Sunnyside Private Nursing Home Limited

Sunnyside Nursing Home

Inspection report

140 High Street
Iver
Buckinghamshire
SL0 9QA

Tel: 01753653920
Website: www.trustworth.co.uk

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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

Sunnyside Nursing Home is a care home with nursing and provides care for adults, some of whom have dementia. The service, which first opened in 1984, is family owned and operated. There are three floors. The ground floor has some bedrooms, all of the communal spaces and ancillary areas like the kitchen, laundry and offices. The first floor and second floor have bedrooms and there are some communal bathroom facilities. In accordance with the current registration, the care home can accommodate up to 40 people. At the time of our inspection 36 people lived at the service.

At our last inspection, the service was rated good.

At this inspection we found the service remained good.

Why the service is rated good:

People were protected from abuse and neglect. We found staff knew about risks to people and how to avoid potential harm. Risks related to people's care were assessed, recorded and reviewed. The management of risks from the building were also satisfactorily managed. We found appropriate numbers of staff were deployed to meet people's needs. We made a recommendation about systems for the recording of people's incidents and accidents. People's medicines were safely managed.

Staff training and support was good. Staff had the necessary knowledge, experience and skills to provide appropriate care for people who used the service. The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People's nutrition and hydration was appropriate. People told us they liked the food. Appropriate access to community healthcare professionals was available. The building and grounds were very well-maintained.

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

We received complimentary feedback about service. People and relatives told us staff were kind and caring. People and relatives were able to participate in care planning and reviews and some decisions were made by staff in people's best interests. People's privacy and dignity was respected.

Care plans were person-centred and reviewed regularly. There was a satisfactory complaints system in place which included the ability for people and others to raise concerns. People had access to a meaningful social life, and the service had expanded their in-house programme and community outings which included an activities coordinator and three community outings each week.

The management of the service was in transition at the time of our inspection. There were appropriate systems for assessing and monitoring the safety and quality of care. We found staff worked within a positive

workplace environment and were well-supported by the management team. Minor improvement was required with regards to the duty of candour requirement. We made a recommendation about staff surveys.

Further information is in the detailed findings below.

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

Sunnyside Nursing 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.

Our inspection took place on 9 October 2017 and was unannounced.

Our inspection was completed by two adult social care inspectors 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. Our Expert by Experience was familiar with the experience of older adults who live in care homes.

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 reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities, clinical commissioning groups (CCGs) and the fire inspectorate. We checked records held by Companies House, the Information Commissioner's Office (ICO) and the Food Standards Agency (FSA).

During our inspection we spoke with the nominated individual, the registered manager, the home manager, a registered nurse and seven care workers. We also spoke with the service's kitchen staff and cleaners

We spoke with 16 people who used the service and five relatives. We looked at six medicines administration records and three sets of records related to people's individual care needs. This included care plans, risk assessments and daily monitoring notes. We also looked at four staff personnel files and records associated with the management of the service, including quality audits. We asked the registered manager to send further documents after the inspection and these were included as part of the evidence we used to compile

our report.

We looked throughout the service and observed care practices and people's interactions with staff during our inspection.

Good

Is the service safe?

Our findings

People were protected from abuse or neglect. Appropriate systems were in place including policies, staff training, contact information for the local authority and records of issues referred to third parties. A staff member told us they did safeguarding training "two or three months ago". Another care worker told us they had completed safeguarding training in the past year. A housekeeper told us they had done "all the training", including safeguarding. When we reviewed the provider's staff training information, we saw that the majority of staff had completed safeguarding training.

A care worker gave us examples of physical and financial abuse. They said abuse included, "If you hit someone" or "If you took money" from a person. They told us if they were concerned about a person, they would report it. They said they would, "Call the manager and report to the nurse. They'd investigate; they check that person's care plan". Another staff member told us that signs that might indicate abuse of a person included, "A bruise on the body or (the person) being scared of certain people (staff)". Staff also showed an understanding of whistleblowing. A care worker told us this, "Is when you report to the manager." They added, if the concern involved the manager, they would, "Speak with the director". Another staff member told us that an example of whistleblowing. They said, "This could be if I find out about abuse and the manager didn't do anything."

