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Our ref: GFM/FC/31
Your ref: LH/AMM/33350

14 October 2013

Louise Hunt HMC
Her Majesty's Coroner for Bridgend
Glamorgan Valleys & Powys
Rock Grounds
First Floor
Aberdare
CF44 7AE

Dear Ms Hunt

Terence O'Connell (deceased)

We represent the proprietor of Monkstone House Residential Home of 1 Locks Common, Porthcawl, CF36 3HU and have been asked by them to respond to your letter dated 28th August 2013 in which you required a response to your Regulation 28 Report to Prevent Future Deaths.

We note that in paragraph 5 you have raised three specific and particular concerns and you have asked for a response to each of these, which we will now deal with as below.

1 Communication Failure

You have indicated that in your view there was a communication breakdown between the care home, the district nurses and the out of hours GP service on 3rd May 2013 resulting in Mr O'Connell not been seen by any clinical staff. With respect, our clients do not accept that there was a communication problem between the three parties who you have indentified. The communication breakdown (assuming that such was the case) was between the district nurses and the GP out of hours service.

On 3rd May our client's staff contacted the district nurses on three separate occasions during the evening. There was also a series of conversations between the out of hours doctor and district nurses which our clients have been made aware of. Our client's staff also spoke to the family of the late Mr O'Connell on three separate occasions. [redacted] (Mr O'Connell's son in law) was the person who was spoken to and there are phone records available to prove this.

RECEIVED
15 OCT 2013

Partners Consultants Associates
Old Bank House Beaufort Street Crickhowell Powys NP8 1AD
Tel 01873 810629 Fax 01873 810485 DX 100751 CRICKHOWELL
E-mail crickhowell@gabb.co.uk (not for service)
www.gabb.co.uk

The last phone call to [redacted] was at 12.40am. During the course of this telephone conversation a senior member of staff at Monkstone House informed [redacted] that neither the district nurses nor the out of hours GP was going to attend to Mr O'Connell at Monkstone House. [redacted] did not want to arrange for Mr O'Connell to go to A&E. [redacted] informed the member of staff that he had spoken to the GP out of hours and he was happy for Mr O'Connell to remain at Monkstone House and he would ring in the morning to see what progress had been made. Staff at Monkstone continued to monitor Mr O'Connell throughout the night and there is documentation available to confirm this. No concerns were noted during this time.

Notwithstanding this, the Monkstone House policy has now been changed with regard to clinical assessment. The effect of this is that if a health professional (either district nurse or GP) will not attend Monkstone House within one hour of being called, the patient will be sent to the local A&E Department.

2 Direct monitoring of all input and urinary output

The late Mr O'Connell was a gentleman who remained in his room throughout his stay. He did not interact with any other residents or take meals in any of the dining rooms. He would call for assistance when necessary. His routine was to watch TV all day, only leaving his room to smoke. The information given to Monkstone House by his family detailed his daily routine, with no concerns with regard to his catheter. Accordingly, it would have been difficult to monitor his urinary input and output as his supply of fluids was supplied by his family and kept in his room, which he drank at his leisure. Also, the information that Monkstone House received from Social Services, provided by his social worker, [redacted] did not provide any express instructions regarding Mr O'Connell's catheter or fluid input and output and only reference to his catheter being emptied three times a day. In addition, there was no mention of any concern made by his family or professionals regarding past or present problems with his catheter before or during his admission to Monkstone House.

Notwithstanding this, the Monkstone House policy has been reviewed following Mr O'Connell's death. The catheter care policy has been reviewed and all staff have now been given extra training. In addition, urinary input and output monitoring charts have been put in place for all clients. The Monkstone House Policy and procedures which are now in place have also been reviewed and approved by CSSIW, as documented in Monkstone House's recent inspection report which took place in August 2013.

