Chiltern Care Services Limited

Cherry Tree Nursing Home

Inspection report

Bledlow Road
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Princes Risborough
Buckinghamshire
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Tel: 01844346259

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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

About the service:
• Cherry Tree Nursing Home is a residential care home that was providing personal and nursing care to 45 older people at the time of the inspection. The service is registered to accommodate up to 52 people.

People's experience of using this service:
• During our previous inspection in February 2018 we identified areas that required improvements. These included records that were not up to date and accurate, and a lack of management oversight and quality assurance. During this inspection we found improvements had been made in all areas. The service has been awarded a rating of good in all domains.
• We found systems were in place to ensure the safety of people living in the service. Records were up to date, and risk assessments had been completed to minimise risks to people.
• Checks had been completed on essential safety apparatus such as fire protection equipment and hoists. Services such as gas and electricity had been maintained.
• People's nutritional and dietary needs were assessed, documented and care was provided in line with their needs. External professional provided professional advice when needed.
• Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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. Where appropriate, advocates were employed to support people with making choices about their lives.
• Information about people was being recorded in a respectful and dignified way. Records were up to date and clear in their content whilst providing appropriate direction for staff in how to care for people. People's health care needs were monitored.
• People were treated equally by the staff. Training was provided to staff the area of equality and diversity.
• Staff told us they felt supported by senior staff. The staff in the service were caring. They told us they worked well as a team. They respected each other and supported each other. They received support from the provider and the registered manager. They also received support through regular training, supervision and team meetings.
• Staff were trained and knew how to protect people from the risk of abuse. Where concerns had been raised these had been dealt with appropriately.
• A recruitment system was in place that minimised the risk of unsafe candidates being employed.
• Medicines were stored, administered and disposed of by trained staff. However, we observed staff signing to indicate they had administered medicines before doing so. This is not safe practice. We have made a recommendation about medicine training for staff.
• Effective quality assurance tools were in place to drive forward improvements, these had been used and their impact was apparent.
• People spoke positively about their experience of living in the service. Comments included "You do feel safe here, I do, seriously. I love this room and I feel safe here. I feel cared for and looked after, they (staff) are there for you and they don't go missing".

• Where possible people could feedback to the provider and share ideas for improvement. This could be done daily via the senior staff or through meetings or filling in questionnaires.
• Activities were available to people. A new activity coordinator had been employed to develop this area of the service.
• Complaints were dealt with effectively and efficiently.

Rating at last inspection:
• The previous inspection was carried out on the 12 February 2018. (Published on 5 April 2018). The service was rated Requires Improvement at that time.

Why we inspected:
• Following our last inspection in February 2018 the provider sent us an action plan. This stated how they would improve the areas we identified that required improvement. We carried out this inspection to check whether the actions had been completed and if the service was compliant with the regulations.

Follow up:
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care.

• For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-Led findings below.

Cherry Tree Nursing Home

Detailed findings

Background to this inspection

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

Inspection team:
• The inspection was carried out by a bank inspector, an adult social care inspector and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. For example, dementia care.

Service and service type:
• Cherry Tree Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
• Cherry Tree Nursing Home is set in attractive well laid gardens. The building has been extended and a lift is available to facilities on the first floor.
• The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
• We did not give the service notice of our inspection on the first day. They were aware of our intention to return to the service to continue the inspection on the second day.

What we did:
• 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 and reviewed the Provider Information Return (PIR). The PIR 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.
• During the inspection we spoke with eight members of staff including the registered manager; the activity organiser, the chef, two nurses and three care assistants. We also spoke with a consultant advisor and a health professional who were present in the home. We observed staff interacting with people and supporting them. We spoke with 14 people and five family members.
• We looked at records related to the management of the service including five people's support plans and associated records. We reviewed the medicines administration records for people and inspected three staff files including recruitment records. We reviewed minutes of meetings and a selection of quality assurance audits and health and safety records.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk, safety monitoring and management:
• During our previous inspection in February 2018 we had concern regarding a lack of risk assessments related to people's health. Information in care plans was contradictory, and documentation related the health and safety of the service was not always up to date or accessible. During this inspection we found these areas had improved.
• People told us they felt safe living in the home, comments included "Yes I certainly feel safe living here".
• One person's walking was "a bit wobbly" according to their relative. They told us "We admire that they (service) encourage him to walk even with the risk. They are respectful of the risk but that is the one thing I love about this place, that freedom".
• Risk assessments related to the care being provided and the environment were in place. We discussed with the registered manager how these could be developed by including more detailed risk assessments and care plans about people's health. We also noted there was a deficiency in the records related to bowel and bladder care for two individuals. This had already been identified by the senior staff. On the first day of our visit, a meeting had been called with the nursing staff to explore how these records could be improved upon.

