Bupa Care Homes (GL) Limited

The Highgate Care 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

Our inspection of the Highgate Care Home took place on 29 and 31 May 2018 and was unannounced. The Highgate Care Home provides accommodation for 52 people who require nursing and personal care. People living at the home required care and support in relation to a range of needs including acquired brain injury, significant physical and sensory impairment, and progressive disabling conditions.

The home is set out across four floors or 'units' with lift access between each. Each floor had a communal lounge and dining area which we saw being used from time to time. A general communal dining area and activity space was provided on the lower ground floor of the building. At the time of our inspection there were 49 people living at the home, some of whom received care in their rooms due the severe and profound nature of their disabilities.

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

We last inspected this service in May and June 2017 when the home was rated as 'Requires Improvement'. At our last inspection we identified failures in the management and recording of people's medicines. We also found that these failures had not been identified and addressed by the quality monitoring systems in place at the home.

At this inspection we found that actions had been put in place to address our concerns. People's medicines were effectively administered, managed and recorded. Regular medicines audits had taken place and we saw that stock counts of medicines were accurate.

Risks associated with people's care and support needs had been identified. Individual risk assessments were in place with along with guidance for staff on how to safely manage these risks.

People told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place. Staff members had completed training in safeguarding adults and demonstrated an understanding of their roles and responsibilities in identifying and reporting safeguarding concerns.

We saw evidence of a comprehensive staff induction and on-going training programme. Staff had regular supervisions and annual appraisals. Staff members were safely recruited with necessary pre-employment checks being carried out.

People were given choices during meal times and their needs and preferences were addressed. People's weight was recorded regularly and action was taken should people lose weight significantly.

The registered manager demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Assessments of capacity were in place and applications to the relevant local authority had been made for DoLS authorisations had been made where appropriate.

We saw that interactions between staff and people were friendly, caring and supportive. Some people were unable to leave their rooms due to the complex nature of their disabilities and we observed that staff members checked on their welfare regularly and engaged them in discussion.

There was a wide range of activities taking place at the home. People spoke positively about these. Support for people to participate in individual activities was provided, including for people who were unable to leave their rooms.

A complaints procedure was in place which was displayed for people and relatives. People knew how to make a complaint.

Staff, residents and relatives' meetings were held regularly and surveys were completed by people and relatives. The home undertook regular monitoring of quality and safety and we saw that actions arising from these had been addressed.

The home liaised regularly with other health and social care professionals on behalf of people. A visiting health professional told us that there were effective arrangements in place to ensure that people's healthcare needs were met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient staff to ensure that people's needs were met. There was a robust recruitment procedure in place.

Risks to people who used the service were identified and managed effectively.

Staff members had received training in keeping people safe and knew how to report concerns.

People's medicines were managed and recorded appropriately.

Is the service effective?

Good

The service was effective. Staff members received regular training and supervision to enable them to carry out their roles.

People's capacity to make decisions was assessed. Authorisations had been sought and received where there was a need to restrict people in their best interests.

People were provided with food and drink of their choice. Measures were taken to ensure that people with specific nutritional or hydration needs received appropriate support.

People were given the assistance they required to access healthcare services and maintain good health.

Is the service caring?

Good

The service was caring. We observed positive interactions between staff and people living at the home. Staff treated people with respect and dignity.

Staff had a good knowledge and understanding of people's backgrounds and preferences.

Care and support provided to people at the end of life was in accordance with their individual requirements and preferences.

Is the service responsive?

Good

The service was responsive. People's care plans were detailed and person centred.

People were offered a variety of activities which were based on their individual preferences.

The home had a complaints policy in place and people and relatives knew how to complain if they needed to do so.

Is the service well-led?

Good

The service was well led. System for monitoring the quality of care were in with and actions to address any resulting concerns had been been put in place and adressed.

There was a clear management structure in place and people and staff spoke positively of the management.

The service worked in partnership with health and social care professionals.

The Highgate Care 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.

Our planned comprehensive inspection of The Highgate Care Home took place on 29 and 31 May 2018 and was unannounced.

This inspection was carried out by one inspector, a specialist advisor with nursing expertise and an expert by experience who spoke to people and visitors and made observations throughout the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information that we held about the service. This included notifications received from the provider, records of safeguarding concerns and complaints in relation to the service and other information that had been received by CQC. We also spoke with two representatives from a commissioning local authority.

Although many people living at the home had limited or no verbal communication due to the nature of their disabilities, during the inspection we obtained feedback from seven people and three relatives. We also observed mealtime sessions and two group activities. 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 spoke with the registered manager, three registered nurses, a senior care worker, two care assistants, the activities co-ordinator, the resident experience manager, the activities co-ordinator, housekeeper and the home's administrator. We also spoke with a local GP who was visiting the home at the time of our inspection.

We looked at ten people's care files and risk assessments, daily care records, eight staff files, staffing rotas and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People we spoke with told us that they felt safe living at The Highgate Care Home. A person said, "I am very happy here, I feel pretty safe. There is always someone about." Another person told us, "The attitude to residents is good. If there is something that needs checking out, they close the door so we are not involved in whatever is going on." A family member told us, "The place is spotless. It never smells unpleasant."

