Jasmine Care Holdings Limited

Jasmine House Nursing Home

Inspection report

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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

Jasmine House Nursing Home is a service providing personal and nursing care for up to 79 people with needs arising from old age. The service included a unit for people living with dementia. Care was provided over three floors, each served by a lift. People had their own bedrooms and had the choice of various communal areas.

At the last inspection, in June 2015, the service was rated Good. At this inspection we found the service remained Good in each area, with good progress having been made, particularly in activities, external liaison and in-house governance.

The service was required to have a registered manager and one was in place. 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.

Further development of the dementia environment had taken place with plans in place for additional improvements, to provide the best environment for people living with dementia. Improvements had also been made to other aspects of the environment, furnishings and equipment.

The service continued to operate a robust recruitment process to try to ensure staff had the necessary skills, attitude and ability to care for vulnerable people. Staff received a thorough induction and a good programme of core and specialist training, which was periodically updated. Staff received ongoing support through regular supervision meetings, annual performance appraisals and observations of their practice to confirm competence. The plan to provide staff with a separate area to take their breaks still needed to be followed through, so it was clear that staff who could be seen were on duty.

People and relatives felt people were safe and well cared for by trained staff who had the skills they needed. They said staff provided effective and responsive care and sought their views and wishes about care. People and relatives felt they had opportunities to raise issues and their opinions of the service were sought and acted upon.

People's nutritional and healthcare needs were met and monitored and the advice of external healthcare professionals was sought when necessary. People's cultural and spiritual needs were provided for to some degree, although there was room for further development. People's dignity was managed well with the exception of hairdressing, which was still being carried out in the Jasmine unit dining area.

People's rights and freedom were protected by staff. Where they had capacity, people were consulted about their care. The views of relatives and other representatives were sought where appropriate. People were supported to have maximum choice and control of their lives and staff supported them in the least

restrictive way possible; the policies and systems in the service supported this practice.

People enjoyed a good range of activities, entertainment and some outings. The appointment of a new team of activity staff had led to improvements in this area. Activities and other staff engaged regularly and effectively with people in lounge areas, which helped them to feel valued. There was a need for additional staff support for people in the dementia unit who chose to spend time away from the main lounge.

Within the service, the management team exercised effective governance and monitored required aspects of the service. There was limited evidence of governance activity by or on behalf of the registered provider. The registered manager thought the recently appointed 'responsible individual' planned to begin a monitoring regime soon, following their initial visit.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Jasmine House 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 was a comprehensive inspection which took place on 3, 4 and 5 October 2017. The inspection was unannounced on the first day. It was carried out by one inspector. We last inspected the service in June 2015. At that inspection we rated it Good overall, and in each domain.

The service had submitted a Provider Information Return (PIR) in June 2017, prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help us plan the inspection.

Prior to the inspection we reviewed all the current information we held about the service. This included notifications we had received. Notifications are reports of events the provider is required by law to inform us about. We reviewed the last inspection report and contacted representatives of the local authority who funded people supported by the service, for their feedback.

During the inspection we spoke with the manager, the two deputy managers and six other nursing, care and activities staff about various aspects of their roles. We examined a sample of six care plans and other documents relating to people's care. We looked at a sample of other records related to the operation of the service, including recruitment records for four recent recruits, management monitoring systems and medicines recording. We spoke with five people receiving support and three relatives to seek their views about the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the lunchtime service and informally observed the care provided at various points throughout the three days of our inspection.

Good

Is the service safe?

Our findings

People were still protected from abuse and harm. The service had a system for reporting concerns about potential abuse and staff were familiar with this. They felt action would be taken on any concerns raised. Where concerns had arisen, steps had been taken to address them and reduce the risk of harm. Senior staff were visible around the service, giving people or relatives the opportunity to raise any concerns or questions they might have. People and relatives said people were safe in the service. One person told us, "I do feel safe here." Another said, "I'm happy here and feel safe." A relative said, "He is safe here," A second told us, "She is definitely safe here."