• We reviewed the fire safety folder and 'grab bag', which included Personal emergency evacuation plans (PEEPs) for each person and the fire evacuation procedure. It also contained a first aid kit, identity bracelets, a high visibility jacket, rainproof ponchos and a torch.
• Checks were made on the equipment and supplies for example water safety checks, including Legionella. Other checks included an electrical installation certificate, gas safety and emergency lighting checks and information related to the safe disposal of asbestos.

Systems and processes to safeguard people from the risk of abuse:
• Staff were aware of how to identify and report concerns of abuse. Where concerns had been raised these had been followed up appropriately by the provider and the registered manager.
• Staff were aware of types and possible signs of abuse. They understood their responsibility to report and record concerns. A floor supervisor (senior carer) told us, if they had a concern about an issue of possible abuse or bad practice "I will go straight to report to the nurse or deputy manager." Their aim was to become a champion for safeguarding and dignity within the service. This was an area of the service the provider wished to develop.
• Safeguarding concerns that had been raised in the service had been dealt with appropriately. The registered manager was clear about how to protect people from abuse. They knew what actions were necessary for them to take to support a criminal investigation.

Staffing and recruitment:
● Recruitment systems were in place to ensure people were protected as far as possible from unsuitable

staff. Checks included Disclosure and Barring Service (DBS) checks, written references, health declarations, and proof of identity and of address.

Using medicines safely:
• During our previous inspection in February 2018 we had concern regarding the records related to medicines were not always up to date or accurate. We found during this inspection improvements had been made.
• People received their medicines by trained staff who had had their competency assessed.
We observed lunchtime medicines being administered by a nurse. This was carried out in accordance with good practice. However, we saw a nurse completed the controlled drugs record book and with another nurse signed the medicine administration record (MAR) before the medicine had been given. This was not good practice. It then came to light the person was out of the building. As a result, the medicine had to be destroyed. A nurse disposed of it using the de-naturing kit and both nurses signed to confirm this had happened.
• Medicines should not be signed as "given" until they are. Appropriate signing of the MAR chart is important as the record reflects the type, amount and time medicines were administered. We spoke with the registered manager about our observations. They told us they were meeting with the nursing staff that day and would address our concerns. We saw the meeting was held. The following day we were told by a nurse "We had a meeting for reflection. We have to learn to improve practice."
• Records related to controlled medicines were checked weekly. We discussed with the registered manager how these could be improved upon. They immediately put daily checks in place, this would enable them to identify the precise time, when any errors occurred.

• We recommend that the service seek advice and guidance from a reputable source, about the safe administration of medicines.

• Other practices included a 'hypo box' containing sugary items such as jelly babies and Lucozade was available for people at risk of hypoglycaemia. (Hypoglycaemia is when a person has low blood sugar levels.) We saw that the service had "When required" PRN protocols in place to guide the administration of 'as required' medicines. We checked stock balances of medicines against those recorded. We found they matched.
• Body maps were in place for people who received medicines through a transdermal patch. (These patches contain medicines, which are absorbed slowly through the skin.) The body maps allowed staff to record where on the body the patch had been applied. This assisted staff to ensure the old patch was removed before a new one was applied, and prevented skin irritation by applying to the same area repeatedly.
Preventing and controlling infection:
● Staff had received training in infection control and how to prevent cross contamination. Safe infection control techniques and systems were in place to reduce the risk of contamination. Hand sanitiser gel, as well as liquid soap, was available in the home.
• We saw that staff used personal protective equipment (PPE) such as disposable aprons and gloves for example when giving personal care or serving food and drinks.
• The registered manager told us they were "doing hand washing assessments every now and then as part of supervision".
• The infection control audit had identified that 'aprons were not always in use' therefore these were now supplied in "all rooms".