Staff were aware of reporting incidents and accidents, and how to manage harm or deterioration of a person's condition. One staff member told us that, "After a fall, they (staff) check the person for some time." Another worker told us about detecting changes in mood or behaviour of people. "When you get to know someone, you seem to know if their mood or behaviour was different. It was important to ask what changed in their demeanour. Carers should involve the person and ask 'Are you okay?" We looked at accident and incident reports and saw these were recorded in a book or on a form. We pointed out that many of the accident and incident reports had no management investigation notes documented.

We recommend that the service reviews the system for managing accident and incident reporting.

Risk assessments were present in people's care plan we reviewed. We saw that, on admission, a "general risk assessment summary sheet" was completed to record the various risk assessments undertaken. These were the pre-admission assessment, dependency, mental health, manual handling, falls, Waterlow (for skin integrity), nutrition (MUST), activities of daily living and continence. Other risk assessments completed, if needed, were for use of bedrails and wound assessment if a wound was present.

We checked that adequate staff were deployed. Thirty-six people lived at the service at the time of our inspection, including a person receiving respite care. The registered manager told us that about 50% of people required the support of two care workers, for example whilst transferring using a hoist. We found the service had a staffing complement of two registered nurses and six care workers during the day and a nurse and three carers at night. In addition, there were management staff that were primarily supernumerary and were not responsible for providing nursing or care. Both the current registered manager and new home manager were registered nurses. We were told on some occasions, management staff would assist with

people's support if other staff were busy or staff called in sick at short notice. The registered manager provided nursing care to people during our inspection.

One relative told us there was not usually a staff member in a communal area where a person liked to sit. The relative stated, "I don't know why they're (people) on their own so much of the time." A relative, whose family member had received care at the home for several years, told us "The majority of staff are still here." This indicated there was a low turnover of staff. We observed seven people were left alone in the sitting room from 9am to 10am, when a staff member came in to offer drinks by showing a choice of juices or water to people. We noticed staff supervision of the room was intermittent during the rest of the morning. After lunch however, we saw more staff were present for longer periods in the room.

We looked at the rotas for 28 August 2017 to 22 October 2017. We saw these reflected the planned and actual staff deployment explained to us by the service's management. A staff member told us there was, "a lot of sickness" and that "We need to be overstaffed" for that reason. This was confirmed by the management team who stated that in order to ensure enough staff were on shift they often rostered one or two additional staff on shift. Another staff member told us there were enough staff; "Sometimes seven or eight staff" when we asked if they thought there were enough staff to meet people's needs. They added that, "People (staff) call in sick" but "We do have the nurses." On the day of our inspection we noted two housekeepers were on duty, one of whom was cleaning rooms and communal areas while the other dealt with laundry. A chef and kitchen assistant were present preparing meals. The nominated individual told us that "We're okay" for nursing staff but that they planned to recruit for a new post of clinical lead, to support the registered manager. During the inspection, although busy at particular times such as meal service, we observed there was satisfactory staff deployment to meet people's needs.

Personnel files we checked contained all of the correct information required by the regulation and associated schedule. This included checks on staff identity, proof of right to work in the UK, criminal history checks from the Disclosure and Barring Service (DBS), references and full employment history. We also noted that registered nurses' PIN references were recorded with the date for annual renewal or three year revalidation. We pointed out one issue with an employee's file to the management team. They wrote to us shortly after our inspection with evidence the matter was appropriately handled. We found the service only employed fit and proper workers to support people.

We checked people who used the service were protected from risks associated with the premises and grounds. We found that appropriate risk assessments and maintenance were completed. This included routine assessments of gas, electrical and water safety. Other risks that were monitored included the hoisting equipment, passenger lift, fire safety and window restrictors. The risk to people and others was satisfactorily mitigated and documented. We asked the nominated individual to review the storage of general and clinical waste within the service's car park and also to consider a dedicated parking bay for people with disabilities.

