are very happy that actions taken since the last inspection; it was very effective and improvements in the care were made with visible improvements to the increase in staff numbers”.

At our last inspection we identified concerns with staff training, people’s nutritional needs and with compliance with the Mental Capacity Act 2005. At this inspection we found that improvements had been made in these areas. Further improvement was still required.

The Care Quality Commission (CQC) is required by law to monitor the operation of 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this was in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any authorisations or conditions to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the MCA and DoLS and had submitted the appropriate applications to the ‘supervisory body’ (the local authority with responsibility for the person). The managers kept a DoLS matrix which also recorded the involvement of any independent mental capacity advocate (IMCA). Most of the people living in Park House had a DoLS application in the process of being considered by the local authority and eight applications had been approved. We saw that the DoLS restrictions were appropriately followed.

We saw that the care records we looked at all had capacity, best interests and DoLS assessments completed and recorded. We saw that consent forms had been obtained for most people and were within their care records and we observed people’s consent being requested for various

things, such as for people to take medication. We saw there were signed DNACPR (do not attempt cardiac pulmonary resuscitation) which had been completed appropriately after consultation with the person and their relatives and there was a cross reference to their capacity and consent to complete this, in the file.

The home was secured by keypads on the external doors and in between the floors, on the stairwell doors. We were told that people who had capacity did not have the codes for these doors, but that they would be given them and the provider has emailed us to say this has been done. All the visitors whose relatives had bedrails said they thought they had only given verbal consent to this, but couldn’t be positive.

Staff had received training in the MCA and the associated DoLS and they were able to tell us about the main points of the legislation. Staff had also received the provider’s mandatory training on their induction and then had received other training as they progressed through their employment, such as NVQ (national vocational qualification) and management training. The provider had started to train staff for the Care Certificate and we saw a schedule for 2016 which demonstrated this. We found the training records to be erratic and difficult to follow and tended to be a record of what had taken place but did not include what was planned. The home manager has since sent us a partially completed plan for training in 2016, but there were no names of staff that were booked to do the training.

Staff told us that their supervision had improved and that they met with their manager every six or eight weeks, either alone or in a group of other staff. We saw supervision and appraisal records which confirmed this.

People and their visitors told us the food was good and tasty. One person told us that the food, “Was really good” and they confirmed there was enough to eat. The dining areas were large and bright and the tables were dressed with flower arrangements and place settings. The lunchtime meal was provided for efficiently and effectively the people taking lunch there ate their meal well and appeared to really enjoy the food and the food choices. Staff were able to chat to people and those who needed support to eat were allocated a staff member.

Drinks were readily available during the day and during the meal. All the staff supporting the people at lunchtime were

Is the service effective?

clean aprons and were observed to wash their hands frequently. People were calm and happy and the meal time was not rushed. There was a radio playing in the background music that people obviously recognised as some were humming along with the tune. Staff had paperwork available to them to see what people's preferences for food were and understood their needs for support or special diets. One member of staff told us that the portion sizes of the food were small and that those people who wanted larger portions could have them. This preference was recorded on the daily list of choices. People's dietary needs were recorded on the daily handover sheets, which also recorded if they were allergic to any foods.

The home was a purpose built large building and had various equipment to aid people's mobility installed, such as hoists and specialist bathing facilities. We saw that appropriate fire-fighting equipment was in place and had been regularly checked and serviced. The area outside was clean and free of rubbish or other debris and had been well-maintained.

Since our last inspection, a re-decorating and refurbishment programme was underway and we noted that many of the carpets and some furniture had been replaced and renewed. Toilet doors and toilet seats were in a contrasting colour which meant they could be easily seen and identified.

All the relatives and people we spoke with were happy with the state of cleanliness of the home, however when being given a tour of the home, in some areas there was an unpleasant odour. We discussed this with the managers who told us there were still areas which needed refurbishment. They showed us the orders which had been placed for the ongoing work. In their email updating us about the home, the managers told us they have updated their redecoration and refurbishment programme, as this they felt was necessary to address this issue. They also told us they had investigated having a professional air freshening system.

The middle floor of the building was designated for people with dementia. It had been redecorated and we noted that there had been an attempt to make the decor dementia friendly and there were pictures of famous people from the 50's and 60's. However, some of the décor proved to be unsuitable, such a life size painting of a telephone box. This was so realistic that staff had had to hang a notice on it saying it was 'out of order' because people had tried to use it. We also saw there was a clock face which was very 'busy' with a geometric heavy pattern on it. Dementia friendly environments generally call for plain colours where possible. The manager has told us that this clock has now been replaced.

Is the service caring?

Our findings

One staff member told us that they were, “Really happy since our last inspection. It made us change the way we thought about the job and the way we cared for the people in the home”.