Learning lessons when things go wrong:
●When accidents or incident occurred, lessons were learnt and where possible themes identified. Information was shared with the staff, and where appropriate they drew up measures to prevent a

reoccurrence. Reflective accounts were kept by nursing staff as part of their nursing revalidation. (Revalidation is the process which nurses complete every three years to renew their registration with the Nursing and Midwifery Council (NMC)).

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance:
• 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 with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Mental capacity assessments had been carried out to ensure individuals were able to actively participate in making choices about their lifestyle and care. Staff were aware of the how the MCA applied to the lives of the people they cared for. Best interest processes were followed and where people required support, records showed they had legal representatives in place such as attorneys.
• Where people were being deprived of their liberty, applications had been made to the supervisory body for approval. This ensured care and treatment was in the person's best interest and in the least restrictive manner. One DoLS authorisation was in place, 14 applications were outstanding and awaiting approval from the supervisory body.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People's needs were assessed prior to them moving into the service. One person's relative described to us the conditions the person was living in prior to moving into the service. They stated the person had "vascular dementia" and was "deteriorating swiftly". The person had previously lived alone and was confused and often falling. The relative praised the [registered manager] for their very swift reaction when being telephoned. The registered manager went to assess the person in their own home the next day and then arranged for their immediate admission. The relative told us "This is a far safer environment and better care regime".
• Risks in relation to the care provided to people and the environment had been assessed.
Guidance was available to staff on how to minimise the risks. For example, how to support people when out in the community.

Staff support: induction, training, skills and experience:
• New staff attended an in-house induction and completed The Care Certificate. The Care Certificate is a recognised set of standards that health and social care workers adhere to in their daily work. These involved

observations of staff performance and tests of their knowledge and skills. Documents verified this. The provider supported staff with training in the areas they deemed as mandatory learning, for example, moving and handling.
• The registered manager had recently introduced champion roles for staff in areas such as infection prevention and control; safeguarding and dignity amongst others. They were offering people who lived in the service the opportunity to be involved in learning and carrying out some of the responsibilities of a champion. One person living in the service had already shown an interest in being a champion in nutrition and activities. Other people who lived in the service were going to be offered similar involvement if they were interested. The registered manager told us this would provide staff and people with "More knowledge of each area and promote best practice. They would act as role models and identify areas that need improving."
• Staff received support and feedback on their performance through regular supervision and annual appraisals. Team meetings were held to enable staff to share ideas and feedback.

Supporting people to eat and drink enough to maintain a balanced diet:
• Care plans reflected people's nutritional and hydration needs. Their risk of dehydration and malnutrition was assessed. Where people required additional equipment or resources to enable them to eat and drink this was provided. People who experienced unwanted weight loss were provided with fortified foods. Where people required specialist advice with their diet this was sought from dietitians and speech and language therapists (SALT).
• Food appeared to be appetising and nutritious. People appeared to enjoy their meals. On the whole comments about the food were positive. They included "Spaghetti Bolognaise, that was lovely, exactly what I asked for, exactly what I got" and "I'm not able to eat stodgy food but they always make sure that I eat the right sort of food".
• The cook told us that food was prepared from fresh items. People had a choice of two hot dishes at lunch, with a range of other options including omelette, salads and sandwiches.
• Some foods were fortified for people due to the risk of weight loss. Mashed potato was fortified with cream or cheese, for example.
• The cook was aware of people's needs for example, sugar free jam, low sugar cakes and puddings for a person with diabetes.
• At lunchtime, we observed people were given one to one support if needed. We saw this was done in an unhurried way, with interaction between the person and the staff member.

Staff working with other agencies to provide consistent, effective, timely care:
• Many specialist professionals and agencies were involved in the lives and care of some of the people living in the service. For example, some people were funded by the local authority.
• People who had specialist health needs for example, diabetes, pressure sores or visual impairments, received support from external professionals. We read documentation related to health appointments with external professionals to assist people with their mental and physical health needs. Where advice was given this was recorded in people's care files. This enabled staff to provide appropriate and safe care to people.

Adapting service, design, decoration to meet people's needs:
• In the older part of the building the corridors in some parts were narrow and winding. The registered manager had put mirrors in place to enable people to see around the corners. This helped people to avoid collisions.
• Signage around the service directed people to bathrooms. The home had been redecorated since our last inspection in February 2018, and as a result one of the lounge conservatories had a much lighter feel to it. The home was clean and well maintained. A lift was available to people who required it.
• People could personalise their own bedrooms. Some people had en-suite facilities, others used communal

bathrooms and toilets.
• People had memory boxes attached to the wall outside their rooms. These were made of wood and Perspex which allowed people to see the objects inside. Boxes held photographs and pictures of people and events that evoked fond memories of hobbies, interests and family life. These helped to prompt interaction and conversation with others.

