Sunrise Operations Beaconsfield Limited

# Sunrise of Beaconsfield

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 19 and 20 November 2015. It was an unannounced visit to the service.

We previously inspected the service on 06 November 2014. At that time we found that people were not consistently treated with consideration and respect in the way their care and support were provided. The provider sent us an action plan to tell us what action they were taking to ensure people were treated with respect and dignity. At this inspection we found that the provider had provided training for staff and we observed caring and compassionate care that did respect privacy and dignity.

Sunrise of Beaconsfield is a care home for older people some of whom are living with dementia. It is registered to provide accommodation for 93 people. At the time of our inspection 81 people lived at Sunrise of Beaconsfield. Accommodation for people is situated over two floors, an assisted living area and a dedicated dementia unit named the reminiscence neighbourhood.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had a relaxed informal atmosphere; we observed people reading papers, books and engaging in meaningful discussions with each other.

People told us that they felt safe living at Sunrise; staff were knowledgeable on how to recognise signs of abuse and knew what to do if a concern was raised.

Risk assessments were conducted and reviewed. The premises were maintained to a high level and maintenance was undertaken as required without any restrictions.

People were supported by staff who respected dignity and supported people to be as independent as possible.

The service responded to changes in people's health. Monthly healthcare reviews were undertaken. The service worked with a range of healthcare professionals to promote quality of life.

People had access to a wide range of activities both within the service and in the community. The service had its own minibus and supported people to maintain contact with the wider community.

People were supported by a provider that had systems in place to help continually improve the service it provided. Regular meetings were held with people, relatives and staff.

## 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.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures in place for staff to follow in the event of any abuse happening.

Potential risks to people were clearly identified and mitigating actions were available to all staff. Risk assessments were reviewed regularly.

People were supported by staff who had been through a robust recruitment process.

### Is the service effective?

Good

The service was effective.

People were encouraged to make decisions about their care and day to day lives. The service worked within the guidance of the Mental Capacity Act 2005.

People were cared for by staff who were aware of their roles and responsibilities.

People had access to food and drink. A hydration project which had been implemented had significant positive results.

### Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with respect; their privacy and dignity were upheld and promoted. People and their families were consulted with and included in making decisions about their care and support.

### Is the service responsive?

Good

The service was responsive.

People were supported by staff who provided person centred care. Pre-admission assessment was completed to gather information about people's life histories.

People were supported to access a range of healthcare services and appointments were made promptly when needed.

People had access to a wide range of activities, both within the service and access to the community.

## Is the service well-led?

Good

The service was well-led.

People and relatives had confidence in the management. Management were visible and accessible.

People were cared for by staff who felt supported by the management team and were confident that any issues raised would be dealt with.

People were supported by management that continually monitored the quality of service provided.

# Sunrise of Beaconsfield

**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.

The inspection took place on the 19 and 20 November 2015 and was unannounced; this meant that the staff and provider did not know we were visiting. The inspection was planned. On the first day of the inspection, the inspection team consisted of two inspectors, a specialist advisor within older people's care 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.
On the second day of the visit the inspection team consisted of two inspectors and the same specialist advisor.

Before the inspection we reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with 16 people who were receiving care and support, seven relatives and two visiting healthcare professionals. We spoke with the registered manager and 22 other staff including deputy manager, care staff, chef and housekeeping staff. We reviewed six staff files and 10 care plans; we also looked at 31 medicines records within the service and cross referenced practice against the provider's own policies and procedures.

Good

# Is the service safe?

## Our findings

People told us that they felt safe living at Sunrise of Beaconsfield. Comments included "I feel absolutely safe here and there is no pressure", "I feel safe as there is always someone around that makes me feel safe". One relative we spoke with told us "The carers are good and people are safe here".