People's medicines were safely managed at the service. We observed the morning and lunch time administration of medicines. Medicines were administered to each person directly from the medicines trolleys. The medicines administration records (MAR) were correctly completed. Regular medicines audits were completed by senior staff and an annual external audit completed by the community pharmacist. Medicines that required stricter controls by law (controlled drugs) were securely stored and correctly documented. All registered nurses were trained in the administration of medicines and had satisfactory competency checks. Temperatures of the fridge and rooms where medicines were stored were checked and appropriately recorded. There was a "homely remedies" protocol in place. "Homely remedies" are medicines that can be purchased over the counter, for example paracetamol. The protocol required more

detail and review. The management team were receptive of our feedback regarding the homely remedies.

Good

Is the service effective?

Our findings

We found satisfactory support was offered to staff in learning and development. When we reviewed the provider's staff training information, we saw that the majority of staff had completed training in moving and handling, the MCA and DoLS. The provider stated that a small number of staff who had not completed this training were already scheduled to undertake it.

The records showed that a housekeeper had completed eight training units including health and safety and control of substances hazardous to health (COSHH). We also spoke with a maintenance worker about their training. They could not recall safeguarding training but the training record indicated they had completed it . The nominated individual told us that, "Our induction matches to the Care Certificate." The care certificate pathway comprises fifteen units or standards for new care workers in adult social care settings.

A care worker we spoke with was the trainer for moving and handling. Another care worker told us, "They are very good" at staff training and referred to doing a training session on behaviours that challenge in the previous week. Staff completed mandatory training. This was face to face, including safeguarding and moving and handling. Some staff had achieved nationally-recognised qualifications in health and social care at levels two and three. A relative told us "I've seen them doing their training." A care worker told us they were engaged in a trainee "nursing associate" programme with Reading University. This two year course aimed to develop skills and knowledge to assist registered nurses with care. Students who completed the programme could subsequently take a shortened (18 month) course to become a registered nurse. Sunnyside Nursing Home was one of a small group of number care home services selected to participate in the initial pilot scheme.

Senior staff told us that the service had introduced a system of supervision whereby registered nurses had received training and would use a supervision template which the supervisee would also sign. We saw that a registered nurse had been allocated four supervisees. When we reviewed records of supervision, we saw that three registered nurses had appraisals in March 2017 and three nurses had supervision in July.

We saw records of supervision with care staff on specific issues, for example not having notified the nurse of a bruise observed on a person's hand. For two other care workers, we saw that supervision had focused on the importance of filling in all food and fluid charts. A care worker told us they had supervision, "Every two months". Another care worker told us they had, "Done more than two supervisions" since they had worked at the service. A further care worker told us they had a supervision in June 2017 and were, "Due another".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We observed that staff sought consent and explained care to people. Care workers we spoke with were able to cite the main principles of the MCA. A care worker told us, "You always assume that everybody's got

capacity." Another care worker told us, "Ask (people) for consent; it's their home." When people's capacity to consent was impaired, we saw that mental capacity assessments were completed for specific decisions, such as consent for influenza vaccine to be administered and regarding a DoLS application. We saw documentation from a local authority that confirmed a DoLS authorisation for a person was authorised. A best interest assessor and a psychiatrist had completed assessments and we saw the person's spouse and a registered nurse from the home were involved in the process. We saw that consent for use of bed rails was recorded. A mental capacity assessment had been completed for another person on the specific issue of support with personal hygiene.

People and relatives were complimentary about the food. Comments included, "The food is quite nice. They always give you nice afters (puddings)", "They let you choose between of things. They ask [my relative] just before the meal", "The meals are yummy. Very well cooked and very well thought out", "We enjoyed our lunch very much", "The food is very good" and "The meals are quite nice. I had lunch today and it was very nice."