The registered manager reviewed staffing levels on a monthly basis using a recognised dependency assessment tool. Staff deployment was effective for the most part. However, in Hawthorne unit at times during the morning, no staff were immediately available to support people using the small lounge and dining room, or those who remained in their rooms. One relative also said staffing was sometimes not sufficient to allow for a staff member to attend to people using these areas in Hawthorne unit. They said this was because they were busy attending to the needs of those in the main lounge. The registered manager told us she planned to request funding for an additional care staff to address this issue during the peak period of the day. One person also commented that during the morning staff were not available in the lounge of Jasmine unit to assist people or respond to incidents. There was already an expectation a staff member was based in Jasmine unit lounge during the afternoons. The registered manager agreed to review staff deployment to enable this cover to be provided in the morning as well.

Potential risks to people were assessed and steps were put in place to reduce them using the least restrictive options. For example, if people were at risk of falls from bed, either raised bedrails or a lowered bed with a falls mat were considered with them or their representatives. Advice was also sought from the occupational therapist. If people at risk of falls were prone to getting up at night unaided, alarm mats were considered, which alerted staff so they could assist them. Risk assessments were regularly reviewed to ensure they reflected changes in people's wellbeing. People's risk of falls, nutritional and fluid intake and skin integrity were assessed as standard. The service had obtained other equipment to help keep people safe, including a chair alarm to alert staff when a person at risk of falls was getting up unaided. People were also safeguarded because regular checks and servicing were carried out on equipment, mains services and water temperatures. The registered manager monitored and reviewed incidents and accidents to identify any future learning or more effective approaches to reduce risk.

Creative ways had been tried to help people who displayed anxiety or could become agitated. For example, the use of 'doll therapy' had been very effective for two people. A significant reduction in the number of night-time falls by one person had been noted once they had been provided with a doll at night. Another person nursed the doll for much of the day, which helped to reduce their anxiety. Night staff working in the dementia unit wore pyjama style clothing to help orientate the people there to the fact it was night-time. They found this had led to a reduction in night time wandering and falls. A variety of actions had led to a significant reduction in the level of falls, from 54 in 2016 down to13 in 2017 for the same period.

The service had a robust recruitment process to check potential staff had the necessary skills and attitude to provide care for vulnerable adults. Feedback from two people within the service was sought as part of the recruitment process. Records showed the procedure was applied consistently and copies of the required evidence of the process were retained. Employment history was obtained, together with references and a criminal records check was completed. Potential staff signed a health questionnaire and received a range of documents describing their role and the expectations upon them. The registered manager had obtained appropriate information about agency staff from the supplying agencies where these had been used to cover gaps in the rota. Significant use of agency staff had been necessary in the period between May and August 2017, although the impact on consistency of care had been minimised by using four regular individuals familiar with the service. More recently, a successful recruitment drive and the end of the summer holiday period had meant the use of agency staff had been reduced to only one in the week of inspection. Five new staff were undergoing induction training, with a further two awaiting clearance to start work. Interviews also took place in the week of this inspection.

People's medicines were managed safely on their behalf by staff who had received training in managing and administering them. Good records were kept of the medicines given and those destroyed. The service used a nationally recognised monitored dosage system to manage medicines. This provided the service with most medicines pre-dispensed in separate labelled doses for the relevant times of administration. Where medicines were prescribed to be given "when required", people had individual protocols describing the appropriate circumstances for them to be given and how this should be done. Where there were best interest agreements for medicines to be given covertly, this had been appropriately documented and agreed with the community mental health team.

The service was clean and staff followed appropriate hygiene practice around infection control. Staff had attended or were booked to attend infection control and food hygiene training. The kitchen had a current rating of 5 from the local authority environmental health department, which indicated the standard of hygiene there was very good.

Good

Is the service effective?

Our findings

People and relatives told us the service was good and met people's needs. One person said, "Everybody is nice here. Staff treat me very well, it's a very pleasant place." A relative commented, "I've had no problems whatsoever, they have been really good. If [name] is happy, I am." They added, "[Name] seems really contented and settled in so well. They cater to all her whims." Another relative commented that some of the agency staff used in the past hadn't been as caring, but said, "The permanent staff get to know people well." Other comments included, "Overall I'd recommend the home in terms of the care they get," and, "Care is very good here. [Name] has improved since being here." One person told us, "I feel part of it. They ask about my support [needs] and get my consent." Another said, "They [staff] talk to me and get my consent. I'm asked what I need help with and they let me do what I can."