3 Failure to undergo clinical assessment

From the Friday to Sunday Mr O'Connell was monitored by staff at Monkstone House and this was recorded in Monkstone House's daily logs. Mr O'Connell was checked hourly throughout the night and his family were kept informed of his condition. No concerns were expressed and no visits were made by the family. Senior staff followed the family's decision not to send Mr O'Connell to A&E. However, if senior staff felt at any point that Mr O'Connell's condition was deteriorating any further, then medical advice would have been sought immediately, notwithstanding the fact that Mr O'Connell's family had requested that he should not be admitted to hospital. Throughout the period from Friday to Sunday Mr O'Connell's catheter was draining. Mr O'Connell appeared to be his normal self and in a jovial mood, evidence of which is contained in his daily records. His condition only began to deteriorate on Sunday to the extent that emergency treatment then became necessary.

Mr O'Connell's daughter arrived at Monkstone House at 12.40pm to pick Mr O'Connell up to return home. She expressed concern to a senior member of staff that Mr O'Connell was not himself. The senior member of staff, [redacted] accompanied Mr O'Connell's daughter to his room where she agreed that his condition had deteriorated since she had seen him last at 12 noon. The GP out of hours was called, however further deterioration was noted by [redacted] and an ambulance was called for by her.

An ambulance arrived promptly and Mr O'Connell left Monkstone House by ambulance at approximately 1.40pm.

Following these events, Monkstone House have reviewed all of their policies and procedures regarding GP out of hours, district nurses requests for visits etc. and the appropriate action in summary has been taken:-

1 Telephone calls are now recorded to confirm the substance of all conversations between families and all other professional agencies.

2 Catheter policy and procedure has been reviewed; fluid input and output has been revised and approved by CSSIW.

3 Meetings have been held with senior staff and if there are any concerns regarding clients, staff are to seek medical advice, ensuring that all clients are seen by a professional. If, for whatever reason clients cannot be seen at Monkstone House and if out of hours GP and nurses will not attend, Monkstone House will send the client to A&E department for assessment as soon as practical.

4 Monkstone House is no longer offering respite facilities to clients.

In conclusion, we are attaching a copy of the Protection of Vulnerable Adults Strategy Meeting minutes, which took place on 18th September 2013 regarding Mr O'Connell together with some other additional policy and procedure documents which are relevant to this matter. These are:-

- Policy and Procedure for Catheter Care
- Policy and Procedure for a client needing clinical assessment
- Pre-Admission Assessment Form
- Fluid Balance Chart
- CSSIW Inspection Report August 2013

We trust that the above information will be of assistance and if there anything further we can assist you with in dealing with, please do not hesitate to contact us.

Yours faithfully

GABB AND CO

Encs.

PROTECTION OF VULNERABLE ADULTS
STRATEGY MEETING

Date, Time and Venue:	18th September 2013, 3pm, Pyle Life Centre
Name of Vulnerable Adult:	Terence O'Connell (Deceased)
Social Services ID No:	310476
Date of Birth:	05.06.1942
Date of Referral:	07.05.2013

1. PEOPLE PRESENT, APOLOGIES, NON ATTENDANCE

In Attendance:

Adrian Bradshaw	Designated Lead Manager, Chair
Russ Warwick	Adult Safeguarding Officer, BCBC
Karen Merrett	South Wales Police
Clive Bevan	South Wales Police
Penny Evans	Social Worker, BCBC
Paul Rowley	Contract Monitoring Officer, BCBC
Liz Collier	Integrated Community Network Manager (Locality Lead for District Nursing)
Morag Liddell	Operational Lead, ABMU GP Out of Hours
Dr Bryn John	ABMU GP Out of Hours
Carol Rice	Inspector, C.S.S.I.W.
Paula Aplin	Manager, Monkstone House
Karen Davies	Monkstone House
Miranda Evans	Admin Support

Apologies:

Gweirydd Williams	Senior Environmental Health Officer, BCBC
Phillip Stanton	Head of Environmental Health, BCBC
Louise Barraclough	Operational Team Leader District Nursing, ABMU
DC Clayton Ritchie	South Wales Police
Mark Adams	H.M. Coroners Officer

2. PURPOSE OF THE MEETING

Adrian Bradshaw welcomed everyone to the meeting and introductions were made. The meeting is held under the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults.

The issues discussed are confidential to the members of the meeting and the agencies they represent. They will only be shared in the best interests of the vulnerable adult.

