END OF YEAR SERVICE REPORT
For: Willerfoss House Residential Care Home

2018 – 2019

Denestar Limited, G15, The Bloc, Springfield Way, Anlaby,
East Yorkshire, HU10 6RJ. TEL: 01482 651028

CONTENT

Section:

1. Definition and interpretations.

1. **Quality Assurance Calendar & Framework -** details how we comply with regulation 17 (good Governance) of the H&SCA 2008 (Regulated Activities) Regulations 2014. The calendar and framework illustrates who is responsible and how we plan and action the monitoring of our service delivery, gather feedback from people who use our service, their friends/advocates, visiting professionals, staff and any other stakeholders over the 12 months period.
2. **End of Year service report schedule -** is a record of the criteria, objectives, action plan and results of the findings used to measure the service delivery of the named care home for the period listed. This information correlates directly with the 5 domains of the regulator (CQC) and details what we set out to do to improve our service during the preceding business year. Our results/observations details where we have made improvements, maintained the level of service and where we need to improve or make changes to our service delivery.
3. **End of Year evidence summary** – this summarises the findings of each of our survey questionnaires that we send throughout the year to the people who use our service, their friends/advocates, visiting professionals, staff and any other stakeholders. The report also includes a summary of the audits we carry out throughout the year
4. **Analysis Data summary** – this illustrates specific risk areas of regular monitoring to identify any additional changes to any part of our service delivery which may be required. The data is input daily, weekly and monthly and gives us the opportunity to act swiftly if we identify an increase of any potential danger or harm incidents to our service users.
5. **Summary Graph** – is an overview by percentage of the findings of people's feedback. Each survey result is collated and measured against performance criteria. Managers then develop a findings report based on the percentage of satisfaction. All of this information is broken down into the key areas of the graph to identify from people's feedback the % level of satisfaction of the service we deliver.

Acronyms:

CCG	CQC	DOL	DN	EOL	GP	H&S	HR	LA	MCA	MD	OD	QA	SFC
Clinical Commissioning Group	Care Quality commission	Deprivation of Liberty	District Nurse	End of Life	General Practitioner (Doctor)	Health & Safety	Human Resource	Local Authority	Mental Capacity Act	Managing Director	Operations Director	Quality Assurance	Skills For Care

DENESTAR LIMITED QUALITY ASSURANCE FRAMEWORK

AGREED STANDARDS

HEALTH & SOCIAL CARE ACT 2008 – (Regulated Activities) Regulations 2014

Key areas of monitoring

- Safe
- Effective
- Caring
- Responsive
- Well-led

Regulation 4: Requirements where a service provider is an individual or partnership (5&6 do not apply to this service)
Regulation 7: Requirements relating to registered managers
Regulation 8: General
Regulation 12: Safe Care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 15: Premises and equipment
Regulation 18: Staffing

Regulation 11: Need for consent
Regulation 14: Meeting nutritional and hydration needs
Regulation 20: Duty of candour
Regulation 18: Staffing

Regulation 9: Person centred care
Regulation 10: Dignity & Respect
Regulation 19: Fit & proper persons employed

Regulation 9: Person centred care
Regulation 16: Receiving and acting upon complaints
Regulation 17: Good governance
Regulation 18: Staffing

Regulation 4: Requirements where a service provider is an individual or partnership (5&6 do not apply to this service)
Regulation 7: Requirements relating to registered managers
Regulation 8: General
Regulations 12 – 22A of the Care Quality Commission

- S1 – Safeguarding and protection
- S2 – Appropriate risk management
- S3 – Suitable staffing arrangements
- S4 – Safe use of medicines
- S5 – Prevention & control if infection
- S6 – Reflective practise & MSP
- H&S - Monitoring & reviews
- Registration of service
- Registration of Manager

- E1 – Effective, consensual care delivery by competent staff for effective outcomes
- E2 – staff skills, knowledge & experience
- E3 – Nutrition and hydration needs & support
- E4 – Collaborative working with Health Care Providers
- E5 - maintenance of good health and access to healthcare services
- E6 – Adaptation, design and decor to meet individual needs
- E7 – Consent to care & Lawful decision making

- C1 – Positive and caring relationships
- C2 – Involvement in decision making
- C3 – Promotion of privacy and dignity

- R1 – Individualised, responsive care
- R2 – Listening and learning from experiences, concerns and complaints
- R3 – End of life support, for a dignified, comfortable & pain free death.

- W1 – Promotion of an open, inclusive & empowering culture, for the best outcomes for people.
- W2 – Demonstration of good governance, management and leadership, measured by quality performance, regulatory & risk management
- W3 – Engagement of stakeholder involvement (residents, staff, public etc.,) to measure the quality care
- W4 – continuous learning& improvement
- W5 – working with other agencies

- S1 – Safeguarding and protection
- S2 – Appropriate risk management
- S3 – Suitable staffing arrangements
- S4 – Safe use of medicines
- S5 – Prevention & control if infection
- S6 – Reflective practise & MSP
- H&S - Monitoring & reviews
- Registration of service
- Registration of Manager

- E1 – Effective, consensual care delivery by competent staff for effective outcomes
- E2 – staff skills, knowledge & experience
- E3 – Nutrition and hydration needs & support
- E4 – Collaborative working with Health Care Providers
- E5 - maintenance of good health and access to healthcare services
- E6 – Adaptation, design and decor to meet individual needs
- E7 – Consent to care & Lawful decision making

- C1 – Positive and caring relationships
- C2 – Involvement in decision making
- C3 – Promotion of privacy and dignity

- R1 – Individualised, responsive care
- R2 – Listening and learning from experiences, concerns and complaints
- R3 – End of life support, for a dignified, comfortable & pain free death.