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. The service had records of best interest discussions where significant decisions had been made on people's behalf. Relevant people and professionals had also been involved. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)." The service worked in accordance with the legislation and had applied for DoLS where people's liberty was restricted to maintain their safety.

The service provided a varied four weekly menu with alternatives for main meals and additional options were offered if necessary. A new chef had recently been appointed following a period of negative feedback about the meals. This had led to increased use of fresh ingredients within meals and improved dietary intake, according to the registered manager. One person said some meals were, "Not appetising in the way they were served up. They need to take more care with serving." Others were more complimentary about the meals. One told us, "Meals are very good, tasty and enough, more than enough, sometimes." A second person said, "The food is lovely, I like the sausages." A relative said of their family member, "[Name] isn't a big eater, they will offer alternative meals. There are no food or fluids issues." Another relative commented that although the food had improved, meals at weekends were still not up to standard and they brought in treats themselves. The registered manager agreed to look into this and a meeting was booked to discuss this with the catering team. People were assessed for risks associated with food or fluid intake which was recorded where a concern was identified. The advice of dietitians and the speech and language therapy team had been sought where required. Dietary and fluid intake was also recorded for the first 48 hours for new admissions and for anyone with an infection. Weight loss was regularly monitored and meals routinely nutritionally fortified. Where excessive weight loss was identified, meals were additionally enhanced and additional snacks were offered. Coloured plates were used in the dementia unit. This was in line with studies that had shown they helped to focus people living with dementia on eating their meal. Some food-related images were also displayed there and tables were laid up with cloths and napkins. People were shown the

meal options plated up, rather than being asked to choose from a menu or a verbal description. Snacks and sandwiches were available outside of mealtimes and some people had one with their bedtime drink.

People's mental and physical health needs were assessed and care plans addressed identified needs, supported by advice from external healthcare specialists where necessary. Care plans took into account people's culture and any individual wishes or preferences. Appropriate technology was used to support people's care. For example adjustable beds, alarm systems, hoists, pressure relieving seating and mattresses. Regarding healthcare one person praised one of the nurses in particular, saying, "The nurse has got my leg better." A relative said, "They look after health well, will call GP and do hospital visits if I can't." Another relative said of the service, "In terms of nursing care, superb. They recognised [name's] condition, liaised well with the GP and tissue viability nurse, and turned wounds around." They felt their family member's mental and physical heath was now better than it had been for several years.

Staff received a thorough induction based on the nationally recognised 'Care Certificate' and shadowed experienced staff initially, before providing care directly. Competencies were assessed as part of the induction process. A series of laminated prompt cards had been purchased to remind staff of key messages around providing person centred care. A programme of ongoing training was provided with regular updates so all staff were aware of current practice and legal requirements. In addition, staff were provided with more detailed training in key areas such as stoma care, catheter management and dementia care. The home had purchased some virtual reality goggles and headphones which recreated the various impacts of dementia. They were used as part of staff training. This training had proved very impactful for staff in improving awareness of dementia. Their comments following the experience included, "I have never felt so vulnerable and helpless," and, "I felt powerless, waiting for someone to tell me what to do next." Staff received ongoing support via supervision and annual appraisals. The provider's expectation was for six supervisions and an appraisal per year. The registered manager said they were now running at about 95% compliance with this, having been behind previously. Supervision was shared between the management team and the nurses.