People were supported by staff who had been trained in safeguarding and were knowledgeable about how to protect people from avoidable harm. We reviewed training records and spoke with staff. Staff confirmed that they had received training. All of them said that they would report concerns to their managers. Some said that they would also report to the local authority safeguarding team if their manager did not take any action. Some did not know that they could raise a report to the local authority. We observed that information and contact numbers for the local authority was displayed in the care offices. However, we noted that this was not displayed in the staff rest room or in a prominent place within the service for people living there. We spoke with the registered manager about this and they advised that they would consider this point. However, the people we spoke with told us that they would always speak to the management team if they had concerns.

The management team took appropriate action when concerns about potential abuse occurred. We saw evidence that referrals had been made to the local authority in a timely manner. The service also awaited direction from the local authority prior to undertaking an action. This ensured the response to the concern was appropriate and proportionate which promoted people's safety and protection.

Routine assessments were carried out and reviewed to identify and minimise risks to people's health and safety. Risk assessments covered a number of key areas which included falls, nutrition, moving and handling to name a few. The service was supported by an internal 'wellness team'; staff from this team undertook routine monthly health checks. This provided the service with an opportunity to review risk assessment and update as necessary. We noted that one person had been assessed as at high risk from falling whilst walking. It was recorded in their care plan that staff should ensure that the person had their walking aid at all times; and that they should accompany them whilst walking. We spent some time on the reminiscence community and saw that the person had their walking aid and staff stayed with them when they moved from the dining area to the lounge. Another person's plan recorded that they required two people, and the use of a hoist, in order to transfer them into and out of their wheelchair. The person confirmed that this happened when we spoke with them. A full hoist sling was seen in their room. They confirmed that they had not had any accidents whilst being transferred using the hoist.

Incident and accidents were reported in line with local policy and these were monitored by the service through recording them on a quality indicator system. Trends in accidents were able to be tracked in conjunction with the health check. We saw evidence where falls had been recorded this had led to an onward referral to a falls clinic.

We found that risks were responded to quickly and appropriate onward referrals were made to outside health care professionals, including the dietitian and physiotherapist.

People were protected from the risk of unsafe premises. As all staff had access to information and had received training on fire procedures. Floor plans were fitted to the walls next to lifts on all floors which highlighted fire escape routes. Information relating to health and safety was available on a notice board adjacent to the staff room. This included basic fire awareness, fire extinguisher types, evacuation procedure, fire alarm procedure, isolation panels and gas leak emergency procedure.

The service ensured robust procedures were in place to monitor all equipment used. The records seen were of a high quality and it was clear any remedial action required was given high priority.

Personal emergency evacuation plans were in place which detailed what support was required in the event of an emergency.

We observed that people were supported by staff who did not appear to be rushed and requests for support were responded to quickly. We noted staff numbers on both days of the inspection and looked at staff rotas. We heard some mixed responses regarding staffing levels. Two people we spoke with thought that there were enough staff available to help them. A relative told us "I am here usually around twice a week; the staff don't know when I am coming, but there always appears to be plenty of staff." Another relative said "We witnessed two urgent calls whereby they (the staff) were there in seconds, and there was a few of them". One healthcare professional visiting the home felt that the support given to people living on the reminiscence neighbourhood was slightly better than that on the assisted living areas. They said they thought this was because "There's possibly more staff." They also added "The staff turnover is quite frequent; not good." We spoke with staff and they did acknowledge that on occasions when staff do not turn up for work it can be more difficult, but advised that staffing levels were generally a lot better than they had been in the past. We spoke with the registered manager; they advised that dependency levels of people were regularly reviewed. This allowed them to alter the number of staff required as needed. Staff received financial rewards for additional shifts worked; this helped the service to ensure that shifts were covered by staff who knew the service.

The service operated robust recruitment processes. Pre-employment checks were completed for all staff. These included employment history, references, and Disclosure and Baring Service checks (DBS). A DBS is a criminal record check.

People were supported with medicines by staff who had received appropriate training; dedicated staff were assigned to administer medicines for each shift. Medicines were managed well within the service. One person told us "They've never forgotten them." Medicine administration records were comprehensive and included a photograph of people due to receive medicines. There were processes and records in place for the safe return of unwanted medicine. Medicines were appropriately stored in a locked clinical area with a secure cabinet. When not in use we observed that the cabinets were kept locked. We observed the administration of medicines and found the process to be safe.