- W1 – Promotion of an open, inclusive & empowering culture, for the best outcomes for people.
- W2 – Demonstration of good governance, management and leadership, measured by quality performance, regulatory & risk management
- W3 – Engagement of stakeholder involvement (residents, staff, public etc.,) to measure the quality care
- W4 – continuous learning& improvement
- W5 – working with other agencies

Audit tools: induction, training matrix, supervision, appraisal, staff handbooks, resident, staff etc., surveys, survey reports, residents meetings, staff meetings, reviews. Risk assessing, appropriate care planning. Medication audits, medication competencies. H&S monitoring and reviews.
Collate information from these tools, report findings and plan action required – including timescales and responsibilities, plus outcome

Key areas identified for improvement are:

Audit tools: pre-assessments, consent evidence, care files, risk assessments, food and diet monitoring and recording, health care record checks (monthly care file checks), residents meetings and surveys.
Collate information from these tools, report findings and plan action required – including timescales and responsibilities, plus outcome

Key areas identified for improvement are:

Audit tools: training matrix, supervision & appraisal, individual SU assessments, capacity training, capacity assessments, EOL training, EOL assessments (optional). Surveys (residents, staff, families, outside agencies), residents meetings, staff meetings, reviews.
Collate information from these tools, report findings and plan action required – including timescales and responsibilities, plus outcome

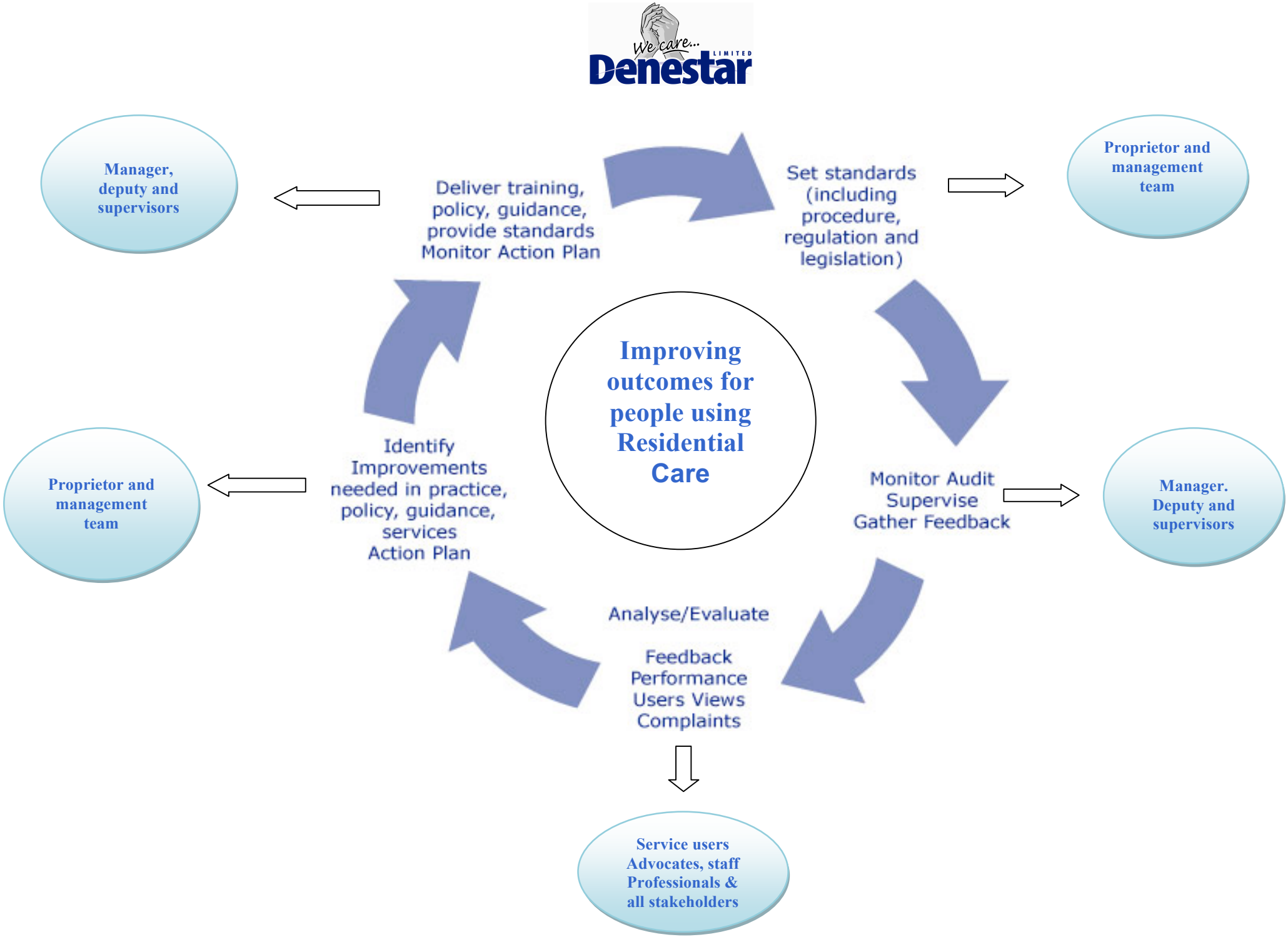
Key areas identified for improvement are:

Audit tools: individual assessment and care planning, with consent and or best interest, pro-active approach to complaints, concerns and requests. Surveys, meetings and reviews. Staff meetings, staff training, hospital/care transfer forms
Collate information from these tools, report findings and plan action required – including timescales and responsibilities, plus outcome

Key areas identified for improvement are:

Audit tools: Managers weekly monitoring function, senior managers audit function, , on-going training and development, appraisals, managers meetings.
From each of the above functions an end of year service report is developed by the provider to determine all shortfalls and achievements from the year and then forward planning - by way of an annual business plan - is then developed from the findings of the EOYSR.