Improvements to the environment and furnishings had continued. Thirty new armchairs had been purchased which incorporated pressure relief cushions, and additional hoists and slings obtained. Redecoration had been carried out and a new extension had been built providing five new bedrooms, three of which were ensuite. Some carpets had been replaced, with others due for replacement in the next cycle. Bedrooms which had been unsuccessfully divided up previously, had been reinstated as premium single rooms, more suitable for the level of needs catered for by the service. One bedroom had been converted into a new wet room shower and disabled toilet and another was to be converted into a staff rest room. This would enable staff to take their allocated breaks in some privacy, which was more appropriate than them sitting apart from, but in view of people and visitors, in the communal areas. Additional alarm devices had been purchased to alert staff to falls or when people at risk of falls tried to get up unaided. When beds were replaced, the service ordered ones which could be height-adjusted to suit people's needs.

Development of the dementia friendly environment had continued, with improved signage, menu and orientation boards, sensory wall hangings and period items to encourage reminiscence. Some items such as hats, scarves and costume jewellery and a carpet sweeper were provided for people to interact with. Some toilets in the dementia unit did not yet have contrasting coloured toilet seats, risers or handrails to help people identify the toilet. Additional seats and risers were ordered during the inspection. Further work to paint handrails, doors or frames in contrasting colours was necessary to optimise the environment but this was in hand. Bedroom doors had the option of placing photos or other mementos in the memory frame to help the person recognise their room. The service referred to appropriate national guidance when making improvements to the dementia environment. An enclosed garden was available with level circular paved paths and raised planting beds. Up to eight people had been involved in helping to replant the area as part

of the 'gardening club'. A series of bird boxes were displayed which people had painted.

Good

Is the service caring?

Our findings

People and relatives said the staff were kind and caring and treated people well. One person told us. "The staff are gentle with me, my dignity is looked after, I'm very grateful to them." Another said, "Staff treat me very well, always gentle. I couldn't be in a better place." People told us they had no issue with their care being provided by the male staff. Another person described staff as, "Very kind, respectful and patient. They say, don't hurry." A relative commented, "The staff treat [name] well." Other relatives told us, "[Name] is happy, she likes the staff," and, "They make you feel welcome here."

We saw that the visiting hairdresser was still carrying out hair care in the Jasmine unit dining area, which was a potential health and safety issue. It also potentially impacted on people's dignity and comfort, given that we saw at least two people chose to remain in the dining area for much of their day. A more suitable venue for providing hair care would address these issues.

In other ways we saw staff respected people's dignity and privacy. Discussions about people were held away from communal areas or behind closed doors, Staff showed awareness of people's privacy and dignity by knocking on bedroom doors before entering. We saw staff adjusting people's clothing on their behalf to maintain dignity, where they would not necessarily be aware of this themselves. One person told us that when washing them, staff, "Use a towel to cover up for my dignity." People were asked where they wished to spend time and were offered simple choices within their capability, so they could make decisions about this and other aspects of their care. Records showed people were asked whether they had any preference about the gender of staff providing personal support and this was respected. Where people expressed a wish for the staff providing their care not to do so, they withdrew and another colleague offered to provide their support. People's files contained a life history document which had been completed in most cases in discussion with the person or their family. This information helped identify people's wishes and preferences so staff were aware and could meet them. Some people had completed plans regarding their end of life wishes too.

During our observations we saw staff greeted people cheerfully when they came into the lounge and people's faces showed they valued this acknowledgement. People were encouraged and reminded to eat their breakfast and offered a choice of drinks or snacks. Activity staff encouraged participation in gentle games and sat with people to engage them. When supporting one person to be more comfortable in the lounge, staff explained what they were doing before folding away their wheelchair footplates. They encouraged the person to lift their own feet to enable this. Another person was asked if they were happy for staff to move their zimmer frame out of the way, before this was done. A staff member moved the medicines trolley to enable a person who had just entered the lounge, to sit in their preferred chair which the person clearly appreciated. Staff responded quickly to the needs of people in the communal areas. When one person became upset, one of the activity staff immediately went over to offer reassurance which had a positive impact on them. The person was singing happily to themselves soon afterwards.

The registered manager said the service was seeking dignity champions from within the team to raise awareness and promote dignity in practice. Staff were approached during the inspection and agreed to take

on the role, with training to be provided. Members of the management team were also going to sign up for the training. The NHS Trust Care Home Support team were also due to deliver some dignity training to the staff team. One of the management team was a member of the local Dignity group which shared good practice between services. The service was signed up to the local authority dignity charter. A week in February was set aside to focus on discussion of issues surrounding the subject, to enhance staff awareness.