Minutes of the meeting are circulated on the strict understanding that they will be kept confidential and stored securely.

In certain circumstances it may be necessary to make the minutes of the meeting available to the civil and criminal courts, solicitors, psychiatrists, other local authority social workers or other professionals involved in the care of the vulnerable adult.

N.B. When you sign the attendance sheet/protection plan please note that you are signing up to the above confidentiality statement.

The purpose of today's meeting is to share information; consider issues relating to the vulnerable adult referral and in particular the level of risk and to decide on a course of action.

Mr Terence O'Connell sadly passed away on 5th May 2013 at the Princess of Wales Hospital.

3. NATURE OF ALLEGATION

The allegation is the neglect of Mr O'Connell during a respite stay at Monkstone House Care Home between 22nd April 2013 and the 5th May 2013.

4. MENTAL CAPACITY/CONSENT/VIEWS & WISHES OF THE VULNERABLE ADULT AND/OR THEIR REPRESENTATIVE

Mr O'Connell was deemed to have capacity although no formal assessment had been documented.

5. PRESENTATION OF REPORTS BY AGENCIES

As a result of the first POVA Strategy Meeting on 15th May the police and local authority carried out a joint investigation regarding the sudden death of Mr O'Connell.

Karen Merrett presented a report for the POVA panel in relation to Mr Terence O'Connell following a period of respite at Monkstone House Care Home in Porthcawl and into the allegation of events prior to his death - at the time it was thought he had capacity. Statements were taken from a large number of witnesses and included family members, staff working at Monkstone House and the on-call District Nurses and GP working on Friday 3rd May 2013. The information obtained from the statements allowed the police to formulate a report that was presented at today's meeting.

From the statements and the evidence, the investigators concluded that there was no criminal element regarding the death of Mr O'Connell. However, from the decision made by Her Majesties Coroner during the inquest there had evidently been a missed opportunity by agencies to provide adequate care to Mr O'Connell which may have prevented him from passing away.

Statements maintained the events leading up to his death showed no signs of severe illness, Mr O'Connell had been smoking and laughing with the staff at Monkstone House. However from the report there were a lot of missed opportunities and concerns.

The police felt whilst there is no Criminal element in the enquiry there are several important matters that need to be addressed to prevent a similar future incident occurring.

Russ advised under policy and procedure and due to missed opportunities this Adult Protection should be considered as a Serious Case Review in view of lessons to be learnt. The panel acknowledged the importance of agencies communicating and working together.

Liz confirmed that she had been working with Chris Griffiths and Carol Killa since the incident. She referred to the Out of Hours contact, and at no point did the District Nurse refuse to attend – the problem was assessed and there was nothing they could do as the Catheter was patent and draining. Karen Merrett confirmed the District Nurse did maintain this in her statement.

It appears that there had been a breakdown in communication between the GP and District Nurse Out of Hours and a number of situations arose. Subsequently, Clinician to Clinician changes have been implemented in respect to the Out of Hours service.

Dr Bryn John outlined that the GP Out of Hours service is based in Swansea but there are 2 GP's in each area of Neath Port Talbot and Bridgend and each GP can identify patients waiting to be seen on screen.

In respect to Monkstone House, Paula advised that all policies and procedures at the home have been revised, clear guidelines have been given and if there is no response in future, the client would be admitted to A&E for assessment.

Russ advised on a handover recommendation; a course of action should be agreed, even if the circumstances change someone should take responsibility. It is understood structures are now in place.

Carol Rice confirmed she has been shown the new policies and procedures at Monkstone House. Staff have reviewed training and changed some policies and procedures – there are no issues with the changes in place and she is happy Monkstone House can provide a level of care regarding a catheter.

Adrian reminded the meeting that no agency/person had been singled out as being the alleged perpetrator, but a missed opportunity noted in Her Majesties Coronor's report, contributed to by neglect. Karen noted that Mr O'Connell was thought to have had capacity.

District Nursing notes for Mr O'Connell were not provided by the family to the home – Russ asked that care managers ensure client's notes are provided for any stays in care homes.