See final end of year service report and business plan for Year:


Manager, deputy and supervisors
Deliver training, policy, guidance, provide standards Monitor Action Plan
Set standards (including procedure, regulation and legislation)
Proprietor and management team
Improving outcomes for people using Residential Care
Identify Improvements needed in practice, policy, guidance, services Action Plan
Monitor Audit Supervise Gather Feedback
Proprietor and management team
Manager. Deputy and supervisors
Analyse/Evaluate
Feedback Performance Users Views Complaints
Service users Advocates, staff Professionals & all stakeholders

Willerfoss House Residential Care Home
6 Victoria Avenue, Withernsea, East Yorkshire, HU19 2LH
T: 01964 614290 **F:** 01964 614290 **E:** willerfosshosue@denestar.co.uk www.denestarltd.co.uk

END OF YEAR SERVICE REPORT SCHEDULE - April 2018 – March 2019

CRITERIA

❖ Safe:

Regulation 4: Requirements where a service provider is an individual or partnership (5&6 do not apply to this service)
Regulation 7: Requirements relating to registered managers
Regulation 8: General
Regulation 12: Safe Care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 15: Premises and equipment
Regulation 18: Staffing

OBJECTIVES

a) **>** Thorough and effective recruitment, induction, training, supervision, appraisal, monitoring, rota planning and disciplinary procedures.
b) **>** Training covers; safeguarding (including whistle blowing), equality & diversity, dignity & respect, manual handling, food safety, health & safety, fire safety, medicines, infection control, dementia, MCA, DOL, end of life and many more.
c) **>** Assessing & managing risk,
> person centred care planning,
> involvement and consent,
> rapid response procedures to medical/health emergencies,
> good relations with external health agencies,
> internal and external notifications policy.
d) **>** Approved suppliers and maintenance contracts,
> effective H&S checking procedures,
> effective fault reporting procedures,
> access to management team at times of crisis, effective emergency procedures and instructions.
e) **>** Open & transparent approach to complaints – active in promoting the value of complaints to give the opportunity to improve;
> effective complaints/concerns procedures to ensure people feel comfortable in making a complaint with positive actions/outcomes,
> various opportunities given to all involved (residents, families, friends, advocates, staff, GP's, DN's care professionals) via, QA questionnaires/surveys, anonymous suggestions box, complaints pack at entrance, staff meetings, staff supervision, residents meetings, residents reviews,

ACTION PLAN

1. Manager to continue using the daily managers monitoring tool and weekly managers bible - which covers/includes all criteria within the 'safe' domain. Completed monitoring form to be sent to head office every Monday morning for compliance checking and action planning with respect to requirements and regulations within this criterion.
2. Operations Director to ensure the review all care files and monitor assessing procedures (which include capacity assessments and best interest involvement evidence) and ensure compliance with current legislation and issue to the manager for filtration through the staff group; newly monthly home audits and weekly ops reports.
3. Manager to ensure that the business plan is implemented throughout the staff group, that there is a comprehensible audit trail of findings and evidence of improvements made (QA audit reports)
4. Person centred care planning/delivery training to be undertaken by all staff and completed by end of the QA year
5. All new staff to undergo revised Induction training and ensure understanding of SFC code of conduct
6. Weekly audits of care plans are carried out by managers to ensure recording of any changes or special requests made by residents with regards to their individual care needs.
7. Welcome packs to be issued to all new residents with details of involvement along with consent requirements
8. Manager to ensure that regular supervisions (either 1:1 or group) are carried effectively through the year to ensure development and support of workforce
9. MO to ensure that external H&S checks/monitoring and certification is completed on time.
10. RM to introduce a verbal response system for comments/feedback made from visiting professionals who are time restricted to complete surveys

