Sentinel Health Care Limited

Cedar Lawn Nursing Home

Inspection report

Cedar Lawn
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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

The inspection took place on 21 and 22 June 2018 and was unannounced.

Cedar Lawn 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.

Cedar Lawn Nursing Home is a converted property and accommodates up to 30 people who require nursing care. When we inspected there were 26 people living in the home. There were three shared rooms in the property, the rest being single occupancy rooms of varying sizes. Most rooms had ensuite toilet and wash basin facilities.

There was a registered manager in post. A registered manager 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. The registered manager had completed notifications as required and was in the process of completing the PIR for the service.

At our last inspection we were concerned there were not enough staff to support people. There were now sufficient staff deployed to ensure that care was safely delivered and the service was now compliant with regulations.

We had also been concerned at aspects of medicines management. This had improved and medicines were safely managed.

Risks were assessed and well-known assessment tools were used to maintain people's health and well-being.

Equipment and systems such as the fire alarm, hoists and passenger lifts were regularly serviced and maintained.

Risks of harm from legionella was minimised with a robust risk assessment and management plan.

People were protected from being cared for by unsuitable staff by a thorough recruitment process.

Staff were knowledgeable about safeguarding and were able to identify possible signs of abuse and knew what actions to take if they suspected it had occurred.

People's needs were assessed and care plans devised to meet their needs.

The service complied with the requirements of the Mental Capacity Act (MCA) and when necessary applied for authorisation to restrict peoples freedom under Deprivation of Liberties legislation.

Peoples nutritional needs were met and the service provided appetising meals to the requirements of individuals.
We made a recommendation that the provider reviewed staff deployment at lunchtimes.

The service was proactive in promoting people's dignity.

Life profiles were completed for all residents which showed what people liked to do at particular times of the day.

End of life care was dealt with sensitively and people were supported to have a respectful and dignified death.

There were robust quality audits which were completed regularly and acted upon.

Policies and procedures were comprehensive, readily available and reflected good practice.

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

Sufficient staff were deployed to meet the needs of people living in the home.

Medicines were managed safely.

Equipment was well maintained and regularly serviced.

Is the service effective?

Good

The service was effective.

Staff received regular training and updates relevant to their role.

Staff were supported through regular supervisions and appraisals with the registered manager.

People were supported to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

Dignity champions had been appointed to promote dignity and respect in the service.

The service supported people in meeting their spiritual needs.

Staff supported people and their relatives in a kind and caring manner.

Is the service responsive?

Good

The service was responsive.

A range of activities and outings were provided in line with people's interests.

Relative and resident's meetings took place regularly.

End-of-life care was planned for in an empathetic way.

Is the service well-led?

Good

The service was well-led.

Robust audits were carried out and findings acted upon.

Staff spoke highly of the management team and told us they were very supportive.

People living in the home and their relatives were invited to participate in questionnaires and meetings about the service.

Cedar Lawn 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.

This inspection took place on 21 and 22 June 2018 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a nurse in the care of older people 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.

Before inspecting Cedar Lawn, we reviewed all information we already held about the location. We looked at previous inspection reports, feedback from health and social care professionals and notifications. A notification tells us information about important events in the service that the registered manager is required to inform us about.

We did not ask the provider to complete a Provider Information Return (PIR) before this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with eight people who used the service and four relatives. We also spoke with two registered nurses, four care staff, two kitchen staff members, a housekeeper, the registered manager, the Director of Care and the owner. We pathway tracked four people and looked at the care records of two others.

We looked at staff files, training records, recruitment files, duty rotas, signing in sheets, supervision records and reviewed the services policies and procedures.

We checked information and records held about the premises and health and safety including water hygiene, fire safety and safety checks on equipment.

The last inspection of Cedar Lawn Nursing Home took place on 31 August and 1 September 2016 and rated the service as good.

Good

Is the service safe?

Our findings

People and their relatives told us they thought the care provided at Cedar Lawn was safe.