With a care worker, we visited two people who received nutrition and hydration via a tube into their stomach (a PEG). We saw these people's nutrition was correctly managed. Throughout the communal areas, we saw that drinks were offered regularly and that people were offered support with meals where required . We spoke with the chef who told us that meals were prepared from fresh ingredients. Kitchen staff had records of people's food requirements for pureed, normal and soft diets. We also saw a record of thickener needs and a clinical review meeting that included food and fluid changes. A person told us they enjoyed the food provided.

We saw that some people who used the service had thickener in fluids or food. A staff member we spoke with correctly knew how much thickener to mix with a drink . When we visited a person's room with a staff member, we observed that a container of thickener was left in the room. The staff member told us it was, "Left in the room for drinks". We discussed the importance of safe storage of thickener, due to the risk of accidental ingestion. A relative also told us that thickener was left in an unlocked drawer in their family member's room. We alerted the service's management to this and they reassured us they would take prompt action to reduce the risks to people.

We saw a range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, district nurses, speech and language therapists (SALT), and dietitians.

Good

Is the service caring?

Our findings

We asked people and relatives how caring the service was. We received mostly positive feedback about the relationships staff had built with people. One person told us, "They're quite nice. They look after us well." Another person said, "I've been very fortunate. They look after me very well." A further person we spoke with commented, "The carers are nice girls." One relative stated, "I had a couple of issues but I have had a word with the manager and she seems to be sorting things out." A further relative told us, "The staff are so good… I think they're great. You can't fault them."

Staff we spoke with felt the service was caring. One staff member told us, "I think they're (staff) very compassionate. They support residents in every aspect." Another staff member stated staff were, "Kind and caring". They told us "It's a nice little home. It's like a family."

We checked if people's choices for care were respected. One person we spoke with told us, "I'm well looked after by the staff. Anything I want or need, they get me. I can't walk but I've got a call bell. They come quickly if I ring it…I sort of choose the time I get up. When I first came here I was not very well and they used to put me to bed at 6.30pm and I'm so used to it [that I continue]. If you did want to stay up you can and the night staff put you to bed. It's a question of choice; nobody pressures you." We asked a person if they can choose what time they get up and go to bed. They said, "No, we have a time." Another person stated, "We are looked after. The staff are always coming in to check on me." We observed the person was in bed with bed rails up and we asked if they liked this. The person replied, "They are great. They make me feel safe." We saw evidence that staff anticipated people's needs and provided support prior to a person requesting assistance.

A person's relative we spoke with said the person would like to stay in bed all day but felt it was better if some of the day was spent in communal spaces. They said, "[My relative] has an agreement with them (staff) that she goes back to bed after lunch." We observed the person's preference was taken into account, as promptly after lunch the person called insistently for a staff member. The person did not wish to be delayed and soon after, we saw a care worker escort the person to their bedroom. The care worker delayed another task they were already working on in order to assist the person back to bed, as they had requested. We noted the care worker asked the person at each stage of the process when their cooperation was needed in moving back to their bedroom. The staff member said, "Would you like to…please?"

Another person told us their bed time was in the early evening, but they did not mind because, "When I sit in a chair my legs hurt and I want to go back to bed." We found the staff were mindful of the person's physical condition and acted in accordance with their preferences. We also checked on people who did not leave their room. We saw one person was in bed alone in their room. We saw they had a call bell within reach; however their cup of water was empty. When we asked the person if they thought staff were caring, they smiled and told us "Yes." Another person was in bed alone in their room. Their first comment to us was, "I've got no telephone (call bell)." We noticed the person's call bell was clipped against the wall out of reach. We asked the person how they summoned assistance from staff. They said, "I have to wait until someone comes. I'm in bed and I can't use the toilet." We alerted staff that the person's call bell was out of reach, and they ensured this was placed near the person's hand.

People's confidential personal records were protected. We saw all computers used for recording information were password-protected and available only to staff with the appropriate access. Paper records of care were maintained, but where these existed they were locked away so that there was restricted access to staff only. Staff records or documents pertaining to the management of the service were also locked away. In some instances, where there was sensitive information, the records were only accessible to the management team.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 (DPA) requires every organisation that processes personal information to register with the ICO unless they are exempt. This ensured people's confidential personal information was appropriately recorded, handled, destroyed and disclosed according to the relevant legislation.