Procedures for medicines prescribed for occasional use were in place, when as required medicine was administered the time was noted. This protected people from overdosing. We found some incidents where medicines had not been signed for. This was a very low number and the service routinely analysed these through a monthly medicine audit. The audit identified the nature of the error and what action was taken. The service also had support from an annual pharmacy audit. The last audit was conducted in August 2015.

Where additional safeguards were needed for specific medicine, procedures and practice ensured that people were not put at risk.

Where assessed as safe to do so, people were supported to self-administer medicine. There was a clear procedure to ensure that medicines were stored safely. There was a process in place to monitor people's safety to continue to self-administer. We saw evidence that these checks identified that someone had become less able to manage this task. As a result and in consultation with them it was decided that staff would administer that particular medicine.

When medicines had been changed a process was in place to ensure that the service received confirmation from the prescribing general practitioner.

People were protected from the risk of infection. The service maintained a high level of cleanliness. The main laundry was on the top floor of the building. Laundry handling systems were in place in order to reduce the risk of infection. The laundry was clean and tidy.

There was a notice pinned up in the staffroom, which gave information about gastroenteritis and described what was best practice should an outbreak occur. Information regarding flu vaccination and hand washing techniques was also available.

A member of the housekeeping team said that they always had enough cleaning products and the correct equipment to be able to do their job. They said that their work was checked by their supervisor.

Good

# Is the service effective?

## Our findings

People, relatives and professionals told us they felt staff were knowledgeable. People received effective and compassionate care, from staff who understood people's preferences, likes and dislikes.

People were supported by staff who received key training sessions to equip them to provide effective care. We looked at the training matrix and staff we spoke with confirmed that they had received training identified. Staff training was a mixture of face to face and online learning. Staff we spoke with felt that they had benefitted from the training; however one member of staff commented that they felt "more in depth training than this" was sometimes required. Staff received a thorough induction programme; this included training, new staff shadowed and worked alongside experienced staff as well as one to one meetings with a line manager. Two new members of staff we spoke with commented that they felt very supported by the management team in their induction period and felt that they were given the opportunity to develop skills and knowledge of the people they were supporting. One new staff member commented that they had "One to one meetings with my manager" adding "I have a lot sometimes. The support has been very good."

The service operated a handover meeting from shift to shift; this provided an opportunity for staff to share important information regarding care and treatment for people. Each member of staff was given a daily assignment sheet which detailed the people they were identified to support and provided information on how the person wanted support. The shift leader updated this document as required to ensure that information was current.

People were supported by staff who had a good understanding of the Mental Capacity Act 2005. Staff had received training and were able to tell us what their understanding was. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. In one case we saw that the service had applied for a Depravation of Liberty Safeguarding (DoLS) assessment in relation to providing accommodation and support for a person living in the reminiscence neighbourhood. We found that the person had an advocate, who had been granted enduring power of attorney (POA) and that the service had recorded this on the DoLS application form. A copy of the POA document was available in the persons care plan file.

We found that a mental capacity assessment and best interest decision had been made and recorded in respect of the person moving from the Assisted Living area of the home, into the reminiscence

neighbourhood. The assessment recorded that the person's POA had been consulted and involved in this decision.

Consent was gained from people in respect of photography, release of information and for examination. We found that some documents which required an authorised signature did not have one; there was not a consistent process in place to ensure that people had provided written consent. However we observed verbal consent being gained routinely.

People told us they were happy with the food. Comments included "The food is very well balanced, nourishing and just the right portions," and "The food is very good I am happy with the choice." Another person told us "I think the food is quite good." People's care plans contained nutritional risk assessments and records of their weight. The manager stated that, as well as three regular meals a day, snacks were available around 8.00 pm. We observed that snacks and drinks were freely available. The service had undertaken a hydration project in conjunction with a dietician and pharmacist. People living in the reminiscence neighbourhood were identified at risk of poor nutritional and hydration levels. The service worked as a team to understand the barriers affecting each person. They considered innovative ideas of how to help people increase hydration levels. Ideas included fitting bottle holders to wheelchairs and walking frames. The service had hydration stations around the building which prompted people to ask for a drink. The project had been highly successful. In the first month they noted a marked drop in reported urinary tract infections (UTI), for the last six months there were no reported UTI in the population of the reminiscence neighbourhood. This in turn had reduced accident and incidents. This project had provided a very person centred approach to improving the quality of life for people living at Sunrise.