When we inspected this service on 31 August 2016 we found it to be in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Staffing. We were concerned that staff were not able to respond to meet the needs of people living in the home. We checked staff rotas and signing in sheets and dependency levels. A dependency tool was completed weekly to ensure that adequate staff were deployed. A dependency tool measures overall needs of people living in the home and calculates the number of staffing hours required to meet their needs. Mornings from 08:00 – 14:00 required six care staff and one nurse, afternoons from 14:00 – 20:00 required four care staff and one nurse and nights two care staff and one nurse. We looked at staff rotas for four weeks and staff were deployed at the recommended levels for almost every shift. In addition, we saw that when needed, the registered manager and director of care would step in and support the staff team. The improvements and ongoing assessment of staffing levels have met the legal requirements and the service was no longer in breach of the regulation.

A second breach of regulations was found at our inspection in 2016. The service had failed to safely manage medicines and was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Not all medicines were being administered as prescribed, directions for the application of topical medicines lacked detail, the effects of medicines were not appropriately monitored and escalation care plans for medicines monitored by blood tests were incomplete and not fully followed. We looked at topical medicine administration record sheets (TMARS). There were body maps with the TMARS, most of which had shading where the medicine should be applied. We saw a detailed care plan for a person who had diabetes which gave clear and specific escalation instructions. We found no evidence of medicines not being administered as prescribed. These improvements meet the legal requirements and the service is no longer in breach of the regulation.

We looked at other aspects of the management of medicines. There was a current medicines policy available (2017) but the good practice guidance document was dated 2001 and we recommend this is replaced with more current guidance. Medicine trolleys were prepared for administration and when not in use were securely attached to the wall. Registered nurses followed the five 'rights' of administration which are the right person, right dose, right medicine, right time, right route. We saw that nurses would support just one person at a time with medicines and were aware of infection control risks.

Medicines administration record sheets (MARS) were clear and contained people's name, date of birth, allergies, and a dated photograph. Refusals to take medicines were recorded and the correct coding was used by registered nurses to explain why medicines were not taken. Staff signatures and initials were held in the medicines file. We cross-referenced MARS with care plans and saw that details matched and the correct medicines were being given as per the instructions on the care plan.

Care plans and protocols were available for all homely and PRN medicines. A homely remedy is another name for a non-prescription medicine that is available over the counter in pharmacies and is used to treat

everyday conditions such as a headache or a cold. PRN medicines are prescribed to be taken as needed and not as a regular dose. Information informing staff when these medicines may be offered was clearly recorded and the homely remedies plans had been signed by the GP. Covert and crushed medicines were given by the service. One person chose to have medicines crushed, the care plan for this had been signed by both the GP and a nurse.

We looked at people's care files and checked to see that risks had been assessed and that measures were in place to mitigate remaining risks. We saw that areas such as mobility, infection control, moving and handling and bedrails had been risk assessed. We saw there were controls in place to minimise risks and that risk assessments were reviewed regularly and reflected changes to the person. Well known assessment tools had been used to calculate risks to people of developing pressure ulcers and the Malnutrition Universal Screening Tool (MUST) was in use. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Environmental risks had been assessed. The water safety risk assessment was thorough and all areas of concern had been acted upon and risks mitigated. The provider had engaged a contractor to monitor water temperatures, take water samples and purge and disinfect the water systems. Recordings of actions taken and monitoring were clear and readily available. The risk assessment is due to be reviewed in July 2018, we have asked the provider to supply us with the risk assessment when completed.

We looked at the providers fire safety documentation and saw clear procedures with contingency plans in the event of an evacuation, who to contact and prompts for fire marshals. Weekly alarm tests and checks on door closers were completed as were regular services of emergency lighting, the fire alarm system, smoke detectors and fire-fighting equipment.

During the second day of our inspection the fire alarm sounded and we saw staff respond quickly and congregate in reception while the registered manager and senior carer swept the building for signs of a fire. The alarm was caused by smoke from fryers in the kitchen and the system was reset. The response of staff was prompt and following the alarm they were seen to be reassuring people and ensuring doors were re-opened.

Equipment in the home was regularly serviced and the maintenance file documented daily, weekly and monthly checks. Certificates and records covering gas safety, lifting equipment, kitchen equipment were all in date and showed that any remedial actions had been taken and equipment had been assessed as safe.