One visitor explained that the care given by the staff, “Had really improved since more staff were on duty as staff now had more time to spend with residents”. Another said, “The carers go the extra mile”

Staff interacted with people appropriately, joking and laughing. We observed staff talking with and supporting people in a dignified manner whilst respecting their privacy. We saw that people were comfortable and happy with the staff. Staff seemed to have time occasionally to sit and talk to people and communicated with them in a quiet and friendly way, showing patience and consideration.

A visitor told us that, “They always talk and explain to Mum what is happening and what staff want to do”.

At our last inspection we identified concerns with lack of staff time to socially interact with people and that people’s privacy and dignity was not always respected. At this inspection we found that improvements had been made in these areas. Further improvement was still required.

The home was quiet and calm and we noted that call bells were answered within reasonable times. Staff responded to people’s request for assistance when they were asked, in a patient manner and we saw that staff were pro-active, offering support to people when they appeared to need it. However, one of the inspection team found a staff member trying to help a person who was on the floor of a corridor but they could not immediately summon assistance because there was no call bell in the corridor.

We noted that people’s cultural and spiritual needs were met, though, for example, people being able to visit their church, have pastoral care in the home and have their dietary needs provided for.

The home had made changes to the décor and was considering further improvements to the layout and other arrangements in the home, in order to improve people’s independence, but this work had yet to be completed.

The staff on duty that day were named on a white board and visitors told us this was helpful as they knew who they could approach. Each person had a keyworker, which was a staff member responsible for aspects of their life, such as activities or additional support during the day. This meant that the people who lived in the home and relatives as well as staff knew who to go to for specific considerations of each resident.

On one floor the area had been split into two to make it easier for the people living there, to move around. This had also made the area more intimate for people. A visitor told us, “Mum wanders less and has fewer falls”.

We were told that the laundry needed to be improved and we had had a concern raised about this prior to our inspection. The managers explained the system and also told us what had happened in relation to the concern, which we saw they had dealt with. However, one visitor we spoke with told us, “The only issue is with the laundry; things keep going missing”. They went on to tell us that this was the only thing the home could improve on.

The home used the ‘six steps’ pathway for end of life and staff had been trained in this. ‘Six steps’ ensures that there is open and honest communication, assessment and planning. It ensures that the person themselves is at the heart of the process, with other people such as relatives and care professionals included and operating in a co-ordinated way. The person’s need for dignity and respect is vital, as is the need to deliver high quality service in the care setting. It is a recognised end of life quality mark for care homes and other organisations. The training was provided by the local community nurse practitioner which demonstrated good inter-agency working.

We noted that people’s confidential information was securely stored. When we asked one staff member how they maintained confidentiality, they said, “You don’t say a word, you don’t divulge anything to anybody”.

Is the service responsive?

Our findings

One person told us, “I’m music mad and like the sing-a-longs”.

When asked if they had been involved with people’s care planning, one visitor said, “They have asked me, but they’ve never sat down with me lately”. Other visitors said, “Yes” and one said, “Not unless it was early on and I don’t remember”.

At our last inspection we identified concerns with care records, reviewing people’s needs, with care and the complaints procedure. At this inspection we found that improvements had been made in these areas. Further improvement was still required.

We saw that there a positive start had been made to improve the records and to make them person centred. The care records we looked at were, in some cases, well completed but in others, had not been well completed. We looked at 15 care records and ‘case tracked’ three of them, which meant that we checked the complete care and medication record and compared it to the person’s actual experience of care.

The service was using evidence based assessments relating to good practice in dementia care, including the ‘Abbey pain scale’ and the ‘Cornell depression scale for older people with dementia’. The use of these were considered by the health and social care sector, to be good practice. Some care files showed good communication with health care professional and prompt response to accidents and safeguarding concerns. However, we saw that some records did not have signed consent forms or signed care plan agreements. Some dependency and MUST assessments had not been completed monthly as the providers’ policy instructed. We also found that some support staff were completing care records in relation to things such as tissue viability and medication, which is not considered best practice as it is unlikely they have had sufficient training to do this. This specialist recording and assessment is normally done by a qualified nurse.

The care plans all contained a photograph of the person they were about. This meant that any new or agency staff could recognise the person they were supporting. We noticed there was a difference in the quality of detail that was recorded in people’s daily records. An example was that some staff (both qualified and unqualified) had written

a token line ‘no change’ in the daily record, whereas other daily records would be more detailed and structured such as specifically talking about a patient’s mood, nutrition, mobility or continence. In the training records we saw that person centred care had been completed by a minority of the staff. We were shown the notes of a meeting in one of the units which noted that the care was not person centred.