At our previous inspection of the home on 31 May and 1 June 2017 we found that home was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. Some people were not receiving their medicines as prescribed and medicines which had not been received by people were recorded as having been taken. Stock checks of medicines had not routinely taken place. During this inspection we found that the provider had taken action to ensure that the regulation was met. Medicines administration records (MARs) were accurately completed and reflected the medicines that people had received. Stock counts of medicines that were not in pharmacy provided blister packs took place immediately after each medicines' round had taken place.

Medicines at the home were administered by registered nurses and a senior care worker who had received training in the safe administration of medicines. Regular staff competency checks of medicines administration had taken place. We made observations of three medicines rounds and found that staff members understood their roles and responsibilities and were familiar with the medicines that were prescribed to people. The nursing staff we observed treated people with warmth, dignity and respect when administering their medicines. They took time with them and checked that people consented to taking the medicine.

Medicines were stored in a 'clinical room' on each floor and we saw that that storage was secure. Temperature checks of the clinical rooms and medicines fridges showed that medicines were maintained within safe temperature ranges. Some people living at the home were prescribed controlled drugs. Controlled drugs are medicines that the law requires to be stored, administered and disposed of under the Misuse of Drugs Act 1971. We saw the home was meeting the requirements of the Act and CQC guidance for providers.

Some people were prescribed medicines to be administered 'as required', for example for pain relief. Individual protocols were in place for such medicines which provided clear guidance for staff on how and when these medicines should be administered. The MAR charts that we looked at showed that as required medicines were not administered routinely, and we observed nursing staff checking on whether or not people required pain relief. Where creams were prescribed for people, these were kept in their rooms. The cream charts that we looked at showed that creams had been administered in accordance with the prescription.

One person living at the home received covert medicines. We saw that a best interests process had been carried out involving their GP and family and that detailed guidance was in place for staff.

Weekly and monthly audits of medicines administration, storage and records had taken place. Issues in relation to medicines management were discussed during regular clinical meetings and supervisions.

The home had identified and assessed risks in relation to people's care and support needs.Risk assessments include plans providing instructions and directions for staff members on how to safely manage identified risks. Risk assessments included information about, for example, mobility and risk of falls, moving and handling, skin care, eating and nutrition, medicines and behaviours. Risk management plans were in place for each identified risk and these provided guidance for staff members on ensuring that risks were minimised. Charts in relation to skin integrity for people who were not mobile or where there were other risks of in relation to the likelihood of pressure area wounds had been reviewed on a regular basis. People's weight was monitored on a monthly basis and MUST (malnutrition universal screening tool) records had been completed. We saw, for example, that where a person had lost a significant amount of weight a dietician and psychologist had been involved in supporting them to eat and maintain their weight.

Staff members had received safeguarding training as part of their induction and this training was updated on a regular basis. The staff members we spoke with were able to demonstrate that they understood their roles and responsibilities in relation to ensuring that people were safe. The home maintained a record of safeguarding concerns and had provided CQC with notifications about these.

The provider had assessed people's need and ensured that staffing was provided to reflect these. We looked at staffing rotas and observed the care being provided in each unit of the home. We observed that there was one nurse available on each of the four floors, along with three care workers. We observed that people remaining in their rooms were regularly checked on. The registered manager told us that during night shifts, in addition to a minimum of two care staff on each floor, three nurses were on shift and it was expected that they covered support across the four floors of the service. People told us that they did not have to wait long when they required support. One person said, "I have a buzzer and mostly the staff come within one or two minutes. It's usually very fast at night as well." Another person said, "You press the bell and they come quickly enough. I don't have to wait. At night people come when I need them". Staff members undertook regular checks on the welfare of people who remained in their rooms and we saw that they responded promptly when people used their call bells to seek assistance. However, a relative told us that they were concerned about the level of support at night. They said, "I worry when I leave him that I can't see anybody on the floor. The doors to rooms are open, but there is nobody around." One person said, "Sometimes at night they forget to give me the bell and I forget to ask for it. It doesn't happen often, but it is very awkward." We spoke with the registered manager about this. They said that they would look into these concerns. They also told us that they made unannounced visits to the home during the night and at weekends to assess care. We saw records of these unannounced visits and noted that these had taken place on at least a monthly basis. The records of unannounced visits showed that actions had been taken to address any resulting concerns.

We looked at the recruitment records for eight members of staff and saw that robust recruitment procedures were in place. We found that application forms had been completed which had included people's employment history, two references had been obtained and there was a record of formal interviews that had been carried out. Where required, evidence of the eligibility of staff members to work in the UK had been obtained. Criminal record and barring checks had also been completed to establish that prospective staff members were suitable to care for people living at the service. Records in relation to nursing staff were in order and showed that nurses working at the home were registered with the Nursing and Midwifery Council (NMC).

Accidents and incidents were recorded and subsequent actions and learning had been implemented. Staff

members knew how to report accidents and incidents.