The District Nurses are currently on a 3 shift pattern, however they will be moving towards a day and night service. The nurses covering the day/evening will therefore be familiar with their clients and they will have specific shifts in order to provide continuity of care.

Paula informed the panel she has ceased respite stays at Monkstone House.

6. INFORMATION ABOUT THE ALLEGED PERPETRATOR

No individual person(s)/agency is responsible, issues relate to multi-agency working and communication.

7. INVESTIGATION

Completed.

8. RISK ASSESSMENT

No Risk to this adult as sadly he has passed away, however we have to consider risk to others in this care setting and any other care setting agencies may support. Risk of reoccurrence of events unless clear structures are in place which would ensure matters of this nature do not re occur when agencies are required to provide support.

9. INDIVIDUAL/GENERAL VULNERABLE ADULT PROTECTION PLAN/SUMMARY OF AGREED ACTIONS

1. Clear instructions to be provided to clinicians involved with ill patients/residents that they are to speak directly to each other and agree on a course of action and identify who accepts responsibility for the patient/resident – ABMUHB

2. If the service provider has no response from clinicians involved in the care of the ill patient/resident then they should consider emergency admission to hospital. This should be incorporated in Policy & Procedure and should provide clear guidance to Care Staff – Service Provider

3. BCBC Adult Services to ensure that Care Managers ensure that records (District Nurse Notes etc.) are provided to the service provider upon acceptance in a care setting whether that be for a respite period or permanent residence. Care Manager should link with relevant persons (including family)/agencies to ensure that records are kept with the service user. In particular when records are kept at the home address of the service user – BCBC / DLM

4. The service provider should request the relevant records of any service user they accept in the care setting whether for respite purposes or for permanent residency – Service Provider

5. Agencies to reply to request from Her Majesties Coroner and inform her what actions have been undertaken to prevent/minimise risk of reoccurrence of events. These actions to be shared with POVA process in review meeting which will be arranged in due course – All agencies requested

6. Matter to be referred to the Western Bay Safeguarding Adult Board (WBSAB) for consideration of this matter being subject of an Adult Serious Case Review Process – DLM & Russ Warwick

10. FEEDBACK TO VULNERABLE ADULT/FAMILY/CARERS/REFERRER/OTHERS

Family members will receive an update from this meeting, however they will not receive the notes presented by Karen Merrett in terms of the investigation - DLM & Russ Warwick

11. OUTCOMES OF ALLEGATIONS

Liz Collier, Dr John and Morag Liddell felt the allegation was likely on the balance of probability but the consensus of opinion was a matter of Proven. Proven was therefore agreed.

12. NOTE CONCERNS AND DISAGREEMENT

13. DATE OF NEXT MEETING

Tuesday 5th November, 2pm at Pyle Life Centre.

Policy and Procedure for Catheter Care

1. All staff must be aware of policy content and control measures required to minimise infection and risk of harm to any client with an indwelling urinary catheter.

2. Any clients with a catheter must have the necessary documentation district nurse notes at Monkstone house. Carers are to seek advice from district nurses at all times.

******D/N notes are to be brought in with the client on admission******

3. ONLY district nurses are to carry out any procedures with indwelling catheters. Care assistants are only permitted to empty the bag.

4. Strict hygiene procedures to be carried out at all times, gloves and aprons to be worn when attending to catheter. Hands must be washed prior and after handling the bag.

5. The bag/urine must be disposed in an appropriate manner. The bag is to be placed in a yellow bag in soiled waste disposal. A single use disposable container must be used for each client, avoiding contact between urinary drainage bag tap and container.

6. All documentation, (fluid balance chart), must be completed immediately after emptying, input and output must be recorded to

monitor to daily total of intake and output, along with any concerns, where the district nurse can be informed immediately.

7. The colour and flow of the urine must always be documented.

8. Ensure the tap is in the appropriate position after emptying to avoid any spillage.

9. Ensure the client drinks adequate amounts and stays hydrated.

10. Monitor for any signs of infection. All staff are to familiarise themselves with symptoms. These could be decreased output, pain, temperature, and change in urine colour/blood. If any of these symptoms are noted, medical advice should be sought.