OBSERVATIONS/RESULTS

1. From date of implementation, the management team has continued to send the monitoring tool to head office every Monday morning , highlighting issues required for resolve or shortfalls requiring attention – care plans are identified as requiring review and more staff supervisions need to be undertaken
2. Care files inspections are now undertaken by the Ops Director, the new inspection processes have had a positive outcome on service users and stakeholders involved in care delivery. On the whole, care plans are audited and checked regularly, there are some improvements required, but all major needs and changes to people's needs are recorded and staff will now take a gradual ownership of the full care planning requirements
3. Manager needs to demonstrate, via supervision and staff meetings, that the business plan is being implemented and shared with the staff group to identify needs and changes in delivery of service. Results of which are reflected in the evidence of QA audit reports (summary of findings attached)
4. Feedback information from Residents, families, staff and external agencies identify that there are no reported issues on safety, that the service is person centred and care plans/delivery of service reflect this. Feedback suggests that people feel safe, are safe and that the manager undertakes the appropriate measures to ensure safety across the regulation and within her remit as the home manager – see analysis charts at the end of this report.
5. Care plan reviews and audits continue on a daily basis as and when needs change together with the implementation of a more robust internal compliance review (2 day monthly full monitoring visit covering all regulations)
6. There is no evidence available to suggest that everyone received a welcome pack. However, consent is sought as practise as and when applicable
7. Supervisions information (feedback, questionnaire responses and staff retention) evidences that staff are very well supported and developed. Additionally, IIP has been retained in this business year and will be reviewed in 2020.
8. There were no out of date requirements for external safety checks and all required actions are completed at the time of this report; these are now checked at monthly home audit via the Ops Director responsibility.
9. The manger continues to obtain verbal comments/feedback for entry into the comments book - regardless of nature. People are always offered the full complaint procedure if negative feedback is given; although our complaints survey resulted in having received no complaints this QA year.
10. The manager has implemented an analysis report to identify a quick overview of falls, hospital admissions, staff performance to ensure that any common themes are picked up and acted upon swiftly. ***See analysis findings at the end of this report***
11. Reflective practise has been instrumental throughout the year across the group to share good practise and identify system failings

CRITERIA

❖ **Effective**

Regulation 11: Need for consent
Regulation 14: Meeting nutritional and hydration needs
Regulation 20: Duty of candour

OBJECTIVES

a) **>** pre-assessments undertaken to ensure that individual needs can be met;
> trail days/visits are encouraged to ensure that prospective service users can make an informed decision about moving into residential care;
> capacity assessments undertaken to ensure that any fluctuating capacity can be supported which does not result in choice being taken away;
> individual needs assessments carried out to identify areas of support required;
> best interest decisions made with appropriate people in the event of a capacity issue; consent sought and evidenced in care files
b) **>** MCA training and access to information (5 core principles) entrenched in staff care delivery ethos;
> supervision/appraisal focus on all aspects of requirements to deliver an effective service for the benefit of each individual resident;
> training programme is considered at each supervision and managers meetings to identify shortfalls
c) **>** Team leaders undergo specific training to deal with medicines and working direct with GP's, DN's pharmacies etc., to ensure that residents are supported with their health care needs;
> systems are in place to ensure that residents have access to any medical professional and thorough recording system to evidence this practise is retained in care files.
d) **>** assessments for nutrition and hydration are carried out and plans developed with the resident/advocates to ensure nutrition and hydration needs are met; these include a swallowing assessment and choking risks;
> care plans are shared with kitchen staff to ensure safety;
> people who are assessed as requiring monitoring for food and fluid intake give consent for monitoring of intake and weight monitoring;
> wherever deemed necessary –through raised concerns – external professional intervention is sought and records kept of care referrals in care files.

ACTION PLAN

1. Managers to ensure there is an auditable trail of actions and outcomes for any service users who present, or are at risk of not receiving consented, personalised treatment and support
2. Safeguarding adults subject to be discussed at all staff supervisions to ensure understanding of the different constitutions of abuse
3. Managers to ensure that outside agencies are offered sufficient opportunities to obtain views of the people involved in our service delivery
4. Managers to keep an auditable trail of information provided by outside agencies along with plans of actions and outcomes recorded accordingly and individually in care plans (QA surveys, reports and action plans)
5. Staff receive training in all areas of the training matrix and managers ensure that training is kept up to date to ensure the quality of service delivered by competent staff.
6. Team leaders oversee, on a daily basis, the implementation, recording and service delivery to ensure pressure care, nutrition and hydration, medical attention and all/any service user needs are met

OBSERVATIONS/RESULTS

1. A 12 month programme of staff training on personalisation, quality monitoring and improvements and the introduction of legislation training; the introduction to a revised Induction process with increased training has helped staff knowledge with this subject, but this training must continue and all new staff must commence the programme on the 1st day. However, the manager & her deputy are both very proactive in obtaining, booking & requesting training to ensure that training is current and up-to-date
2. Safeguarding adults training is identified at inspection to staff files. The Manager records the different areas of abuse/neglect which is discussed at supervision.
3. External agency feedback suggests that the service is effective and no issues or complaints have been received. Feedback was very positive and complimentary
4. QA demonstrates active compliance to the monitoring of the service delivery by the home manager &
5. All staff undergone Nutrition training. Nutrition Champion elected to positive outcome for service users. Training matrix up-dated monthly.
6. Records & CQC inspection report evidence that the service delivery is effective
7. Summary of QA includes all notifications which demonstrates compliance with Reg 20 (Duty of candour)

CRITERIA

❖ Caring

Regulation 9: Person centered care
Regulation 10: Dignity & Respect
Regulation 19: Fit & proper persons employed

OBJECTIVES

a) **>** Thorough and effective recruitment, induction, training, supervision, appraisal, monitoring, rota planning and effective disciplinary procedures.

b) **>** Team leader training; encourages empowerment and 'Lead by Example' ethos;
> resident's choice options: - meeting questionnaire; staff selection; QA questionnaires; reviews;
> 1:1 key working; open and transparent operation from MD through the staff group to operate with care and compassion putting people's needs at the forefront of everything we do.

c) **>** policies and procedures, reviewed and up-dated annually and in accordance with legislation changes
> staff operational handbooks (SFC Codes of Conduct, CQC guidelines, SFC Care Certificate Standards),
> open ethos on complaints and concerns

d) **>** optional End of Life planning.
> Management attendance of EOL training and planning with LA's