Accidents and incidents were recorded, analysed and learning from them shared. For example, if someone sustained injuries from falling, they would receive first aid support and medical attention such as paramedics called as needed. Injuries were documented and photographed and a report written. Reports were reviewed by the registered manager and the fall was investigated and if possible, a cause found for the fall. The persons relevant risk assessments were reviewed and adjusted to minimise future risks. These actions were shared with team members and as needed families were informed. The process was overt and a 'falls huddle' where causes and prevention of future falls were discussed took place.

The provider had a robust recruitment process to ensure only suitable people worked in the service. Applicants completed an application form, were interviewed, supplied full work histories and two references one of which was their last employer. All employment gaps were accounted for. Disclosure and Barring service (DBS) checks were completed for all staff before they commenced in post. The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable

people. This ensures that people employed at the service are suitable to work there. The provider had also checked that nurses employed were registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practice in the UK must be on the NMC register.

The provider was in the process of introducing a new infection prevention and control policy and procedure. The new policy was extensive and covered both day to day hygiene concerns and clinical hygiene levels. The housekeeping team had been involved in improving infection control in the home and the Clinical Auditor for the provider had spent time working with them to ensure they were aware of the importance their role held. The head of housekeeping, head of care and the registered manager were all 'infection control champions' leading the team in meeting standards. Documentation had been improved, there was improved access to spill kits, new mattress cleaning schedules and turning plans were implemented. A weekly environmental cleanliness check took place where three rooms were checked and a deep cleaning schedule had commenced, each room was deep cleaned on its corresponding date, room 1 on 1st of the month etc. Hand hygiene was regularly audited and a recent check had identified one person wearing a bracelet and another a ring. These were dealt with as per the policy and a record of actions was held.

Staff could protect people from possible abuse as they received regular training and updates in safeguarding. Staff could tell us possible signs and symptoms of abuse, different types of abuse and what they would do if they suspected someone may have experienced abuse. We checked safeguarding records which showed there had been no safeguarding alerts in the previous twelve months.

Good

Is the service effective?

Our findings

People's needs were assessed on admission to the home and continually reviewed from this point onwards. We saw detailed records of people's needs including their communication needs, mobility, falls, and nutrition. Care plans were developed to meet identified needs. Both care plans and assessments were completed with the person or their relatives.

Staff completed induction training when they commenced employment at the service. The induction records were comprehensive and covered all aspects of the post such as moving and assisting and safeguarding. Training was mainly updated annually but staff received quarterly fire training. Training completion dates for staff were stored on a spreadsheet and gaps in training were easy to identify. When we inspected, staff training was up to date and staff told us they could complete additional training such as Health and Social Care Diplomas if they wished.

Staff received regular, monthly supervisions with the registered manager and an annual appraisal. Staff told us that their supervisions and appraisals were useful, "We learn a lot, we have a topic of the month. Appraisals are reflective and we try to improve on our practice". The topic of the month was also reflected in a monthly display compiled by the registered manager for staff to improve their knowledge.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

Staff members could tell us about the five principles of the MCA and understood that decisions should be made in a person's best interests. They knew it was important to offer people choices and ask for consent before delivering care.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Relevant applications for a DoLS has been submitted and when we inspected only two people were subject to a DoLS authorisation. The home provided nursing care and people who were living with dementia were cared for in another of the providers homes. During our inspection the registered manager sought DoLS authorisations for giving covert medicines to two people.

People could access external healthcare services. GP's attended the service regularly and people were referred to services such as dieticians and speech and language services as required. Advice and information was also sought from the tissue viability service but care was delivered by the providers nursing staff.

At lunchtime we saw staff rushing between tasks. Staff in the dining room were mainly able to remain with

the person they were supporting and someone could oversee the room but staff supporting people with meals in their rooms would have to leave them and support other people with personal care. Staff told us, "This is not an isolated incident and often we have to leave the resident we are feeding to attend to someone with toileting, it is very busy here". Another staff member confirmed this was the case.
We recommend evaluating where staff are deployed or whether additional staff may be needed for the lunchtime period to deliver unrushed and person-centred care.