11. Any concerns where medical advice needs to be sort, ring prime care. Note the time of the call. If you have not received a response within 30 minutes, repeat the call. If after another 30 minutes, there is still no response, arrange to take the client to A and E.

Policy and procedure: in the event of a client being unwell/funny turns etc

If a client is unwell or has funny turn: monitor and if you have any concerns, call the GP or prime care for advice.

If you are waiting for feedback from prime care and they have not responded within 30 minutes, repeat the call for advice. If you have still not received a response from prime care after another 30 minutes, arrange for the client to go to A and E.

If at any time, the client suffers any further deterioration, ring for an ambulance immediately.

Document any advice given in general recordings and inform next of kin.

If a client has to go to hospital, follow admission procedures.

If in doubt seek medical advice always.

SERVICE USER

PRE-ADMISSION

ASSESSMENT

PLEASE COMPLETE ALL PAGES AND SIGN BELOW

NAME:

SIGNATURE:

ADMISSION DETAILS

REASONS FOR ADMISSION

.....
.....
.....
.....

SERVICE USERS PERSPECTIVE FOR ADMISSION INTO CARE

.....
.....
.....
.....

FAMILYS PERSPECTIVE FOR ADMISSION

.....
.....
.....
.....

OTHER AGENCYS PERSPECTIVE (please comment on social work, GP. Etc)

.....
.....
.....
.....

HEALTH ISSUES

PHYSICAL HEALTH PROBLEMS (comment on past and present problems)

.....
.....
.....

LAST SEEN BY THE GP

DATE.....

CONTINENCE ISSUES (PLEASE TICK APPROPRIATELY)

COTINENT.....

INCONTINENT..... URINE..... DOUBLY.....

CATHETER..... COLOSTOMY.....

****ANY DISTRICT NURSE NOTES MUST BE BROUGHT IN ON ARRIVAL****

MENTAL STATE (comment on past and present mental health problems)

.....
.....
.....
.....

SOCIAL AND EMOTIONAL ISSUES

.....
.....
.....
.....

CURRENT MEDICATION (please state if person self-medicates)

PLEASE LIST ALL CORRECT MEDICATION

WITH ANY WARFARIN TREATMENT, THE ANTICOAGOLANT BOOK MUST BE BROUGHT IN ON ARRIVAL.

.....
.....
.....
.....

PLEASE GIVE DETAILS OF ANY HOSPITAL APPOINTMENTS OR ANY CONSULTANT LEAD CARE

.....
.....
.....
.....

SERVICE USER PERSONAL DETAILS

Title:	Date of Birth:
Surname:	Age:
Forenames:	Known As:
	Nationality/ Origin:
Address:	First Language:
	Religion:
	Married/ Single/ Widowed/ Divorced

PRINCIPAL CARE DETAILS	NEXT OF KIN
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:

PRIMARY CARE TEAM		
Doctor:	CPN:	Tel No.
Surgery:		
Address:	Chiropodist:	Tel No.
Telephone:	Social Worker:	Tel No.
District Nurse:	Clinic:	Tel No.
Telephone:	Other:	Tel No.

HOSPITAL DETAILS (Inpatient)	
Date of admission:	Ward:
Date of planned discharge:	Consultant:

ADMISSION DETAILS	
Date of admission:	Temp placement:
Residential/ Nursing Care/ Other	Respite Care
Permanent placement:	Room No:

ADDITITONAL INFORMATION

SPECIALIST SERVICES	YES	NO	COMMENTS
Occupational Therapy			
Physiotherapy			
Regular out patient appointments			
Chiropodist			
Dentist			
Dietician			
Speech Therapist			
Community Psychiatric Nurse			
District Nurse			
Optician			
Counselling			
Palliative Care			
Other			

FINANCIAL DETAILS			
Person responsible for finances		Funding Details:	
Name:		Self Funding	
Address:		Part Funded	
Relationship:		Other	
AGENT	APPOINTEE	EPA	COURT OF PROTECTION

WISHES ON DEATH	
SOLICITOR	FUNERAL DIRECTOR
NAME	NAME
ADDRESS	ADDRESS
Tel No.	Tel No.