ACTION PLAN

1. Managers ensure that new recruits are recruited in accordance with company policies and procedures, following the organisational & CC induction process
2. Managers ensure that each staff undergo the appropriate training for their individual posts and complete 2 week induction training before shifts commence
3. Managers ensure that all service users have an appropriate risk assessment completed to protect them from harm
4. Only those staff who are qualified and named to administer medications do so.
5. Managers complete weekly medications audit and act swiftly and appropriately to any anomalies
6. Managers ensure that safeguarding training is incorporated into supervisions.
7. Managers carry out regular infection control audits and ensures compliance in this criteria
8. The provider to obtain regular surveys on H&S, internal and external property maintenance from the maintenance operative

OBSERVATIONS/RESULTS

1. Revised Induction training has been implemented by group training manager & Ops director and continues to be effective; new staff undergo thorough checks and are issued with Op books detailing the law, national & operational requirements; these tools are used at supervision. Evidence indicates that this practise is thorough and effective
2. Training planners sent to head office every month, checked and shortfalls identified and training booked in; manager & CTM are very proactive with training
3. Service users risk assessments are checked at inspection for compliance anomalies and omissions rectified – now being reviewed/checked monthly.
4. Medications audit carried out in accordance with MMR (Managers Monitoring Report) and checked at inspection – details sent to OD weekly with Ops info.
5. Operation details are sent to HO every week with Managers bible (MMR) info – managers highlight and address any anomalies
6. Manager includes safeguarding at supervision, evidence suggests that this subject is constantly addressed to ensure understanding & compliance. New supervision processes have improved the supervision outcomes for both staff and service users (see Reflective Practise info in the home)
7. Managers send IC audit to HO as applicable/requested - and in the event of any breakout
8. Surveys checked at QA schedule times and incorporated in the End of Year Summary of Feedback report

CRITERIA

❖ Responsive

Regulation 9: Person centered care
Regulation 16: Receiving and acting upon complaints
Regulation 17: Good governance
Regulation 18: Staffing

OBJECTIVES

a) **>** individual needs assessed and plan developed to meet the assessed needs;
> staff training (personalised care);
> key working programme;
> a strong ethos throughout our service delivery of CHOICE! CHOICE! CHOICE!!
b) **>** activity programme that covers a wide spectrum of group, internal & external and individual fulfilment opportunities;
> clubs (baking, reading, housekeeping, arts & craft etc.,);
> residents meetings to plan activities menu's etc..
>dedicated activity coordinator to ensure individual needs are met.
c) **>** open and honest approach to complaint handling which is disseminated through the staff group to ensure people feel that complaining or bringing a concern is a positive process;
> Residential forum followed to ensure correct staffing levels
> clear and concise management of complaint handling and reporting;
> publication of outcomes in our service info provided at entrance to the home;
> end of year service report detailing outcomes for the last year and plans for forthcoming year

ACTION PLAN

1. Care plan developed with each individual; specific to their needs to demonstrate individual needs of service users in order for staff to have a good understanding of how to meet people's needs in the way they chose for them to be met (or in their best interest in accordance with the MCA)
2. Staff to undergo foundation and continuing training on all subjects of the training matrix
3. Manager and leaders to lead by example to ensure that choice, dignity & respect is upheld by all involved in the service delivery
4. Complaints policy and procedure and all associated processes to be adhered to and manger to ensure that all complaints – in whatsoever nature – are reported to head office immediately
5. Managers to ensure that all areas of the QA are completed accurately and are effectively operated to identify and ensure constant improvement to the service (this includes Reflective Practice process).
6. Managers ensure a system of supervision and development to support staff to continue to improve the service we deliver

OBSERVATIONS/RESULTS

1. There is evidence to suggest that staff knowledge about the content of care plans and the need to follow and up-date them has significantly improved.
2. Evidence suggests that the company induction and continuation training programmes are effective; which results in staff being competent to carry out their roles.
3. There is clear evidence that manager/deputy and leaders lead by example and cascade their own knowledge throughout the staff group; evidenced in practise and at Internal compliance reviews/Monthly Home Audits.
4. Complaints information submitted at the end of the year suggests that the 'open door' policy is effective and that there are no persistent or recurring complaints. There have been no complaints in this business year, indicating that the open door policy is working well and people feel able to approach management with any concerns
5. QA, on the whole, appears to be complied with; specifically that views are sought from residents and stakeholders. ***See analysis info within this report***
6. Supervisions are mostly on target and evidence suggests that staff receive plenty of support and development through supervision, appraisal, one to one and regular staff & team meetings; significantly, teh IIP has been reviewed and retained again within this business year – July 2018.

CRITERIA

❖ **Well Led**

Regulation 4: Requirements where a service provider is an individual or partnership (5&6 do not apply to this service)
Regulation 7: Requirements relating to registered managers
Regulation 8: General
Regulations 12 – 22A: of the Care Quality Commission (Registration) Regulations 2009

OBJECTIVES

a) **>** Registered home managers continuity and commitment to continuous training;
> home manager promotes and 'open door policy' ensuring everyone and anyone feels comfortable bringing concerns and complaints to the manager;
> HR procedures to ensure that confidentiality is maintained when disciplinary action is required;
> access to specialist employment law advisors who guide through processes of disciplinary or grievance issues;
> comprehensive and supportive supervision and appraisal process;
> commitment to 'Investors In People' programme

b) **>** strong and effective management team led by the MD; with a circular (wheel style) organisational structure, illustrating the value of each person involved in the service delivery without hierarchy;
> precise accountability within each stream of leaders to ensure the company ethos of an open, honest and transparent operation flows throughout the organisational structure;
> team leader training provided to all leaders; **>** hands on management team;
> regular meetings with team leaders, and managers to share good practise within individual homes and across the group;
> company aims and objectives follow government initiatives and are published and shared with the staff group through QA and End of Year Service Reports.