We observed two meal times, and noted that people were offered choice of meals on a menu at lunchtime. The order was then prepared. The kitchen staff had details of people's preferences, and had a checklist to ensure that everyone had received a meal. A recent food survey was completed in October 2015; 19 people choose to complete it, 75% of people rated the food either as good or excellent.

Where people required it, support was provided with meals. On the reminiscence neighbourhood this was on a one to one basis. On assisted living one member of staff supported two people. However it was identified in their care plans that encouragement to eat was required rather than full assistance.

People were supported to have access to a wide range of healthcare professionals. On the days of inspection we noted that podiatry and district nursing representative were visiting. The monthly healthcare visits, helped to maintain good healthcare, any concerns were reported quickly. One healthcare professional told us that they thought the care and support given was "excellent". They added "They have taken my advice on board and there is an improved skin care regime".

People were relaxed in the environment, we observed people moving from one seating area to another depending on the activity they were undertaking. One person told us "it's a pretty good place to be, it's got that comfortable feeling". There was a bistro area on the ground floor where people living in the service met, socialised and where drinks and snacks were provided. Different seating was available around the building, some of it was not always accessible to people with mobility issues. We discussed this with the management team and they had already identified this as an issue and had an action plan in place to replace with more suitable furniture.

Good

# Is the service caring?

## Our findings

At the previous inspection on 6 November 2014, the provider was found in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010 – Respecting and involving service users, which corresponds to Regulation 10 – Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) 2014. An action plan was received from the provider in May 2015. We reviewed the information contained in the action plan and made observations of staff providing support to people. Staff had received additional training in dignity and respect. Additional monitoring of quality had continued and a resident survey was completed this year. We observed that people's dignity was respected on the days of inspection. We observed interaction between staff and people living at the service were friendly. This was also confirmed by a relative who said "she (relative) has good rapport and stimulation with staff".

People were supported by staff who gave compassionate care. People told us that "The staff are nice", "I don't know why I am here, but the people (staff) here look after me and are very kind", "All (staff) very sweet", "They (staff) do all that you want them to do." "I am very happy here and haven't found any difficulty at all. The staff are always ready to listen to me". "They (staff) are excellent and very hard working, friendly and generous". "They (staff) are excellent and cheerful and helpful, treat me with respect, and most are quite charming". These comments were echoed by relatives we spoke with. Comments included, "They (relative) are well cared for and the staff are helpful". "My wife and I visit at least twice a week and the staff are terrific", "They (the staff) understand dealing with elderly and mentally infirmed people here", "Since coming here, everything has been faultless". One other relative advised us that "The really telling thing was that we took X out today and when they got back they said It's good to be back home, so X seems really happy here".

Staff spoke passionately about people they supported. One staff member said "You just have to think what if this is me". Another said "I wish more people could understand how rewarding care work is", "I love it". A visiting healthcare professional told us that they felt the staff were "caring" and that the people living at Sunrise were "Very well cared for".

People were encouraged to be part of the care planning process. We observed that likes and dislikes were recorded. People's preference on how they would like to be addressed was recorded.

We found mixed practice in the documentation of do not attempt cardio pulmonary resuscitation (DNACPR). In the care plans we looked at there was not consistent evidence that the person who had a DNACPR had been involved in the decision. We spoke with the registered manager about this and they were aware of this. They advised us that they had arranged to meet with the GP practice to review their current protocol for DNACPR.

The service had been working at improving communication and care planning for people at the end of their life. An end of life project was being led by the deputy manager. It was clear from their conduct that they were dedicated to supporting people experience a dignified death. Where people had expressed end of life wishes, these were recorded.