Burial
Cremation
Special considerations to be made
Comments

ACTIVITIES OF DAILY LIVING

SOCIAL NEEDS	YES	NO	COMMENTS
Good social skills			
Enjoys company			
Enjoys group activities			
Prefers to spend time alone			
Maintain interests/ hobbies			
Enjoys outdoor activities			
Regular church goer			
Member of any organisations			
Enjoys reading			
Enjoys listening to the radio/ music			
Enjoys watching television			
Is the person a welsh speaker			
Other			

RELATIONSHIPS	YES	NO	COMMENTS
Strong family relationships			
Long standing friendship			
Enjoys forming lasting friendships			
Enjoys going out with family/ friends			
Regular visitors			

COMMUNICATION	YES	NO	COMMENTS
Difficulty in expressing themselves			
Speech difficulties			
Visual impairment			
Wears glasses/ contact lenses			
Any visual aids/ equipment required			
Hearing impairment			
Wears a hearing aide			
Any hearing equipment required			
Other			

Fluid Balance Chart

Date	Time	Input	Output	Comment
	eg 08:00 am	A Cup = 250 ml	eg 100ml measuring jug or mark out a disposable cup	E.g Draining/flow Urine colour

Total Daily Intake.....

Total Daily Output.....

Any
Comments.....
.....
.....
.....

CSSIW

Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Care and Social Services Inspectorate Wales

Care Standards Act 2000

Inspection Report

Monkstone House Care Home

1 Locks Common Road
Porthcawl
CF36 3HU

Type of inspection – Focussed
Date of inspection – 1 August 2013
Date of publication – 30 August 2013

Please contact CSSIW National Office for further information
Tel: 0300 062 8800
Email: cssiw@wales.gsi.gov.uk

www.cssiw.org.uk

Summary

About the service

Monkstone House, owned and operated by J & P Residential Homes Ltd is situated in Porthcawl, a short distance from the town centre. The home is within walking distance of nearby small shops, pubs, takeaways and cafes. The building is set back from the main road in its own grounds. The home enjoys views of the Bristol Channel. There are good bus links and the motorway is only minutes away by car.

Monkstone House is registered to provide personal care and/or dementia/mental infirmity care for up to 41 people over the age of 65 years. The home can also provide care for two younger persons requiring personal care.

The registered manager and responsible individual is Paula Aplin.

This was a scheduled focussed inspection which took into account a recent concern received by the Care and Social Services Inspectorate Wales (CSSIW) regarding catheter care and fluid intake. The inspection focussed on Quality of Life.

What type of inspection was carried out?

Information was collated for this report following an unannounced visit to the home, information held by CSSIW, scrutiny of the returned self assessment of service and annual data collection documents. We spent time in the lounges observing staff with people using the service, examined the care files of two individuals and had discussions with staff and people resident at Monkstone House.

What does the service do well?

There was a warm welcoming atmosphere at the home and it was evident that the staff make considerable effort to provide person centred care.

What has improved since the last inspection?

Parts of the building have been upgraded. Seven new ensuite facilities have been provided.

There was a secure outdoor area with a waterfall which was very pleasant.

The laundry room had been extended.

What needs to be done to improve the service?

There were no areas of non compliance.

Quality of life

People using the service at Monkstone can be assured that they receive a good standard of care. From discussion and care records we saw that people are supported to make choices with regards to their care. People told us that staff treat them with dignity and respect.

There was an activity co-ordinator at the home, however all staff were expected to assist with the delivery of the activity programme. The day we visited, people were sitting outside and enjoying the sunshine. The outside area of the home had been improved and a water feature installed. This was a very pleasant area and was safe for people to wander and easily accessible. We saw evidence of the activity programme that had been delivered in July which included armchair aerobics, singers, bible reading, church services, music for health, games and film afternoons. A fete was planned for the following Saturday, which people said they were looking forward to. Previous fetes at the home had been well supported by friends and relatives of people using the service. There were life histories on people's files which outlined their preferences in regards to activities and socialising. This was taken into account when planning the activity programme.

