Nottinghamshire County Council

Quality Monitoring Audit Form

Name of Home

Radcliffe Manor House

Home Name:	Radcliffe Manor House Care Home		
Manager: (Are they registered with the CQC?)	Karen Squire (CQC Registered)		
Provider:	The Trustees of Radcliffe Manor House		
Type of Service:	Residential Dementia Care		
Home Address:	52 Main Street, Radcliffe on Trent, Nottingham, NG12 2AD		
Email Address:	karensquire@radcliffemanorhouse.co.uk		
Date of Audit:	12 August 2019		
Band:	5	Previous Band:	5
Score:	50/57	Action Plan Required?	Yes (received)

Key:	**Excellent**	**Good**
	Improvement Required	**Does Not Meet**

Standard One: People who use the service experience outcome focussed person centred care: People who receive a care service receives outcome focussed person-centred care, which considers their choices and preferences. Care is provided in a positive risk-taking environment, which supports people to make decisions regarding their care.

1.1 Each service user has a personalised support plan which identifies patterns of daily living. Service users and / or families / advocates are involved in the process and are able to contribute their views.

Score	Recommendations:	Observed Evidence
Good	Ensure all residents individual Personal Emergency Evacuation Plans are reviewed and up to date (PEEP's).	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was good. We spoke with residents about the care they received. They said, "It's very good", "The staff are delightful" and "Staff are amazingly kind to me". We looked at a sample of care plans and found that these contained detailed information about the individual and the care they require. We looked at the Personal emergency evacuation plan (PEEP's). We found that each resident has one. However, we also found that these require a review. This means each resident has a personalised assessment and care plan that identifies, through inclusion, the patterns of daily living in relation to their assessed needs, individual's wishes, choices, goals and sets out how the support, care or treatment is delivered. All residents' Personal emergency evacuation plans to be reviewed.

1.2 Care / support plans include identified areas of risk and details how these will be managed and are reviewed, supporting service users to make informed choices.

Score	Recommendations:	Observed Evidence

1.2 Care / support plans include identified areas of risk and details how these will be managed and are reviewed, supporting service users to make informed choices.		
Good	Ensure a risk assessment is compiled and implemented for the use of the sensor mat.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was good. We spoke with residents regarding choices they were given by staff. They said, “They are always asking me what I would like to eat, drink and when would I like to have a bath” and “The care staff know what care I need”. We looked at a sample of completed risk assessments and found that these were being reviewed within appropriate timescales. Example, SB falls risk assessment completed and last reviewed on: 24/07/2019. Records seen indicate this risk assessment is working effectively. The requirements of the mental capacity act are met. We also found that a risk assessment had not been completed for: SB for the use of a sensor mat. We spoke with the manager about this. This means care plans include identified areas of risk and detail how these will be managed and are reviewed. Risk assessment for the use of the sensor mat needs completing. Residents are supported to make informed choices.

1.3 Accurate records relating to service users are completed in a timely way and stored in a safe place.		
Score	**Recommendations:**	**Observed Evidence**

1.3 Accurate records relating to service users are completed in a timely way and stored in a safe place.		
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We looked at care records and found that significant events were being documented and this included where residents had refused aspects of care. For example, declined to have a bath and didn't want to take part in the activities. We looked at the storage of residents' records and found they were kept securely and confidentially. Records were kept in a manner which staff could access quickly. This means a live record of significant events in the life of each person is maintained, including the refusal of an aspect of the service. Staff recognise and maintain confidentiality in respect of information about residents.