Good

# Is the service responsive?

## Our findings

People received personalised care that was responsive to changes in need. Pre-admission assessments were completed by a senior member of staff. All the people we reviewed had a care plan. Information on the cover of the care plan included their room number, date of birth, any allergies/special conditions they had (such as a pacemaker or diabetes) and a current photograph.

Inside the care plan was a section relating to the person's life story. This included information such as how they preferred to be addressed, where they were born and raised, family background, occupation, religion, social groups and close friends. Information relating to daily routines and preferences such as sleeping, leisure, washing and bathing was also recorded.

The care plan contained further information relating to consent and capacity, risk assessments and emergency information. Individual support plans that related to specific issues, such as mobility, nutrition and hydration and tissue viability were also in place. Plans were evaluated on a monthly basis.

One person had been assessed in relation to nutrition and swallowing. Their care plan recorded that they had been seen by a speech and language therapist (SALT) for a swallowing assessment. The SALT had recommended that the person had a soft, moist diet and thickened fluids. We asked a care assistant about the food and drink the person had. They were able to tell us about the consistency of the food and that fluids were thickened t. We saw that the person was provided with a soft moist meal at lunchtime in accordance with their swallowing requirements.

Where people required catheterisation records were not always up to date. One person had an indwelling urinary catheter. The individual support plan relating to this described some of the care required to protect the person from acquiring urine infections and preventing blockage, such as ensuring the catheter tube was not kinked and the catheter bag was emptied when required. However; there was no guidance on other issues such as cleaning the catheter, frequency of changing catheter bags and maintaining adequate fluid intake. Records did indicate that the catheter had been changed by a district nurse at the prescribed intervals. The most recent change was not recorded in the plan, although it had been carried out 19 days prior to our visit. We discussed this with the senior carer and they advised that records were also kept by the district nursing service.

People were supported to reduce the risk of pressure damage to skin. One person had been assessed as being at risk of developing pressure sores. Their skin was recorded as being intact. They had a profiling bed in their room, which was fitted with a pressure relief contour mattress. There was a slide sheet for staff to use whilst changing the person's position in bed, in order to prevent friction damage to their skin. We reviewed the records of two people who had been admitted to the service with existing pressure wounds. The wounds were graded towards the highest scale indicating that they were of concern. The service made appropriate referrals to district nursing services and worked with them to support the healing process. The care plans were person centred and gave care staff clear instructions on the skin care routine. Both these pressure areas had healed. This indicated that care staff were responsive to people's needs and staff provided

personalised care.

Another person's care plan recorded that they were at risk from developing pressure sores. Their sacral area had been reported as tender and red. We found that they had been supplied with a pressure relief air mattress for their bed. This had been set at an inflation level appropriate to their weight. The person also had a pressure relief cushion for their wheel chair.

Another person's file included an information sheet saying the person's movements needed to be monitored as they were at risk of absconding. We found that this information was no longer relevant and had been put in place following an incident in April 2015.

We looked at the care and support given to some people living with dementia in the reminiscence neighbourhood. We found that they had care plans which contained information relating to issues such as socialisation and capacity to interact with others. Care plans were personalised and provided information to staff on what caused people to become agitated.

For example one person's care plan recorded 'I often get my sentences mixed up and this frustrates me.' Further information detailed how the person often became upset whilst receiving personal care. We spoke with a staff member who was able to describe how the person's behaviour challenged staff and what triggers caused the behaviours.

The service employed a full time activities and volunteer coordinator. They told us that they were supported in their role by two activities assistants who worked a total of 37 hours per week. One assistant was currently on sick leave, which meant that it was sometimes proving difficult to fully meet people's social needs.

Volunteers had been recruited to come and support people with activities, which had proved helpful; although the coordinator reported that they occasionally had to cancel planned activities when not enough staff were available to provide support.

The activity coordinator said that they were trying to arrange more activities that people living in the home could get involved in. They were also trying to encourage care staff to get involved in arranging activities if they wanted to.