We looked at the care records of two people using the service. The care plans were detailed and reflected personal choice. The care documentation was supported by a range of risk assessments, and both the care plans and the risk assessments had been reviewed on a monthly basis. It was evident that for one individual whose condition had deteriorated, the documentation had been reviewed often according to changes in her needs. We visited this individual who looked well cared for and looked peaceful and comfortable. We saw evidence that staff had visited regularly and were providing fluids on a regular basis. Following the receipt of a concern regarding fluid intake and catheter care, we saw that people using the service were receiving a good level of hydration and that drinks were available throughout the home. We checked the records of one individual with a catheter and he had a detailed care plan in place regarding his catheter care. There was also an intake/output record and staff were carefully monitoring this, and ensuring he had a good fluid intake and that his output was satisfactory. Staff had received training on how to provide catheter care and we talked to two staff members who described in detail how to care for this individual's catheter. We found no concerns regarding catheter or provision of fluids for people at this visit. Records also showed that the health and welfare of people using the service was promoted and timely input from other health professionals was evident.

The staff had a good rapport with the district nurses who visited the home regularly and also a good rapport with the local authority. The home was recently scored by the local authority as part of their quality monitoring. The home scored 95.5% and should be commended on their efforts to provide a high standard of care, services and facilities.

We talked to people using the service about the facilities and services at Monkstone. They spoke very highly of the home and the staff, and were happy living there. They commented positively on the food served and stated that they could order alternatives if they didn't like what was on the menu. Alternatives were offered at each mealtime and on the day of the visit a roast chicken dinner was served with freshly cooked vegetables and rhubarb crumble and custard for dessert. This looked and smelled appetising and people were enjoying their meal. Staff closely monitor people during mealtimes and observe what they are eating to ensure that they have a good nutritional intake.

We observed the care staff with people using the service. The care staff were trained, experienced and skilled in recognising the needs of the people in their care. We saw good relationships between staff and people using the service. People were supported to go out and receive their visitors in private if they so wished and a visitor's room was available to allow people to make tea and coffee for their guests.

Overall Monkstone provides a good standard of care to people in clean, comfortable surroundings.

Quality of staffing

The inspection focussed on Quality of Life. CSSIW did not consider it necessary to focus on Quality of Staffing on this occasion. However this theme will be considered at future inspections.

Quality of leadership and management

The inspection focussed on Quality of Life. CSSIW did not consider it necessary to focus on Quality of Leadership and Management on this occasion. However this theme will be considered at future inspections.

Quality of environment

The inspection focussed on Quality of Life. CSSIW did not consider it necessary to focus on Quality of Environment on this occasion. However this theme will be considered at future inspections.

How we inspect and report on services We conduct two types of inspection; baseline and focussed. Both consider the experience of people using services.

- **Baseline inspections** assess whether the registration of a service is justified and whether the conditions of registration are appropriate. For most services, we carry out these inspections every three years. Exceptions are registered child minders, out of school care, sessional care, crèches and open access provision, which are every four years.

  At these inspections we check whether the service has a clear, effective Statement of Purpose and whether the service delivers on the commitments set out in its Statement of Purpose. In assessing whether registration is justified inspectors check that the service can demonstrate a history of compliance with regulations.

- **Focussed inspections** consider the experience of people using services and we will look at compliance with regulations when poor outcomes for people using services are identified. We carry out these inspections in between baseline inspections. Focussed inspections will always consider the quality of life of people using services and may look at other areas.

Baseline and focussed inspections may be scheduled or carried out in response to concerns.

Inspectors use a variety of methods to gather information during inspections. These may include

- Talking with people who use services and their representatives
- Talking to staff and the manager
- Looking at documentation
- Observation of staff interactions with people and of the environment
- Comments made within questionnaires returned from people who use services, staff and health and social care professionals

We inspect and report our findings under 'Quality Themes'. Those relevant to each type of service are referred to within our inspection reports.

Further information about what we do can be found in our leaflet 'Improving Care and Social Services in Wales'. You can download this from our website, Improving Care and Social Services in Wales or ask us to send you a copy by telephoning your local CSSIW regional office.