1.4. Service users are afforded a choice of suitable nutritious food and in sufficient amounts in accordance with their identified needs and wishes.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We spoke with residents regarding the quality and choice of food. They said, “Meals are nice” and “They will provide a choice” and “I do like the roast dinner”. During our observation at lunchtime we heard residents saying positive things about the meals they had. One resident said to a staff member “Thank you for a lovely desert, I enjoyed that”. We looked at a sample of documentation in relation to nutrition, and we found that Nutritional assessments had been completed where required. We were informed by a member of the management team that at the previous Care quality commission (CQC) inspection, a recommendation had been given in regard to having table menus. We looked and we found that table menus had been compiled, implemented and used. Residents told us they found these menus helpful. A sample of records were seen in regard to resident’s weights. We found these were being measured either monthly or sooner if needed (weekly). Of the records viewed we saw that any concerns with resident’s weight increases or decreases are being managed appropriately. We spoke with kitchen staff and they were able to provide a good knowledge and understanding of resident’s dietary requirements and any special dietary needs. We saw documentation which is kept in the kitchen area in regard to each residents likes, dislikes, preferences, allergies and special dietary needs. This means residents are afforded a choice of suitable nutritious food and in sufficient amounts for their needs in accordance with their identified dietary requirements and wishes.

1.5. Service users are supported with dignity through individual stages of life, by staff respecting their choices and preferences.		
Score	**Recommendations:**	**Observed Evidence**

Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. An example of what we found to make this judgement was: We spoke with residents regarding how they felt staff spoke and interacted with them. They said, “Very nicely” and “They are a good bunch”. We observed staff speaking respectfully with and about residents. When staff spoke to each other about residents, they did this respectfully and confidentially. For example, a care worker found a resident to be distressed about where to go after lunch. We found the care worker to be kind and compassionate with the resident, by being supportive and providing reassurance of where to go. We saw care staff assisting residents to the toilet, and we found they did this discretely without drawing too much attention to this. During our visit we monitored the lounges and found staff representation in these lounges. We spoke with care staff and they told us they make sure there is always staff support in the communal areas. We found three care plans documented person-centred end of life care. We found consideration had been given to the residents’ preferences and wishes regarding care, support and treatment. The information included reference to the resident’s life history, personal relationships and considered their religious or spiritual preferences. We spoke with the manager and they told us staff at the home followed end of life pathways to support residents into their end of life. We looked at training records for staff and found that a number of staff that care for residents in their last stages of life had received ends of life care training. For example, (Death, Dying & Bereavement) JB: 06/08/2019, MB: 21/11/2017 & MV: 16/03/2017. Records seen show that all refresher and expiry dates for this training are recorded on the training matrix. We spoke with the management and they told us they establish which resident have Lasting power of attorney (LPA) representatives. We looked a number of documents which support this. For example, SB: LPA Dated; 04/05/2015 (property and finance).

		This means staff always refer to, speak with and interact respectfully, supportively and in confidence with residents. Staff have received End of life care (EOLC) training.

Standard Two: Keeping People Safe: People are protected from abuse or the risk of abuse, including financial abuse and the safe handling of their medication. People are supported and needs are met in line with MCA and DoLs / DoLiC requirements.

2.1 Service users are protected from abuse or risk of abuse. Their human rights are upheld through the effective operation of safeguarding arrangements. These identify and prevent abuse and are responded to appropriately.

Score	Recommendations:	Observed Evidence
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. An example of what we found to make this judgement was: We looked at the safeguarding procedures and found this to be detailed and included the contact details for Nottinghamshire County Council's adult safeguarding team. We spoke with staff regarding their understanding of adult safeguarding and found they knew what abuse is and how to report this, using the local reporting requirements. We looked at their safeguarding records and found Nottinghamshire County Council's and the Care Quality Commission's procedures were appropriately followed. We spoke with staff and we found they had a good knowledge and understanding of the procedures. We looked at the records for any safeguarding referrals and found that these had been addressed and investigated appropriately by the provider. For example, referral submitted by the management regarding misconduct of staffing members. Didn't meets the thresholds for a full S42 safeguarding. Staff dismissed and referred to Disclosure and Barring Service (DBS). All investigated and resolved appropriately. Training records show that staff have received safeguarding training. For example, DT: 26/09/2016, JD: 09/05/2019 & AP: 24/05/2019. Records seen show that any DoLs referrals have been submitted and have been and are being managed appropriately. For example, any conditions are looked at and transferred in to the respective care plan for the resident. Any

2.1 Service users are protected from abuse or risk of abuse. Their human rights are upheld through the effective operation of safeguarding arrangements. These identify and prevent abuse and are responded to appropriately.		
		actions are addressed. Training records seen show that the staffing team have received DoLs training. For example, KG: 08/01/2019, DT: 18/06/2019 and EG: 08/05/2019. This means residents are protected from abuse or risk of abuse.