As part of maintaining dignity, people were enabled to maintain as much independence and manage their own care as far as they were able and wished to. Equipment was provided to assist them to do so. For example, plate rims were available to enable a person to continue to feed themselves. People were referred to external specialists including the occupational therapy and physiotherapy teams to obtain support to maintain their mobility. Talking books were available for those whose eyesight prevented them from reading. We saw staff offered to clean one person's glasses for them. People's spiritual needs were met through visits from a range of relevant clergy. Culturally and medically appropriate diets were available when requested and people's experience was enhanced because family were also encouraged to bring in appropriate foods and treats. One person who was fed via a tube directly to their stomach, had the option of having tasters by mouth for pleasure.

People at end of life were supported to be as pain free as possible and care plans referred to their wished when they or their representatives had been happy to discuss them. The service liaised effectively with external healthcare services to support their end-of-life care.

Good

Is the service responsive?

Our findings

People and relatives spoke positively about the flexibility and responsiveness of staff. One person said staff always responded quickly and added, "All the staff are good here." A relative told us, "They cater to all her whims." Another said the service kept the family in touch with any changes in wellbeing. A third relative was happy the service kept them informed and had supported their family member to a dental appointment when they had been unable to do so. One person was happy the service had arranged for a staff member to take them to an outside event when their family couldn't go with them.

People received personalised care that was responsive to their needs. People and their relatives or other representatives, where appropriate, were involved in planning their care. A relative explained how their family member's care plan had been discussed with them together. People's care plans noted where they retained the ability to carry out aspects of their own care as well as describing the degree of support they required.

People were supported to remain in contact with relatives and maintain other important relationships. A relative said they were always made welcome and encouraged to come in as often as possible. Relatives and friends were encouraged to visit and to bring in treats and other items for people. Relatives sometimes brought in culturally appropriate meals or other food treats. The recently appointed chef planned to discuss the provision of additional culturally appropriate meals within the menus as options for people to improve their experience.

People were provided with a range of activities and entertainment opportunities and encouraged to participate to promote integration and mobility. Those who declined to join in with group activities were provided with individual ones or staff spent time talking with them, to reduce the risk of isolation. One person said, "I prefer to stay in my room. The staff come and see me here." Another person told us, "I join in activities when I can." A relative said their family member, "Prefers to knit in her room, she's happy there. She comes down two or three times a week. It's her choice." One person said they were bored sometimes and wanted more exercise activities. A relative felt there was still room for improvement in activities provision. The service had a team of two full-time and two part-time activities staff. This meant activities were provided Monday to Friday and alternate Sundays. Additional Sunday cover would be provided if they successfully recruited to a further part time activities post.

The service had recently developed links with another similar service and people had visited there supported by staff, to attend concert shows and meals. People said they had very much enjoyed these outings. One of the activities team had met with their counterpart in the other home to share ideas for new events and entertainment. Another of the team attended meetings provided by the NHS Trust's 'Care home support' team, which also shared ways to provide physical and emotional stimulation. The service held monthly coffee mornings to which families and friends were also invited and people had been taken out one-to-one to visit a local cafe. Twelve people helped organise and prepare for the service's annual barbecue in August, which people told us they had enjoyed. People from both units had taken part in a photoshoot which led to the creation of a calendar for the service. This was subsequently sold to families to

help raise funds for further events. People had enjoyed dressing up for the photographs. Feedback about the improved activities provision within resident's meetings had been positive and the meetings had been used to inform people of upcoming events. Relatives commented positively about having seen staff sitting with people talking about the newspaper.

During the inspection external entertainment was provided one afternoon by a visiting singer/guitarist, which was clearly enjoyed by a number of people who were either singing or moving along with the music. He provided entertainment to the people in both units. The service had signed up to a youth project called "The Challenge". This had led to six visits from young people who spent time talking with people, reading, and put on shows to entertain people.