Good

Is the service responsive?

Our findings

We visited five people with complex needs in their rooms, accompanied by staff or relatives. We saw four of the people required a hoist to move, while another person could mobilise using a walking frame with two staff supporting. We noted that people were only moved in accordance with their care requirements and wishes. We saw that these five people were comfortable. We saw that a person with a pressure relieving mattress, to prevent pressure ulcers, had this set correctly for their weight. Their repositioning chart was correctly completed. A staff member we spoke with at the time told us that people "should be asked" their preferences as part of the initial assessment. For example, they told us this would include the chosen gender of the staff members who assisted them. The staff member told us that, before giving personal care, "I'd always explain; I'd always ask them (the person)."

We found care planning and delivery was person-centred. We reviewed three people's care plans. We also reviewed progress reports (daily notes of care). Care plans included an "activities of daily living assessment" and a "general risk assessment summary sheet." For example, we saw that a person's mobility assessment described them as "fully mobile". We saw that care plans and risk assessments were reviewed monthly. Care plans were based on people's activities of daily living. There were 40 care plan templates, which could be used by nursing staff to personalise care to people's individual risks and needs. We observed these included maintaining a safe environment, personal care, nutrition, continence and mobility. A care worker told us that, "[The] nurses update (people's) care plans." Registered nurses relied on information of care workers to help populate and review people's care plans.

A registered nurse we spoke with explained that they were updating a care plan for the 'resident of the day'. This method is used to ensure all people's care documentation are reviewed at least once per month. We observed that care plans had a dedicated advanced decisions section, indicating people's end of life wishes. We saw that a person who had an advanced decisions care plan also had "do not attempt resuscitation" (DNAR) orders in place.

We observed that people's records were held in various different places within the service. This included the care plan, progress notes (daily notes of care), food and fluid changes, and positioning charts. The service's preference was for care records to be situated at appropriate locations within the building so that notes could be recorded at the time of a person's care or support. However, the nominated individual gave an extensive explanation and demonstration of an electronic care programme they had developed. The system was due to commence with a small number of people's documentation in the week of our inspection. One of the advantages was a single point-of-view for people's care plans and records of daily care. This was a good strategy to provide innovation in managing care documentation.

We reviewed the daily report maintained each shift by staff . This included aspects of people's care such as "resus and fire status", "DoLS and conditions", "Diet, food, fluid charts", "Positioning", "Behaviour chart", "Mobility", "Medical history and allergies." This was a portable document that staff could refer to during their shift if they quickly needed to confirm something about a person, without obtaining the care folder from the staff station. We checked people's care records against the daily report. We observed, at 12.30pm that a

person's repositioning or 'turn' chart had not been completed since 5.45am. A care worker we spoke with told us that the person should be assisted to reposition every two hours. However, 'turn' charts we saw subsequently had been completed and were up-to-date.

We asked people about their social life. One person said, "I enjoyed the trip to Flowerland. We go on a mobility bus. It's nice to go outside for a change and get some fresh air... like singing. We've got the church coming after lunch. We'll sing songs with them; they bring song sheets in for us... We have communion here every month..... Sometimes we get a lady who brings animals: snakes and lizards, spiders and rabbits." Another person said, "They took us to [Flowerland] yesterday; it was very nice. We had lunch, fish and chips, very nice." Other comments included, "I stay in my room as I find it a bit depressing in the sitting room…. I like to read and listen to the radio", "I go to church services (held in the service) and I go on outings sometimes" and "I prefer to stay here in my room reading magazines...I go downstairs in my wheelchair." A relative told us they felt welcome whenever they visited. There were no restrictions to visiting people at the service.

On the day of our inspection, activities included a visit by a local church group and an entertainer who sang for people. The home manager told us that activities available included trips and outings at least three times a week into the local community. There was evidence from photographs and testimonials displayed at the service that people enjoyed the activities and outings. We spoke with the activities coordinator who was new in the role and completing their induction at the time of our inspection. They told us the service offered music therapy with people from the church, art, dance exercises as well as trips into the community. The activities coordinator told us, "We try to bring the happiness back (to people) with reminiscence."