We saw that the care provided, however, generally was, person centred and that staff acted upon the information they received at their handover session, at the change of each shift. Care was provided to people and their individual situation and needs were accommodated. An example we saw was that one person with a PEG had the remainder of their support tailored around their repositioning and feeding needs, their mouth care and personal preferences. We asked staff how they would find out about the needs of a person admitted to the home when they were off and one staff member told us, “I’d get to know them by talking to them. We have a handover and I would read their care plan. We have a handover book”. They went on to say, “I would read the handover book on my break”. We saw copies of the handover sheets for the first day of our visit.

We saw there was a complaints policy which was available on the noticeboard and the majority of visitors said if they had a complaint they would speak to the manager. We asked those visitors who had complained if the complaint had been resolved to their satisfaction. One visitor told us about a number of concerns and complaints they had. However, they told us they were mostly happy and that one complaint had been resolved but that another was still unanswered. A third visitor told us their complaint had been resolved.

We observed there were notices throughout the home advertising activities which were planned in the coming days and weeks. The home employed three activities co-ordinators over a seven day week and the managers told us that some of the other staff were also involved in providing activities. The activities equipment was available to all staff now, we were told. During our inspection, we saw that there was poetry reading, bible study, a movie afternoon and a walk in the garden planned. The hairdressing salon on the ground floor was busy with a lot of people using the facility. We also heard a lot of chatter and laughing coming from the room.

Is the service responsive?

We asked the visitors how the people spent their time during the day and one said “She’s got a walker, she goes to events on a regular basis and she especially likes the sing-a-longs”. Another visitor said, “She watches TV and listens to music”. A third visitor told us, “There are activities, there are more than before and I know she joins in”. However, one visitor complained to us that their relative, “Had hardly seen the outside since she came”.

We spoke with one activity coordinator and they told us they had a budget of £80 per month, but it was going to be increased. They said that activities provided also included ‘memory matters’ which was provided by an outside organisation, story telling, entertainers, painting, drawing,

textiles, weaving, dancing and chair exercises. They were keen to promote people's exercise and were trying to get someone able to take a group to do this, they told us. They said, “We went to the pantomime but we need to do that more often. In February we are going to a tea dance.”

We asked if they had rummage boxes and the staff member told us, “The rummage boxes are out on the floor, we are making reminiscence books and we have boxes with hats, but it’s difficult because residents keep taking things”. When we asked how they celebrated people’s birthdays, they said, “Cook makes a cake if it’s a special birthday, but the floors tend to do their own parties”.

Is the service well-led?

Our findings

When we asked people and visitors how they thought the home was run, one person told us, “It’s OK” and a visitor said, “It’s 90% efficient, some things need tweaking”.

Another visitor told us, “They are trying to make the place better”.

A staff member told us that they felt supported by the home manager, but then went on to say “There’s no teamwork”.

At our last inspection we identified concerns with quality assurance systems, audits and that people’s views on the service were sought or acted upon. At this inspection we found that improvements had been made in these areas. Further improvement was still required.

The home had two managers, one called the home or general manager and the other called the clinical manager. The home manager had recently applied to be the registered manager with CQC and the other manager told us they would also be applying to become a registered manager. They had composed a list of the various duties a manager was required to do and had divided this between the two managers. The home manager was responsible for checking such things as staff training, health and safety and housekeeping and the clinical manager was responsible for such things as people’s care, medication checks and staff meetings.

They had submitted all the required notifications to CQC and met the registration requirements. Staff told us the managers were easy to talk with and open and transparent. They told us they had a good relationship with them. Many staff told us they were happy to work in the home, especially in the last six months.

We saw that the home had various policies and procedures related to its running, staff and its practices. The service required systems or process’s to be effectively operated to ensure compliance with the requirements. The managers were responsible for checking and auditing many of the systems of work and the regional manager also did some of this work and performed quarterly checks. These checks included the fire system, maintenance logs and the equipment in the home. We saw that there were also such things as dining audits, bedrail checks and medication audits, wound analysis and also an analysis of incident with the investigation and outcome.

We were concerned that although audits had been completed, many of these had been only recently instigated since the last inspection and that at the time of this inspection we were not able to see a record of how the home had been managed over a period of time.

The interaction between the registered manager and the people living in the home showed us that the people were very familiar with them and that they knew each other well. There was a lot of chat and banter between them as we were shown around the building and we noted that people and staff were very relaxed with them and with us.

We saw that there had been staff and relatives meetings monthly since September 2015. This was confirmed by staff who told us they, “Were useful”. Relatives told us they were sent questionnaires every six months and we were told they and other visitors were being encouraged to use the iPad which had been placed at the main entrance to record their experience of the home. We were shown a record that demonstrated improving satisfaction scores in recent months and that in January 2016, 100% of those who input to this device, said they would recommend the home to someone else. We were told that the management of the service used the iPad records to spot any issues or trends and that they would then address these.