People and their relatives told us they were impressed with the quality of the food served in the home. Meals were served both to the taste of individuals and as per their nutritional needs. Drinks were thickened to the right consistency and thickening granules were locked away when not in use. Some people need to have fluids thickened if they have swallowing difficulties and are at risk of choking. Meals were pureed to the correct texture for people. Foods were pureed separately and the chef made meals look appetising. We saw people being supported with their meals at lunchtime. People had chosen their meal the previous day but could change their minds. We saw one person unable to understand the different choices of sauce to go with their meal. Staff put a small amount of each sauce on a plate and the person tasted them and chose which they preferred. We spoke to the chef and were told that food was prepared using fresh ingredients daily and in addition to the main meals in the day there were home baked cakes and biscuits served in the afternoon. The kitchen had achieved the highest rating in a recent check by the Food Standards Agency.

The home was clean and bright and suited to the needs of people living there. Some areas needed an update, we identified some faulty areas of flooring in all three of the communal bath / shower rooms. One shower room was being refurbished the week after our inspection and the owner told us they would complete the other areas of flooring as well. There were extensive grounds and plans to improve areas of the home such as developing the conservatory to provide somewhere for recently bereaved families to meet and speak to staff.

Good

Is the service caring?

Our findings

People and their relatives told us they felt cared for. A person who lived in the home told us, "The attitudes of staff are very friendly and kind…it's never too much trouble to help me when I need it". One relative told us, "My mother receives a good level of support and all staff are kind, caring and respectful to her needs".

Maintaining people's dignity and showing them respect was a key focus area for the service. The service had been developing their practice around maintaining and promoting people's dignity. They have begun to encourage staff, people living in the homes and their relatives to become dignity champions. A dignity champion is someone who passionately believes that dignity is a basic human right and not an added extra. Dignity Champions had been promoted by 'Dignity in Care'. The group of dignity champions was growing and they have met to discuss how best to promote dignity in the service. One example of staff showing respect to people was for one person whose room was in a place where they could see people moving about the service. This person almost always called out hello to anyone passing by and staff members would respond each time regardless of how busy they were.

We saw staff members interacting in a kind and respectful way with people. Staff knocked on people's doors and waited to be invited to enter, they greeted people with their preferred name and frequently checked on people's well-being. We saw care being delivered in a kind way, people were spoken to throughout the process of being supported to move from a wheelchair to a dining chair, and staff would get down to people's levels when addressing them so they were on an equal footing with them. Before supporting people, staff asked for consent. At times staff members became more task-orientated, for example when getting people to the dining room for lunch, however this was brief and once there, staff were friendly and took time to be with people.

A detailed life plan was available in each person's care file to give an idea what their life experiences were before moving into the home. Some had more detail than others but all had areas that could be used as talking points with people. Care plans were person-centred and would enable a new staff member to support the person well. There were many different parts to the care plans including sleeping, end of life, social life, pain, mobility as well as the more core areas of mobility and personal care. Relatives told us they were pleased to have been able to contribute to the assessment and care planning processes with the person as they felt it helped them receive care as they wished to have it. Peoples personal preferences were seen in care plans such as someone who preferred a wash in bed rather than a bath or shower and someone who liked to have bed rails and bumpers as they made them feel safe. Care files were stored in line with current data protection legislation.

A life profile was completed for people living in the home. This was a plan showing when people liked to do at different times of the day. When they liked to wake up, whether they liked a cup of tea and a biscuit in bed before getting up, what they liked as a mid-morning drink and snack, whether they preferred lunch in the dining room or their bedroom and night-time routines such as a milky drink and sitting watching TV shows or reading before bed. These profiles were very detailed and gave a good overview to staff and enabled them to plan who to support and when at different times of the day even down to how many pillows a

person preferred.

Spiritual needs were catered for by the service. They had forged linked with Romsey Abbey and services and communions were live streamed on a regular basis for people to participate in. Volunteers from the church also visited the home and provided pastoral care to people in the home. One church volunteer had been able to support a person in the home as they spoke in the persons native language to them which was very special to the person.

A new addition to the home is 'Silver Wishes'. Staff have asked people in the home for ideas of things they would like to do, a 'bucket list' of plans that can be enjoyed both by individuals and everyone at the home. The first wish to be 'granted' was a screening of the film Paddington. One person really wanted to see the film so a copy was found, the lounge set up like a cinema and curtains pulled. The movie was shown and people enjoyed refreshments of marmalade sandwiches. The person who had the wish was thrilled with this outcome. Another wish to be met soon is for a keen football supporter to attend a match. Staff explained they would start with a smaller local match and if successful they would take them to the Premiership team they supported. Some of the wishes were small however they meant a great deal to people.