Supporting people to live healthier lives, access healthcare services and support:
• The provider's PIR stated "We are working in close contact with Palliative Care Team, Tissue Viability, Speech and Language team. Our staff are contacting them by phone or emailing them. We have a prompt response from them. Other Specialist Service are contacted via referrals." Records showed staff were responsive to people's health needs and when needed support was arranged from a number of external sources. Other professionals included in people's care included GP, Podiatrist, Optician, Dentist and Physiotherapists.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
• One relative told us "The carers (staff) are his friends here and that is an important role when he has lost so many of his life friends". Other comments included "I trust them (staff) completely" and "The carers (staff) are good and do what they have to do".
• The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service was working towards being compliant with the standard.
• The Home had built a new, bright and welcoming Reception area and there was a receptionist on duty and lots of information and literature and items to see in this area. Some residents liked to sit here during the day. The Home had lots of daily newspapers on display and readily available for people and visitors.
• In the reception areas, there were large electronic display screens. Information was in a written form with pictures to enable those who had problems understanding written words.
• Where people had hearing problems, they were supported to wear hearing aids. We noted sub titles were displayed on one of the televisions to assist those with hearing difficulties.
• One person's care plan stated they were registered blind. Staff were instructed to describe the surroundings to them, to assist them with orientation.
• Some of the staff were from eastern Europe. Not all of them were fluent in speaking or fully comprehending English. However, overwhelmingly people claimed that whilst they were more than aware of this situation, they were comfortable and acknowledged they did not think that this in any way compromised their care. The provider supplied training for staff for individuals where English was not their first language. The registered manager told us, moving forward they planned to include an English test as part of the recruitment process.

Supporting people to express their views and be involved in making decisions about their care:
• People could share their views and be involved in decision making. Those who wished to took part in relatives and residents meetings. We saw from the minutes of meetings, people had raised suggestions about the food that was provided in the service. Following this the registered manager undertook a focussed survey. As a result of the survey, the registered manager met with the cook to discuss and implement the findings and suggestions.
• Care plans were audited every six months with the person and or their representative, this helped to keep information up to date and accurate.

Respecting and promoting people's privacy, dignity and independence:
• We observed people being treated in a dignified and respectful way by staff. At lunchtime a staff member collected a pile of aprons from a cupboard. They asked each person if they would like to wear an apron and

they respected people's decisions. We also noted staff knocked on people's bedroom doors before entering.

• We observed positive interactions between people and staff. Staff were patient, kind and gentle with people when supporting them with care. Staff engaged well and there was lots of conversations and laughter between people and staff. Staff were discreet when speaking to people and were alert to any concerns people had.
• One person who was cared for in bed had an adaptation made to their bed. A mirror had been placed at the foot of the bed. This enabled them to see the outside scenery of trees and bushes and the birds using a bird feeder just outside their window. Something they enjoyed doing.

Good

Is the service responsive?

Our findings

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• The service had employed an activity organiser. There was a mixed response towards the activities in the service. Two people told us separately, they had been promised to be supported on a shopping trip to Marlow. They said they had been waiting for some time and had not received confirmation of when it might take place. One person had given up on the prospect that it would happen.
• Two people told us the activity coordinator came into their rooms for a chat, they didn't view this as a positive thing. Another person told us "We could have more activities, we like quizzes but the ones we have we all know the answers before we hear the questions".
• The activity coordinator was new in post, and was getting to know people, their life histories and hobbies before planning activities for people.
• One person was delighted the new activities co-ordinator had arranged for them to visit Aylesbury library recently. This was somewhere they were very familiar with in the past. They were an avid reader and had now registered at the library. They showed us their library card with pride. They said, "I asked them to take me down there and it has made so much difference".
• Another person's relative said "They go out of their way and try hard to find things for him to do and keep him occupied and we often speak with them to talk through things and ideas". The activity coordinator had found out about his proud and distinguished background in the Army. They spoke with their family about arranging a trip to the Imperial War Museum. "She (Activity coordinator) is so sweet and asked if she could arrange a trip to the museum, it was lovely and a great idea but I fear it will not be practical".
• Another person used to be an avid and passionate gardener. An area of Cherry Tree's garden had been allocated for them to use. They had been given access to a raised bed plot that allowed them to keep up their interest.