2.2 Where the service user lacks capacity to make decisions, the requirements of the Mental Capacity Act 2005 are met.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure the requirements of the mental capacity act (MCA) are fully met.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was good. Of the care plans we looked at [4] we found that the requirements of the mental capacity act were mostly met. However, we also found that there are care plans that didn't. For example, SB: No MCA/BI for the use of equipment. We spoke with the manager about this. We looked at staff training records and found that the majority of the staffing team have received Mental capacity act (MCA) training. We also saw that some staff members will soon require refresher training in this area. This means the requirements of the mental capacity act (MCA) are mostly met. MCA/BI assessments for the use of equipment are to be implemented.

2.3 Service users are protected and supported to live with the least restrictions to their liberties. Where the service user is subject to restrictions and restraint, they must be authorised under the Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty in Community referred to in Nottinghamshire as (DoLiC).		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. Records seen show that any DoLs referrals have been submitted and have been and are being managed appropriately. For example, any conditions are looked at and transferred and used in the respective care plan for the resident. Any actions are addressed. Training records seen show that the staffing team have received DoLs training. For example, KG: 08/01/2019, DT: 18/06/2019 and EG: 08/05/2019. This means the requirements of Deprivation of Liberty Safeguards (DoLs) are met.

2.4 Service users are protected from financial or material abuse.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We did not speak with residents regarding whether they had access to money being kept safe by the care home provider. We asked the manager to provide a copy of procedures regarding safe keeping of residents' money. They complied with our request. We looked at these procedures and found that the provider does manage and handle resident's finances. We spoke with the staff and they told us that they do manage resident's finances at the home. The administrator told us that solicitors and

2.4 Service users are protected from financial or material abuse.

		relatives that have Lasting power of attorney for finances manage these and this can also include involvement for social services. We looked at the system used. We looked at four resident's money accounts for personal allowances, and we found all checked totals matched the mounts recorded. We counted that physical money contained within individual money pockets for each resident. For example, DC: £54.00 total recorded, and money counted was £54.00. Receipts seen matches any transactions and purchases. We asked the management if they hold any credit, debut or bank cards with PIN numbers for residents. The management said "We don't keep any bank cards for residents". The management also told us they would try and avoid holding bank cards and PIN numbers for residents wherever possible. We spoke with the manager who was able to provide a good understanding of the system used, and they provided us with copies of receipts for purchases and for relatives depositing money with the home staff to top up money floats. We saw written summaries where the system and accounts had been audited by the provider. We also saw records that linked in with chiropody and hairdressing. We found these records were up to date and clearly documented. We found that all residents' money is locked away appropriately when not needed. Safe used to keep monies locked away safely. This means that residents are protected from financial abuse.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

Score	Recommendations:	Observed Evidence
Improvement Required	Ensure risk assessments are completed when residents are having their medication administered covertly.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard is improvement required.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

	Ensure guidance and support is obtained from the pharmacist when agreement for medication to be administered covertly is agreed by the GP (safest way to hide and disguise medication). Ensure a new place to store the medication trolley when not in use is found. The care office which is currently being used to store the trolley is too warm for storing medication. Consider purchasing an air conditioning unit or find a cooler location. Ensure plastic medicine pots are not left to air dry in the kitchen area. Best practice from an infection prevention and control perspective is to wash, dry and store away. Consider using one use disposable medicine pots. Ensure all TMAR charts are reviewed to show that creams are being applied correctly. Ensure all creams being used have a date of opening on them.	We did not speak with residents or relatives about medication. We requested that the provider show us their medication policies and procedures, they complied with our request. This also included policies regarding the administration of covert medication. We looked at the care plans for [4] residents and found that these included consideration of their medication. We saw that where changes in medication had been made, care plans were updated accordingly. We found care plans described how residents preferred to receive their medication, and our observations demonstrated this to be true. We found that where people were identified as lacking the mental capacity to make decisions regarding their medication, best interest decisions are appropriately completed. We also found that it was agreed for one resident to have their medication administered covertly. We looked at the documentation and found that MCA/BI assessments had been completed for this. However, we also found that a risk assessment wasn't in place and guidance and support from the pharmacist to support the best way to administer medication covertly. We spoke with the management about this. The management told us they would look into this. We looked at the storage of medicines and found that this was in line with the provider's policies and procedures. We saw that medication trolleys used were secured to a wall in the clinic room, when not in use. We saw that there was a daily record of medication fridge and treatment room temperatures, and these were in line with best practice guidelines. However, we also found that the measurements recorded were running slightly high. For example, 29/06/2019: 28.9c and 30/06/2019: 27.8c (care office temperature where the medication trolley is stored). We spoke with the management about this. They told us they would look into this sooner rather than later. We looked at the system for ordering residents' medicines. We found the system ensured there was sufficient quantities in stock to meet individual