Some activities/entertainment was provided which was culturally relevant to individuals. For example we saw Reggae music was played for two people of Caribbean origin. It was evident both enjoyed this and one person was smiling and singing along to the CD. There was room for further development in providing culturally relevant events and activity.

People had access to a complaints procedure and issues raised had been addressed satisfactorily. One complaint had been made anonymously. In order that the complainant was aware of the resulting actions the registered manager made these known within the information available to visitors on arrival by the signing in book. One person said they had, "Not made any complaints, but would be happy to raise something if there was a need to." Another said they would raise it with staff or the manager, but hadn't had to make any complaints. A relative told us they had, "Not had to complain," but said they knew who to speak to if necessary. A second relative said, "I would feel able to raise any concerns if I had one." Improvements made as the result of complaints or other feedback included changes to the environment, improvements to the garden and car parking facilities.

Good

Is the service well-led?

Our findings

People and relatives felt members of the management team were approachable and listened to their views. They felt involved and consulted in aspects of the home's operation through the residents and relatives meetings and that their views about the service had been sought. The service had a statement of purpose and its aims and objectives were made known through policy statements and the service user guide.

The views of people and relatives had been sought about the service provided and they confirmed this. The most recent survey had been carried out in April 2017. A summary report identified any issues raised, mostly around catering and activities and how these were addressed. Comments were made about the loss of light in one of the lounges, due to the building of the extension. Mural paper with woodland scenes had been placed in the alcoves where the windows had been, to try to distract from the loss of the windows. Consideration was being given to the provision of additional skylights to make up for the loss of natural light. Questionnaires had also been sent to external professionals in March 2017, but none had been returned.

The management team monitored the day-to-day operation of the service through regular daily walk-arounds, staff observations as well as using a variety of monitoring and audit systems to maintain an overview. Regular audits included those on nursing care, catering and housekeeping and each noted any necessary actions. Members of the management team had carried out unannounced out-of-hours visits to monitor care. Daily discussions took place between senior staff where any concerns, issues or appointments were discussed. These took place at morning handover, while night staff were still present. The registered manager said staff would report concerns about care practice and challenged each other if they had concerns. Relatives also reported any issues of concern to management. In order to increase the understanding of senior care staff about their role, each had attended a course about their responsibilities in the previous 12 months.

Governance within the service was in place and effective. However, there was limited evidence of monitoring with regard to governance by or on behalf of the registered provider. The registered manager told us a new nominated person had been employed by the provider who had visited the service once during a social event although no report had resulted. Following the visit, tracking files had been established to monitor falls, infections and hospital admissions. The registered manager thought the new nominated person planned to carry out periodic visits to meet the expectations of provider level governance. The service had a development plan and annual business plan which were made available to people and relatives within the information folder in the entrance hall. The accidents audit showed effective strategies had been put in place to reduce accident levels and the risk of resulting injuries.

The views of staff were sought through a survey and six monthly, minuted staff meetings and staff received more regular supervision and appraisal than in the past. Monthly meetings also took place with the nursing staff to discuss clinical issues. The registered manager told us staff morale had been low previously but had improved more recently. She felt this was due to improved consultation with and involvement of members of the staff team, which had led to them being more open to new ideas. Such things as giving staff additional

responsibilities as 'champions, had also contributed to this. The role of champions was to take the lead on promoting their particular area of responsibility within the team. A staff member told us the service was developing and had made, "lots of progress." They felt that, "Overall management support was very good," and said staff, "Were involved in decision-making."

Incidents of concern and accidents were monitored to identify patterns and creative ways had been tried successfully to reduce accidents due to falls. For example, through the use of doll therapy to reduce one person's restlessness and wandering. Following this success the service had ordered more dolls and a book on doll therapy to inform staff about the technique.

Links with the local community and other external resources had been strengthened since the previous inspection. There were plans to increase the involvement with outside resources and share good practice between local care services. For example, the service had signed up to 'The Challenge', a programme which involved young people in spending time in care homes with people to their mutual benefit. This had proved very positive. The activities team had made links with another local care provider. The advice of the NHS trust Care home support team had been sought as well as that of district nurses and other health professionals.