We reviewed the provider's complaints log. Two complaints were recorded since our previous inspection. In the most recent case, we saw a detailed written response from the home manager to the complainant. It gave clear accounts of progress on each of the seven points raised by the complainant. The nominated individual had responded to the other complaint after investigation of the circumstances. The response appropriately stated the action taken by the provider.

Good

Is the service well-led?

Our findings

The service is required to have a registered manager as part of their conditions of registration. At the time of our inspection, there was a registered manager. The management team explained a change in the structure of the management was underway. A new home manager had commenced at the service and initiated their registration with us. The existing registered manager was cancelling their registration with us and returning to working as a registered nurse at the service, whilst supporting the new home manager. The nominated individual was very involved in the service, and we noted a good working relationship between all three parties. The home manager and registered manager told us the nominated individual was very supportive and flexible to any needs of the service.

There was a positive workplace culture at Sunnyside Nursing Home. All staff who we met during our inspection were asked if they felt supported by their management team. A staff member told us that, "I feel that I can" approach senior staff. They said, "I think they've been very understanding. They make sure you're okay. They're very supportive with everything." Another staff member confirmed the service's senior staff provided guidance, "If we're not sure about anything." Another staff member we spoke with told us that both managers were approachable and that, "They do listen to me." The worker added that the service was, "family run" and that the owners, "Take us out at Christmas." We saw there were regular staff meetings, and we viewed the minutes from September 2017. There were no regular surveys of staff.

We recommend that the service considers the implementation of staff surveys.

Services are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and providing an apology (including in writing).

The service had an appropriate duty of candour policy in place which gave clear and specific instructions for management to follow when the duty of candour requirement was triggered by safety incidents. We noted that on one occasion the duty of candour requirement was not fully met by the service. Although we found the relevant person was verbally informed and facts were noted about the incident, a written apology and details of the investigation were not sent. After we pointed this out, the provider promptly sent a written apology and other required documentation to the relevant person.

The service had established effective quality assurance systems to assess, monitor and improve the quality and safety of people's care. We found audits undertaken covered areas such as infection control, care plans, medicine audits and health and safety. The audits varied in frequency from monthly to annually, depending on the area of the service being checked. We noted recommended actions were followed up and completed by the relevant staff. We saw there were appropriate risk assessments in place which were reviewed annually. We also saw a list of completed and current service improvement projects. The home manager commenced at the service as a consultant to undertake a quality improvement project. We viewed the

service improvement plan. We saw this included steps to improve people's experience of care, for example recent changes in the provision of social activities.

We saw a feedback book in the reception area of the service. Anyone who visited the home could record comments in the "concerns and complaints" book. When we reviewed the content, there were complimentary remarks left by relatives and other people who visited. The book also served as a method for the management team to review any issues that were recorded in their absence. We saw the book was monitored regularly when we examined the September 2017 contents. We found the management team provided written responses to any feedback within the book. This was a good method of involving people, relatives and visitors in communication with the provider and management team.

The nominated individual was very passionate about technology in the adult social care environment. They had used their knowledge and expertise to commence and sustain improvements in the service's processes and had a list of further planned ideas. We viewed a list of the projects and activities at our inspection and received a copy for further examination. Different ways of working included changing paper-based job application forms to website-based, psychometric (behavioural) testing of new applicants to check their ability to work constructively, automated alerts for overdue staff training, and a service compliance 'dashboard' for viewing and recording areas which required improvements.

We found the service had achieved benefits over time from the implementation of the projects. For example, the electronic job application system had improved and streamlined recruitment processes. The service had access to its own searchable CV and applicant database, where there were 550 candidates. The system also provided tools to automatically create job adverts and screen potential candidates by scoring them based on answers given to job specific questions. The projects would, over time, further enhance the good governance of the service.

We saw the service's rating from our prior inspection was conspicuously displayed throughout the service, and on the provider's website.