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

residents' needs and in line with their prescriptions. We looked at the homely remedies and found these were being managed appropriately and safely and in line with the provider's procedures. We looked at the system used for the disposing of medicines, and found the records matched the quantities of medicines held awaiting return. We spoke with staff and their description of the process for returning medicines matched the provider's policies and procedures.

We looked at the medication administration records (MAR) for six residents. We found that records of medicines being administered matched those identified in in the care plans. We saw 3 handwritten MAR charts and found these contained two signatures to indicate the information written on the MAR charts matched that contained on the prescription.

We saw where medicines were not administered; the records indicated the reasons for this on the MAR charts. Our observations of staff during the medication round found that they were administering medicines safely and in line with prescribing instructions. We found residents were informed by staff of what was happening prior to administration and we saw that staff ensured the medication trolley was locked when not being attended.

We saw where residents have been identified as requiring their medicines 'as and when required' or PRN; we found these to be managed appropriately. Our discussions with staff assured us they understood the provider's policies and procedures in this area. We looked at the residents' care plans and found that reviews of PRN medicines were taking place on a regular basis. We saw that records of resident's prescriptions were kept and a current copy of the British National Formula (BNF) was accessible for reference in the clinic room.

We looked at the records of medicines controlled by the Misuse of Drugs Act 1971. We found that the records were accurate and reflected the quantities of medicines held. The storage and administration of controlled drugs was in line with the provider's policies and procedures. We found consideration had been

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

given to the placing of patches, to ensure residents did not receive double doses. We found Body maps used and completed appropriately.

We found systems in place for the safe disposal of controlled drugs. We spoke with staff regarding their understanding of how to administer and safely dispose of controlled drugs. Their description assured us they were ensuring residents medicines were being administered safely. We saw the care worker administering residents' medication safely at lunchtime in the dining room and in other parts of the home.

We spoke with staff regarding how they would deal with an adverse medication incident; Their description of the actions they would take matched the provider's policies and procedures. We found for those residents who were responsible for their own medication, we found appropriate systems in place for the assessment, safe storage and handling, whilst maintain the residents' independence. We also found evidence to support plastic medicine pots were being washed and left to air dry in the kitchen. This is not acceptable and contravenes the infection prevention and control policy. Management to review this process.

We looked at the provider's records of training, and found that all staff had received recent training in the safe handling of medicines. We saw that prior to staff undertaking medication administration, their competency was checked. For example, MB: 07/03/2019 & EG: 05/07/2019. We spoke with the management regarding their actions should issues be identified with staff administration practices. They told us they ensured they were competent prior to them starting administering medication. We saw copies of completed medication audits documentation that had been completed. For example, Medication audit dated: 23/07/2019. We found any actions highlighted and needed attention following these audits had been addressed appropriately. We looked at documentation relating to the application of medication creams.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

We found that these were being applied and recorded. However, we also found some gaps in the recordings. For example, SB: Zerobase cream (apply twice a day) missing dates: 04/07/2019, 10/07/2019. Also DC: Zerobase cream (apply twice daily) missing dates: 04/07/2019. We looked and found that opening dates on cream dispensers were not always being recorded on these. For example, RL: Dermol 500. We spoke with the management about these.