People in the home looked cared for. We saw people wearing clean clothes. They were offered clothes protectors at lunchtime and there were regular opportunities to see a visiting hairdresser. People were offered a choice of clothing and spills of food and drink were sensitively cleaned if needed. We saw people being encouraged to be independent as much as possible, being supported to remain mobile and encouraged to socialise with others in the home.

We monitored the time it took to answer call bells and there were no significant delays in answering them. During the morning shift when there were more calls, a care assistant was nominated to answer bells as they happened and support people until other carers were free to help them. Though care was not necessarily delivered faster with this system, people were reassured there was help coming.

Good

Is the service responsive?

Our findings

We received mixed feedback from people and their relatives as to whether they had been involved in the assessment and care planning process. Some care plans and consents had been signed by people and their relatives and some clearly had input from family members. Plans were personalised, and had clear preferences as to how care should be delivered, any preferences in terms of gender, whether doors should be open or closed and practical details such as which sling and hoist should be used.

Care files were comprehensive and held other details such as medical histories, contact details for next of kin, property lists and continence requirements.

Peoples preferences about activities were recorded including whether they liked large or small groups, one-to-one activities, preferred TV shows and whether they liked their own company. People were supported to be active as much as they liked and a range of different activities were available. Some people did not join in activities but were aware of them and told us that care staff regularly asked if they would like to attend. One person told us, "Activities are organised on a daily basis and if they interest me then I will attend. I enjoy the quizzes, bowling and skittles".

When we inspected there was a word game during the morning which was attended by five people who were engaged throughout. Other people were seated reading newspapers and looking out into the grounds. In the afternoon, the activities coordinator suggested that people rested for a short while before they set up a skittles game. Other activities included entertainers, bingo, coffee mornings, puzzles and basketball. Planned entertainment was a singer, a pianist and visiting donkeys. On the second day of our inspection a group of residents and relatives had gone out for the day on a boat trip around the Solent. A relative had told us that their parent had been invited to go along and said, "She is really looking forwards to it".

On entering the home there was a 'Welcome Board'. This held lots of useful information for visitors and people living in the home. Important dates for events and phone numbers were displayed as was the complaints procedure and information on meetings for residents and for relatives.

The complaints procedure was readily available however when we asked them, relatives preferred to speak directly to the registered manager if there was a problem and told us that their concerns would usually be dealt with immediately. When asked, people in the home did not have an awareness of the complaints procedure but echoed the response of relatives in that they thought speaking to staff or the matron would be sufficient to solve any problems.

Regular meetings were held with people who lived in the service. These focussed on topics that were relevant to most people in the service and not on individual matters. Each person was encouraged to participate and there were slips that people could complete before the meetings so that issues they felt were important could be discussed in the event they could not attend or did not feel confident to speak up.

Meetings were held for relatives three times per year. Dates for the year were displayed in advance so that

people could set time aside to participate. In addition, relatives were participating in the quarterly dementia champion meetings. A suggestion box was also prominent in the entrance lobby and ideas for improvements were welcomed from all.

The provider dealt sensitively with end of life care. When a person died they would leave the home through the front door and people and staff would stand and see them out. An image of a red rose would be attached to the persons door and a similar image displayed in the lobby to notify visitors there had been a death. A tree had also been set up to pay tribute to people that had died at the home. Laminated red roses with the persons names on were hung from the tree as a memorial of them giving people and staff a focal point if they wanted to take time to grieve.

Care plans for end of life were comprehensive. Religious preferences such as a wish to have a Catholic mass, along with more practical details of specified funeral directors were recorded and anticipatory medicines were retained in good time for their use. Not every person had an end of life care plan, these were produced with people and their relatives only if the person wanted to have one. No one was receiving end of life care when we inspected.

The providers policy concerning end of life stressed the importance of handling each stage of this process sensitively and the aim of plans was to 'ensure that people can die in a dignified and respectful manner, as free from pain and distress as possible and in accordance with their own wishes'. They also held the principle that 'a person should be cared for in their final days as if he or she was in their own home if that is their wish'.