Improving care quality in response to complaints or concerns:
• The responses to a survey sent to people and their families demonstrated people were happy to raise concerns or complaints. Over the previous three months prior to our visit there had been six complaints and 22 compliments. 15 compliments were from children at a local school.
• Records showed the complaints had been dealt with to the satisfaction of the complainant. The registered manager was clear they used feedback to improve the quality of the service. People told us the registered manger was accessible and they could raise concerns. One person told us "[Name of registered manager] always comes by to look in, he does it every day, not just because you are here today". By carrying out a daily walk around of the service, people felt they could spend time with the registered manager to raise any issues or concerns.

End of life care and support:

• Records showed discussions had taken place with people about their end of life wishes. Not everyone was comfortable discussing this. In these cases, it was noted in the care plan, and discussion were held with people's representatives. Care plans identified people's wishes and their funeral plans where these had been organised.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• During our previous inspection in February 2018, we had concerns about the lack of management oversight of the service. This had led to records not being up to date and accurate and a lack of action from carrying out quality assurance audits. During this inspection we found these areas had improved. Since our last inspection the manager has registered with the Commission, and is now the registered manager.
• The registered manager had introduced and implemented the use of various documents to record the care being provided, for example, an 'Intentional rounding'. (This was a structured approach whereby nurses conducted checks on people at set times to assess and manage their care needs). Categories recorded included; moving and repositioning; toileting; nutrition and hydration and mouth care/ personal hygiene. The registered manager had also introduced a 'food tracker' to record a person's food intake and a weight monitor. We found records had improved in quality and in their usage. A staff member told us that "Every change is mentioned in the care plan."
• Audits were in place to assess the quality of the records in care plans. Other audits had been undertaken including medicines, call bell audits, accident and incident audits and environmental audits. These had assisted the registered manager and the provider to drive forward improvements.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
• There is a legal requirement for providers to be open and transparent. We call this duty of candour (DOC). Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, states when certain events happen, providers must undertake a number of actions. We checked if the service was meeting the requirements of this regulation.
• We found there was a culture of openness and honesty. Records of staff meetings confirmed incidents were discussed, this allowed the staff team to share thoughts and learn from each other. The registered manager was aware of the duty of candour and their responsibility to implement this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• There are nine characteristics protected under the Equality Act 2010. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. The service had an inclusive culture, both for staff and for people living in the service. They catered for people with varying religious beliefs including Roman Catholics, Christians and Orthodox

Christians. We were told if appropriate people's sexuality would be considered and every effort would be made to support people who may be heterosexual, trans-gender, lesbian or homosexual. People's physical and mental health needs were also considered, and appropriate care was provided.
• The PIR stated local schools where invited into the service and children sang, played piano or taught people to use mobile devices. A Ukulele Club which was part of Princes Risborough Community Centre and regular Pet therapy visited the service. This protected people from social isolation and boredom.

Working in partnership with others:
• Records showed how the provider worked alongside other professionals to provide appropriate and safe care to people. These partnerships included a local palliative care team; GP; tissue viability nurse; physiotherapist; dietitian and a speech and Language therapy team amongst others. Feedback from one health professional stated the staff always made appropriate referrals and were keen to make sure they were doing the right thing.

Continuous learning and improving care:
• An external consultant had been used to carry out an audit of the service. Recommendations had been made, and we could see improvements had been made because of their input. For example, support for nursing staff to improve practice.
• The consultant was also carrying out training with staff. In line with the introduction of "champions" in the service, specific training was to be offered to the staff covering the topics of Certificate in Understanding the Safe Handling of Medication in Social Care. Certificate in Common Health Conditions; Certificate in Falls Prevention; Certificate in the Principles of End of Life Care; and Certificate in Understanding the Care and Management of Diabetes. Their aim in doing so was to equip staff with the necessary skills to drive forward improvements in the service.
• It was clear to us that learning from the previous inspection in September 2017 had taken place. Overall there had been improvements in all areas. Systems had been introduced to ensure the service was meeting the requirements of the regulations, and further improvements were planned. This demonstrated the provider's intention for continuous improvements to the service for people.