This means that there are systems in place to manage, store, administer and document resident's medication to ensure residents are protected. Medication creams being used need a date of opening on them. Medication fridge and clinic room temperatures need reviewing. See recommendations given.

Standard Three: People who use services are supported by competent staff: People are supported and cared for by sufficient numbers of staff who are suitably recruited and sufficiently inducted and trained to provide them with the knowledge, skills and experience to be competent and professional.

3.1 Robust recruitment processes are completed with structured probation, supervision and appraisal arrangements in place for staff in line with Policies and Procedures

Score	Recommendations:	Observed Evidence
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We looked at a sample of staffing files [3] and we found that all appropriate checks have been completed. For example, obtaining 4 forms of identification, Disclosure barring service (DBS) checks. A further example is: DBS MV dated: 13/08/2018 Clear and DBS EG dated: 10/05/2016 Clear. We found completed copies of Staff induction programmes. Also Employment contracts, terms and conditions of employment. Also references from past employers. There are identification photographs on the staffing files. We spoke with the managers about supervision and appraisals for the staffing team. Asking how they provide support. They told us they received formal supervision every 2 months. One staff member said “I do find these meetings helpful”. We looked at supervision and appraisal records [4]. We found that the timescales for completion of supervision sessions is approximately every 2 months. We also found that staff meeting are be held and completed on a regular basis. For example, minutes of completed staff meetings: Senior care team dated: 30 July 2019, and Night staff care team dated: 26 July 2019. We found the recordings of these meeting minutes to be detailed. We looked at the provider’s supervision plan and found this to be correct. We looked at the record of supervision for the last 12 months for (4) staff members

3.1 Robust recruitment processes are completed with structured probation, supervision and appraisal arrangements in place for staff in line with Policies and Procedures		
		and found this matched the manager's supervision planning. We found from records seen that the majority of staffing team had received an annual appraisal for 2018. We also looked at minutes form staff meetings held. For example, 25/09/2018, 15/08/2018, 13/03/2018 and 17/01/2018. This means structured supervision and appraisal arrangements are in place for staff. Staff meetings are held regularly. Staff have the opportunity to meet with the management when they wish (the manager has an open door policy).

3.2 Staff have the knowledge, experience, qualifications and skills to support the service users.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure refresher training needed is completed within set timescales. Ensure all staff receive General data protection regulation (GDPR) training.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was good. We observed the care practices of staff. We found they understood the needs of residents, and we found they were responsive and person-centred in their actions. We spoke with three care staff about the specific needs of residents. They were able to describe to us the residents identified needs and how they support them. We looked at five training records for staff, and found records of training within the last 12 months. We found that most of the staffing team had received training in subjects deemed as compulsory. We asked for a copy of the completed training matrix. The manager complied with our request. We looked at this training matrix and found that staff have received training in various topics. For example, safeguarding, dignity and respect, Infection prevention and control. We also found that there are some that require refresher training. For example, GHH: Theory of moving people safely expired: 28/08/2019, VR: Moving & handling practical expired: 13/12/2018, DJ: Infection prevention &

3.2 Staff have the knowledge, experience, qualifications and skills to support the service users.		
		control expired: 08/07/2016, CO: Fire safety workbook expired: 25/08/2019 and JB: Health & safety expired: 31/08/2019. We spoke with the management about this. All staff require training in General data protection regulation (GDPR). We spoke with the manager about this and they told us they would arrange this. We spoke with staff regarding the training they received. They told us they received a lot of training, which they found helped them do their jobs more effectively. We looked at training records for three care workers and found that they had completed an NVQ/QCF equivalent. This means that staff has knowledge, experience, qualifications and skills to support the residents safely and effectively. There are areas where refresher training is required. All staff to complete GDPR training.