c) **>** Comprehensive QA programme developed to meet the set 'Agreed Standards' (Fundamental Standards);
> daily managers bible guide to ensure all aspects of quality of service is addressed/assessed and monitored.

d) **>** MD direct links to Care Association and other providers/CCG & LA sharing best practise guidance and initiatives;
> MD board member on the East Riding Safeguarding Adult Board
> strong links and active support to the LA training programme and Care Home Forum workshops/safeguarding events attended by managers and MD

e) **>** Policies covering all aspects of care deliver, H&S and HR (employment law);
> effective management and our open ethos encourages people to feel confident that they will be supported should adverse information be required to be shared;
> staff are encouraged to embrace adverse information from others as an opportunity to improve;
> staff have feedback opportunities at staff meetings as well as in private 1:1 with managers, CTS's or TL's.

f) **>** Descriptive and comprehensive Job Descriptions; **>** staff operational handbooks; **>** staff handbooks; **>** specific supervision criteria;
> Notifications policy (internal & CQC);
> 'no secrets' instilled across the staff group from management through all scales of staff.

ACTION PLAN

1. Provider and manager will ensure that an appropriate and adequate quality monitoring programme is in place, is followed, is effective and actions taken in a timely manner
2. The manager will ensure that each new service user receives a copy of the company Welcome Pack detailing everything about the care home and how we operate , including the company complaints policy and how to access, Social Services and the Commission
3. The manager will ensure, by way of internal notifications policy, that the provider is notified of ***all*** incidents, accidents and events which may require the involvement of other agencies to protect the service user/s
4. The OD will ensure that a log of notifications is kept, monitored and audited annually to determine any re-occurrences, failings or areas for improvement
5. The manager will keep a record of all concerns and complaints and log, in accordance with the company policy and procedures on complaints, will act accordingly and positively to any concerns or complaints and will seek the support/advice of the provider on any recurring concerns or complaints.
6. The manager to ensure that individualised care plans are kept and that all information therein is kept confidential and only shared with appropriate persons in an appropriate manner, in accordance with the company policy on confidentiality and sharing of information.
7. Provider to send appropriate notifications to the commission of those subjects as detailed within the H&SCA 2008 (Regulated Activities) Regulations 2014
8. Manager to ensure that appropriate and effective supervisions, personal development and appraisals are carried out to support the staff group to continually strive to improve the quality of service
9. Manager to ensure that all new staff members are equipped with both the Staff Handbook and Operational Handbook; which details CC standards, CQC guidance on meeting regulations, SFC codes of conduct & MCA principles
10. Manager to ensure that all new staff sign a declaration of receipt of 'tools' to do the job

OBSERVATIONS/RESULTS

1. Evidence of the QA programme is detailed within this report.
2. There is no information provided to evidence that new service users have received a welcome pack – managers must send completed contracts to HO without exception.
3. Evidence is now provided to ensure that the manager has notified the OD of ***all*** incidents, accident and or events which may require the involvement of outside agencies other than seeking views from the CQC. – New QA procedures has ensured that evidence is provided to the OD via weekly Ops report and the notifications summary within the QA process.
4. The evidence available suggests that there are no patterns to incidents or concerns/complaints about the service delivery. All notifications have been sent to HO and have been logged by the manager and dealt with in accordance with company policy
5. Complaints log identifies that there have been no complaints received. However, the Reflective Practise content (viewed at Ops Director review) identifies that areas for improvement are dealt with in accordance with company policy satisfactorily and thereafter shared with other homes within the group to ensure continuity of care provision across the homes.
6. Evidence – at care plan audit – suggests that all care plans are personalised, confidential, stored correctly and information about people who use the service is shared in accordance with company, local and national guidance. This subject is also audited at monthly home audits by the OD.
7. All notifications sent to the Commission and a record of notifications kept at HO.
8. Evidence suggests that the supervision, personal development and appraisal system is being effectively managed.
9. Evidence suggests that all staff are equipped with the correct information at the start of their employment and that it is used through supervision and continual development process.
10. Evidence seen at Internal Compliance Review (2 day monitoring visit) that new staff have signed receipt of Operational handbook and Induction

Signed: 

Print: Mrs Gaynor Saunders

Date: 4th April 2019

Position: Managing Director

END OF YEAR SERVICE REPORT EVIDENCE SUMMARY

Please detail below, the results of feedback surveys, meetings & summaries of QA to identify any common themes, actions and evidence to support that people have been listened to and supported for improvements to service.