We saw many cards thanking the service for the care they had provided. One card from a relative stated, 'Our thanks to your wonderful manager and their staff for caring for [relative] so well during their time with you…. Your nursing staff dealt with [relative] in such a loving, caring and professional way and [registered manager] kept us informed at all times'. Several other relatives thanked the staff and management team for the care and kindness shown.

The provider used some assistive technologies in their care provision. Falls sensor mats were used as was a call bell system. There were key-pad locks to doors which held either hazardous items such as cleaning product or those containing sensitive data such as care files. We discussed with the provider if they had plans to use an electronic care file system however there were no plans at this time as they had not yet found a system that would fully meet their needs.

Good

Is the service well-led?

Our findings

Staff we spoke with gave positive feedback about the management of the service, area managers and the homes owners. They would be happy to approach any of the senior team with concerns, ideas and requests and felt they would be listened to and actions taken. People and their relatives told us that they regularly saw the registered manager and that they were hardworking and assisted the team with day to day tasks.

The registered manager was also the matron for the service and the senior clinical staff member. They were supported closely by the provider and the director of care. There were senior staff in all departments such as catering, housekeeping and care and the registered manager met with them and ensured they could keep their teams informed. The registered manager was able to maintain their skills and knowledge through the provider and meetings with other managers of services.

A clinical governance meeting was held monthly and was chaired by the registered manager. The staff team also met monthly. Minutes were produced and shared from these meetings to keep all informed of current developments and care requirements. Staff told us they were kept up to date effectively by the registered manager.

Handover meetings were held at the beginning of each shift and all staff members involved with care attended. There was a handover sheet that was regularly updated to reflect people's requirements and the chef told us that after handover had happened someone would let them know any changes to people's needs in terms of pureed meals and specific requests.

The provider employed a Clinical Auditor who attended the service monthly and audited medicines, infection control and a selection of care plans. The medicines audits were thorough and findings were clearly reported. For example, in January 2018 there were two body maps for topical medicines that needed to be shaded to show where to apply the medicine. A miscount of a person's aspirins was also noted. All identified areas had been annotated by the registered manager as they were acted on. If there was a reason for the omission this was also recorded.

Infection control was audited monthly and we reviewed the last audit. Actions included ensuring that clinical waste bins were stored in the compound or anchored to the wall, adding 'sharps injury' posters to the clinical rooms and ensuring mattresses were thoroughly rinsed with water when cleaned with chlorine as it was damaging to the surface. The infection control audits were newly introduced along with the new policy which had been discussed with housekeeping staff before its introduction. Along with areas that needed improvement the auditor had added tips for meeting their 'gold standard' such as washing mop heads daily rather than weekly. Every week three bedrooms were closely checked and hygiene and maintenance concerns noted and passed on to relevant persons for action.

Other audits included infection where details of infections were collated to see if there were identifiable patterns, tissue viability monitored pressure sores and whether they were improving. Accident and incident reports were audited, patterns noted and measures put in place to minimise future events and there was a

weekly random audit of daily care charts. All audits were completed and acted upon by the registered manager who evidenced this with notes as to actions taken.

The provider issued a quality assurance questionnaire to people and their relatives annually. The 2017 responses were generally positive about the services. Areas people were less happy about were communication with relatives, they had not always felt informed about outings, hourly checks at night were felt to be intrusive by a person and activities were not all that stimulating for everyone. The provider had responded to each point and was always open to new ideas for activities and improvements and had engaged both resident and relatives with meetings to promote ongoing discussion.

The provider maintained a broad range of policies and procedures and when asked for them could produce them immediately. They were accessible to managers and staff and the content was in line with current legislation and best practice. Staff members were aware of policies and procedures relevant to their roles and update were communicated to them through supervision and meetings. The topic of the month displays also reflected the services policy.

Staff were positive in their feedback to us, one staff member told us "I love it here, the atmosphere is lovely, I knew when I came for my interview that I would be happy working here", Another said, "It's like a family, everyone gets on and have close relationships with residents". Staff morale appeared to be good, staff were busy but the atmosphere was welcoming and people chatted as they worked.