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We spoke with staff regarding the staffing levels during day, night and weekend and they told us that they feel there are enough staff on duty and if anyone is off sick or on leave, there are enough staff to cover any shortfalls. The looked at the staff rotas for 4 weeks and found the named staff identified to be on shift at the time of this visit were on duty. Our observations found there were sufficient staff. We didn't observe staff rushing around or residents being left unattended for long periods of time. We looked at how staff were deployed around the care home and found they were

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
		well distributed (daily allocation lists are compiled and used). We found activities were planned and the staff were available to facilitate these activities. We found that activities were seen as an important part of care delivery. Dependencies for the assessed needs of each resident are completed to further support the numbers of staff required on each shift, and to meet the assessed needs of residents being care for. This means staffing levels for the service are determined and deployed according to people's assessed needs.

Standard Four: Services are managed effectively: People receive high quality care through an effectively managed service. The provider/manager takes responsibility, is accountable for their actions, and has an effective system for identifying, assessing and monitoring the quality of the service provision.

4.1 People receive high quality care through an effectively managed service.

Score	Recommendations:	Observed Evidence
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We spoke with residents and asked them whether they knew who the home manager was, and what they thought of the home manager. They told us they did know who the manager was and the manager spoke with them most days. We looked at the provider's CQC registration on our visit, and found that care was delivered in line with the registered regulated activities. We found that where conditions to the provider's registration were documented, the provider was adhering to these conditions. For example, the number of beds. We found that the home manager was registered with the CQC. We looked at the manager's qualifications, experience and training and found this to be appropriate, up to date, and suitable to lead the team. The staff we spoke with told us the manager is very nice and supportive. Our observations of the home manager found they were able to lead the team. We asked the management if we could see a copy of the business continuity plan. The manager provided this. We spoke with the home manager regarding their vision for the service. We found this matched that advertised by the provider in their statement of purpose. We found that staff had an understanding of this vision for the care home.

4.1 People receive high quality care through an effectively managed service.		
		This means the service is registered for the appropriate regulated activities and managed by an experienced, suitably qualified manager who is registered with CQC. There is a robust business continuity plan in place.

4.2 There is an effective system for identifying, assessing, monitoring the quality of service delivery.		
Score	**Recommendations:**	**Observed Evidence**

4.2 There is an effective system for identifying, assessing, monitoring the quality of service delivery.		
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We spoke with residents regarding whether they were able to influence and contribute to the running of their home. They said, 'We are". The provider told us that they carried out audits on a monthly basis covering all areas of the service provision. This includes: Medication, Infection prevention & control, Environmental audits and Health & safety audits. We looked at completed documentation and found this to be true. For example, Kitchen audits dated: 13 June 2019 & 23 July 2019. Residents meetings are held to provide information and to listen to feedback, thoughts and feelings on all manner of subjects within the home. Minutes are produced in a suitable format for the benefit of anyone not able to attend the meeting, and to remind the residents of all the subjects discussed. For example, residents and relatives meetings dated: (residents) 09/04/2019 (relatives) 09/04/2019. Records seen show that Quality assurance questionnaires are completed with residents and visitors covering subjects such as food and drinks, care plans, medication, dignity and activities. From the information returned an action plan is formulated in regard to any actions needed. Records seen and provided for the completion of the quality assurance assessment for: 2018. Spoke with the management and they told us they are in the process of sending out the questionnaires for 2019. These assessments are completed annually. This means there is an effective system for identifying, assessing, monitoring the quality of service delivery and risks to health, welfare and safety of residents.

4.3 There is an effective system for identifying, receiving, handling and responding to and learning from complaints and concerns raised.

Score	Recommendations:	Observed Evidence
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. An example of what we found to make this judgement was: We spoke with residents and asked them whether they knew who they could make complaints to or raise their concerns if they weren't happy with the care they received. They said, "I would speak with the manager [manager's name]" and "My [relatives name] supports me as well". We looked at the provider's record of complaints and found any complaints received had been recorded appropriately and actions taken (none received recently). We also saw a number of compliments and greeting cards and letters saying thank you for the good care and service provided. We spoke with staff about the whistle blowing policy. The staff we spoke with able to provide a good a knowledge and understanding of this policy. One staff member told us they had received a copy of the policy. Another staff member was able to say where the policy was located. We found this to be true. This means there is an effective system for identifying, receiving, handling and responding to and learning from complaints. There is a whistle blowing policy in place.