Evidence Criteria	Evidence Summary/Findings	Evidence Actions Completed
April: 1. Families, Friends, Advocates: The Home & service delivery 2. Residents: Care Plans, Key Working & Activities 3. Staff supervisions (overview)	1. 100% positive result. The feedback from family was excellent with comments such as "first class" 2. 100% positive feedback - 18 surveys received back completed. Activity coordinator WMN assisted with residents and recorded their responses – enjoyed activities – offered different things – residents knew how to make a complaint and who to tell	1. No actions required 2. No actions required 3. support required to complete overview
May: 1. Overview of resident reviews (SS or private/in-house) 2. Internal safety survey 3. Staff meeting (overview) 4. H&S review	1. Evidence found from previous manager showed positive feedback from the reviews- no further comments found – no further concerns 2. Training not up to date – inductions not signed off 3. General positive feedback – weights not being completed on time – room checks not completed – supervision dates implemented 4. Not completed	1. No actions required 2. CTM currently addressing training and is booked in 3. CTM to carry out staff audit 4. 4. Ops Director to complete
June: 1. Outside agency survey 2. Residents: food & drink 3. Residents meeting (overview) 4. overview of managers monitoring	1. Surveys were issued to 10 outside agencies including the Homes hairdresser, GP's, DN's, Physiotherapist, Social worker, Trade supplier, Chiropodist and the Optician. Only 2 returns were received, both positive and there have been no concerns or issues reported by other professionals 2. 18 service users have the capacity to understand, weigh and make decisions about the questions asked in this survey 100% gave positive feedback with 22% additions:- On the whole the responses indicate that service users are happy the food and fluid intake service delivery. However 4 people made comments that they felt they did not get the opportunity to make changes to the menu –see managers comments 3. completed 09.01.19 – residents happy with staff, changes to menu, wanted a pet, outdoor activities, not happy with singer 4. completed 09.01.2019	1. Given that 100% of respondents indicated a positive response to this survey and none left any specific comments for any actions no actions can be determined. 2. 22% of residents (4/18) require additional support (daily) to ensure that they have full opportunity to be involved with menu planning 3.changes to menu implemented, X2 budgies purchased, church service organised 4. currently working with CTM as of 2019 as the new registered manager working to get all targets up to date – current ongoing process

Evidence Criteria	Evidence Summary/Findings	Evidence Actions Completed
July: 1. Staff: codes of conduct, whistle blowing & transparency 2. Residents: Safeguarding 3. Care file audit	1. Surveys were issued to all 27 staff members -100% of respondents indicated a positive response to this survey and left no specific comments for any actions 2. 10 of the service users have the capacity to understand, weigh and make decisions about the questions asked in this survey - 100% reported to be happy & said they feel safe and protected from any potential harm 3. Refer to MMR – Audits indicate improvements are required regarding up-dating and staff understanding	1. No action required 2. No Action Required 3. Staff training planned in for full staff group to take ownership of care plans for people to whom they key work
Aug: 1. Residents: privacy, dignity & choice 2. Staff: training, policies & procedures 3. Staff file audit 4. Training matrix	1. 100% of responses indicate that people are happy that their privacy, dignity and choice is maintained daily 2. Given that 100% of respondents indicated that Service users are cared for by a competent staff group, who receive full support and training in order to effectively meet their needs. Staff are trained to a minimum NVQ level 2, respondents are fully supported by company polices which meet current legislation. Where policies are specific to safeguarding adults, these are revisited at supervision and as regular as the need permits and respondents are fully conversant with the correct procedures within the home and how to deliver their duties effectively. Staff are monitored, supported and developed to ensure that they have the skill to follow the correct procedures at all times. 3. Staff files all up to date & compliant with Reg 19 4. Training needs identified	1. – No comments were made about areas of improvement so on this occasion no changes can be made to the service delivery. 2. Respondents have made no comments with regards to any required improvements or any opinion about how we could improve training, policy or procedures 3.CTM carries out weekly checks on all files 4. Booked in and ongoing
Sept: 1. All stakeholders: complaints 2. H&S checks 3. Staff: care plans, key working & activities	1. No complaints have been received this business year 2. All checks completed and audited weekly– occasional anomalies identified and rectified in a timely manner without posing any risk to service users 3. Evidence indicates that 100% of respondents have a good knowledge of care plans, key working and activities. One or two comments made from staff about spending more leisure time with service users.	1. No action required 2. No action required 3. Staff to be educated on the Care Hours Forum and how time is worked out and funded
Oct: 1. Medication audit 2. Infection control audit 3. Managers overview 4. Resident meeting (overview)	1. BNF not up to date 2. completed by JLC 09.01.2019 3. completed 09.01.19 4. completed 09.01.19 – residents happy with how their feedback has been listened to and acted upon.	1.BNF – right breath app and BNF app for all TL's 2. Require up-date from OD to identify any actions required 3. Action plan required 4. No further action required