They said that they assessed people's social needs when they were admitted and tried to arrange appropriate activities for them. They gave an example of one person who used to practice Yoga in the past, who was now attending Yoga and Tai Chi sessions in the home.

One person's care plan recorded that they preferred to go to their room and watch sport on their television during the afternoon. We visited them and found them watching tennis on the TV.

There was a list of planned activities for the following month on display in the foyer. There was also a visual display of a flat screen that advertised upcoming events. A copy of the activity calendar for the current month was on display in the home's lifts and a copy was given to people living in the home.

As well as visiting entertainers, activities that people could join in and contribute to include a poetry club, quizzes, knit and natter, and an art club. A music therapist visited the reminiscence neighbourhood. Religious services were also held. There were display cabinets throughout the service that contained art work and pottery made by people who lived there. Books were also available.

The service had a minibus, which could be adapted to take people who used wheelchairs. Trips were arranged to take people out. These included trips to the cinema, a Christmas fayre and the Christmas lights in London.

People also had access to a computer and could access the internet and communicate with friends and relatives.

The service routinely sought the views of people using it; this included a food survey and a general survey. We noted that the service had a complaints policy which we observed it followed. People we spoke with had confidence to speak with any member of staff including management if they had concerns. One person commented "I am an intelligent woman and if something bothered me I would be able to complain". The reminiscence neighbourhood coordinator told us how they had dealt with the concerns of a person's relative about an aspect of their care. They had met with them and discussed the issues, explaining the reasons for the care given to the person. They said that this helped the relative gain a greater understanding of the person's needs.

A copy of a residents and family survey was attached to a noticeboard in the staffroom. As a result of the 2014 survey a separate team was created to manage people's health care. The staff who worked in this team managed GP appointments, medicine re-ordering and undertook monthly health care visits to everyone living at Sunrise.

Good

# Is the service well-led?

## Our findings

People were supported by a service that was well-led. The management team demonstrated a commitment to improving the quality of service people experienced. Previous breaches in regulations were acted upon and the service had continued to improve its monitoring of the quality of service provided.

People and staff felt that the management were approachable and available for them to talk with. People, relatives, staff and healthcare professionals, stated that there was good communication within the service. Comments included "They visit me and ask me if I am all right, they are quite approachable", "X keeps us informed and nothing seems to be too much trouble, I cannot fault X", "X is very approachable, we can talk to X anytime if we need to", "X is great, they really knows stuff and gets the best out of people. X has a clear vision about quality care and keeps on top of things to make sure the home runs well".

Staff we spoke with were aware of the vision for the service and were passionate about achieving it. Staff also had confidence to share their views and suggestions for the service to improve. They felt that when they have made suggestions these have been taken seriously and felt valued as team members.

The service had an on-going community action plan. The central action plan document was updated by all members of the management team. Regular health and safety monitoring was undertaken. The provider had an action plan to improve the quality of people's care. We noted on the second day of our inspection, feedback given on day one was already recorded, with appropriate actions identified. A number of quality audits were undertaken on a regular basis, these included infection control, complaints and accidents. This provided the service with an opportunity to review its success and make appropriate changes.

The registered manager and provider were pro-active in improving the quality of life for people living at Sunrise. The service had taken part in a hydration project. We were advised that a case study had been provided to care England in respect of the project. As it was highly successful in reducing UTI's for people living with a dementia illness.

The service had comprehensive policies addressing key areas. Policies were available for safeguarding people, data protection, rights, choice, privacy and dignity to name a few. Staff members were provided with a code of conduct and handbook detailing polices and expected levels of performance. We observed that the service followed these polices in particular with medication and complaints.

The service regularly sought feedback from people, relatives and staff. Staff meetings and resident council meetings were held and recorded. The service undertook annual resident and staff surveys. The information from these was collated and analysed. The registered manager developed an action plan from the results gathered. We reviewed the action plan from the survey conducted last year. We saw that actions had been taken. For example a review of activities was carried out; when we conducted the inspection we found the service had a wide range of activities available.

The registered manager was aware of their responsibilities and they had notified us of significant events, this

included when a decision had been made about a DoLs application.