4.4 How is technology used to enhance the delivery of effective care and support?

Score	Recommendations:	Observed Evidence
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. We spoke with the management at this service. We asked them whether they use any technology. The management told us residents use Skype for

4.4 How is technology used to enhance the delivery of effective care and support?

		contacting relatives, family and friends if they wish too. We were told that I-pads are used. We looked at one and found that these are also used by residents and for taking and storing photographs. Staff told us residents sometimes use them for playing games. The homes has an electronic call bell system in place. Two residents told us they use theirs in the night sometimes, and said “It comes in handy when you need staff to assist you”. This means residents do have access to technology as and when needed.

Standard Five: Environment is safe and homely: People live in an environment which is clean, safe and personalised.

5.1 The accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. There are effective cleaning and maintenance schedules in place which ensure suitable standards of living are maintained.

Score	Recommendations:	Observed Evidence
Good	Ensure any damaged walls in the home are repaired and decorated.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was good. We spoke with a resident regarding the physical environment of the care home. They said “The home is lovely”, “It’s clean, tidy and they do their best to make it a homely place to live”. We looked around the care home, at communal spaces, residents’ rooms, bathrooms and toilets. We found the premises to be mostly maintained to a good standard. We spoke with the lead of the charity which supports this home. We asked them about repairs and redecoration with some walls in the home. They told us this would be looked into. We looked at the exterior and grounds and gardens of the care home, and we found these to be maintained to a high standard. This means the accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. Some walls in the home require attention regarding repair and redecoration.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.

Score	Recommendations:	Observed Evidence

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.		
Excellent	None identified.	Robust evidence was gathered and assessed relating to this standard during the annual audit process 2019/20. Our judgement was that the standard was excellent. During our tour of the care home, we found hand washing facilities available in resident's rooms, bathrooms and toilets for staff. We found adequate supplies of liquid soap and paper towels for staff use. We looked at the sluice facilities and found these to be clean and there were sufficient to meet the needs of residents. We looked at the laundry facility and found it clean and well-organised. We found that systems were in place to protect residents from the risk of acquiring or spreading healthcare related infections. For example, we found that soluble laundry bags were used for soiled or potentially infected clothing and this laundry was washed separately. Our observations of staff found that personal protective equipment (PPE) was used effectively and changed between tasks. We spoke with staff regarding their knowledge and understanding of infection prevention and control measures. What they told us assured us that they did have a good understanding. For example, one member of staff told us how they would barrier nurse a resident should the need arise. The staffing team have received Infection prevention and control training and COSHH training. Records seen support this. For example, CO: COSHH dated: 23/02/2018, KD: COSHH dated: 15/03/2019. LLH: IPC dated: 21/08/2018 & EG: IPC dated: 10/05/2019. We spoke with staff about the emergency exits and they were able to say where these were located. We looked at a sample of residents completed Personal emergency evacuation plans (PEEP's). Of the sample we looked at, we found they contained relatively detailed information about the individual, and the best way to transfer them out of the building. This means there are systems in place to help prevent and control of health associated infections. The premises is clean, well maintained and smell pleasant. The staffing team have received the appropriate training. Personal emergency evacuation plans (PEEP's) are in place for each resident.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.

What was observed in relation to innovation or creative ways of working whilst visiting? Did you have any conversations with staff, service users, and family members?

This section can be used to demonstrate innovative practice highlighting where provider / staff have gone above and beyond and to document good practice and the lived experience of the people living within each home / service.

Observed / Conversational Evidence:

We looked at the social activities records and activities plan and we found that there are a number of activities offered and available for residents to get involved with. For example, 11.00am on Tuesday13 August 2019: Colin Jackson (Jazz Singer) visits the home to entertain residents. Also Friday 16 August at 11.00am a company called: “Engage in Care Exercises” visits. Records seen show that the feedback from residents in regard to this entertainment is very positive. Records seen show that the most popular social activity provided, are the days when the local infant school children visit the home to see the residents. We spoke with two residents who told us they loved seeing the children.