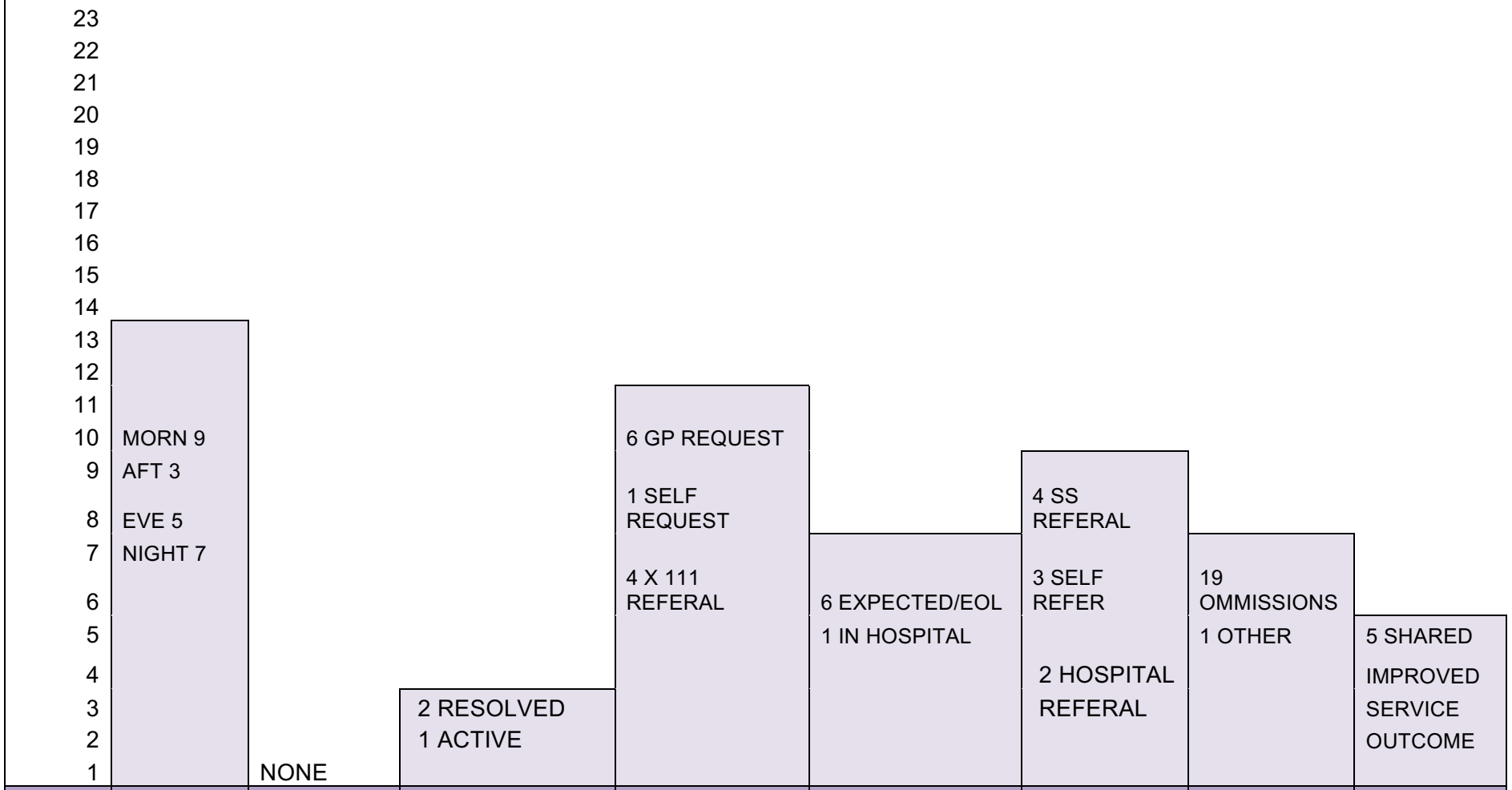
Evidence Criteria	Evidence Summary/Findings	Evidence Actions Completed
Nov: 1.Overall assessment of residents reviews 2. Overall review of residents meetings 3. Overall review of staff meetings 4. Overall review of supervisions/appraisals	1. No overall review assessment completed this business year 2. Review indicates that service users are happy with process and outcome of action plan 3. Review indicated improvements are required for new handovers, room checks, confidentiality, staff incentive & communication book. 4. Not completed in December	1.As a priority reviews for 2019 which should take place in May have been brought forward to March and are now all booked in; review to be completed thereafter t ensure people are happy with their care. 2. No further action required 3. The following items/processes have been reviewed and implemented: 24h Handovers, room checks to be checked by CTM, staff incentive was discussed/agreed, communication book re-issued. 4. supervisions and appraisals are currently behind – new supervision packs have been implemented and TL's have been given training and competed the supervision DVD – action plan to ensure supervisions and appraisals are up to date and line for all requirements to be complaint within 12 months of service.
Dec: 1. Review SOP & SUG 2. Review of all notifications 3. Staff Meeting (overview)	1. SUG & SOP are part of the Welcome Pack and have been reviewed by the MD 2. 17 incident reports – 3 CQC – notifications 21 3. New handovers, room checks completion allocated, confidentiality discussed, staff incentive discussed/agreed and communication book re-issued.	1. New updated version currently being printed 2. All completed and reported; no further action required 3. No action required
Jan: 1. Overview of Policies and procedures	• MD	
Feb: 1. Full H&S annual review	• MD	
March: **END OF YEAR SERVCIE REPORT AND FORWARD BUSINESS PLAN**	**Please attach this findings summary to the end of year service report for the service it refers to for publication by head office**	

Additional Comments:

Although some residents (4/22) indicate that they do not have the opportunity to review menu's, this is minuted at residents meetings; some people may have chosen not to attend or may have forgotten what has been discussed. In any event, we have an 'if it's in the larder its available for you' ethos as it would be at home. Any requests outside of the menu are always honoured

Completed by: Francesca Burkinshaw	**Sign:**	**Date:** 02.04.2019

WILLERFOSS RCH - REGISTERED NUMBER:	24	WEEKLY AVERAGE NUMBER OF RESIDENTS APRIL 2018 - MARCH 2019:	19



FALLS:	Increase night time monitoring and possible meds reviews
Meds:	Identify through meds audit if errors can be mitigated through training, supervisions or disciplinary
Referrals	Consider meeting with SS team to identify why only 4 referrals have been made in one year!

Willerfoss Residential Home – Summary Graph of service delivery outcome 2018 – 2019 = 99% overall satisfaction