The safety of the building was routinely monitored and records showed that checks and tests of equipment and systems such as fire alarms, emergency lighting and gas and electrical safety had taken place.

The home was clean and free from unpleasant odours. We observed that cleaning took place throughout the days when we inspected. Infection control measures were in place and we observed staff using disposable gloves and other protective clothing appropriately. Clinical and other waste was managed and disposed of safely.

We saw there was a Personal Emergency Evacuation Plan (PEEP) for each record and that these were specific to their individual needs. They outlined how the person should be evacuated from the building if required. Copies of PEEPS were maintained on each floor of the home with a master copy on the ground floor that could be provided to, for example, the fire brigade if they were involved in evacuating people. We saw that equipment such as fire extinguishers and evacuation slides were in place and had been regularly serviced. Staff members had received fire safety training and fire drills had taken place regularly. Window restrictors were in place for all windows at the home. We saw that these were in working order and that checks of the safety of these had taken place each month.

The provider maintained an 'out of hours' manager on call service. The staff members we spoke with said that they were aware of this and would use this if they required advice and support during the night or at weekends.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. A person told us, "I can't fault them. They are really good in helping me." A family member said, "My [relative] is well looked after here."

New staff members completed a comprehensive induction programme before working at the home. This consisted of a four day classroom based training programme followed by two weeks of shadowing and observation of more experienced staff prior to assessments of competence to work alone. The induction training met the requirements of The Care Certificate. The Care Certificate provides a nationally recognised framework for induction training for new staff members in health and social care services, A recently appointed care worker told us that they felt that the induction training and shadowing was excellent. They said, "I feel confident that I can help people in a good way."

We reviewed the training records for eight staff members. We also looked at the home's training matrix which identified the training received by all staff members. These showed that training had been provided in a range of subjects including safeguarding adults, the Mental Capacity Act, infection control, nutrition and hydration, and manual handling. Specific training in relation to individual needs had also been provided. For example, PEG (tube) feeding, catheter care and tracheostomy care. The staff members that we spoke with were generally positive about the training that they had received. However, staff members said that they would like further training on tracheostomy care. We spoke with the registered manager about this and they told us that further training in this area was planned by the provider.

Staff members told us about the support and supervision they received. They said they felt well supported within the home and that there was always someone to go to for advice. The staff records that we viewed showed that they received supervision from a manager every two to three months. Annual performance appraisals had also taken place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care plans showed that assessments of their capacity to make decisions had taken place. Authorisations in relation to DoLS had been obtained where required. Where people were unable to make specific decisions about their care, best

interests meetings had taken place involving health and social care professionals and family members or other representatives.

Staff members had received training in MCA and DoLS. They were able to describe their roles and responsibilities in relation to reporting and recording any changes in people's ability to make decisions.

People's care documents showed that they had been asked to consent to their care plans and had signed where they were able to. Where people did not have capacity, or were physically unable to give their consent, we saw that family members or other representatives had been involved in supporting decisions about their care.

The majority of people at the home ate their meals in their rooms, whether due to physical needs or preferences. However, we were able to observe communal meals and speak to people about the food that they received. The majority of people we spoke with told us that they enjoyed the food provided at the home. One person told us, "The food is good with enough choice. I always know I am going to have something nice because I get to choose it. If it's not to my liking you can ask for something else from the kitchen like a sandwich or scrambled egg which is good if you are not feeling like eating." Another person said, "I am vegetarian and they do a nice meal for me. The cook is very nice and I can talk about what I want. The meals are varied, which is not always the case if you are vegetarian." One person said about their dietary needs, "I was very ill when I came here and the dietician put me on [nutritional supplements]. I was putting on too much weight and they are helping me get down to the right weight. I had difficulty swallowing so I had pureed food, but now I am having proper food, as long as it is cut up. The food is good." However, one person told us that the food was not always to their liking, and a relative said, "It's sometimes like school dinners."

We observed that where people required support to eat and drink this was provided. For example, we saw that staff members sat with people and spoke with them whilst supporting them to eat. They gave people time to eat their food and checked that they were happy to receive more where required. Some people at the home received their nutrition through a PEG. A PEG is a means of providing nutrition and/or medicines via a tube which is passed into a person's stomach. Information and guidance about supporting this procedure was included in the person's care plan. We saw that staff members who were involved in supporting people with a PEG had received training from a suitably qualified professional and that competency in undertaking this support had been assessed. Information and charts in relation to people's food and fluid intake was well maintained. Where there were concerns about people's weight or ability to eat or drink referrals had been made to relevant professionals. For example, for a person who had lost weight, input had been sought from a dietician and psychologist. We noted from their records that the person who had recently lost weight and was being offered a wide range of food options to tempt them to eat.

People's food preferences were recorded in their care documents and information about this was also maintained by the catering staff at the home. A staff member we spoke with described their knowledge of a person's food preferences and how they supported the person to make choices in relation to this. Cultural preferences were also met. For example, kosher meals were provided where this was a religious requirement. Some people liked to have a beer or glass of wine with their meals and we saw that they were supported to do so.

The kitchen at the home was well maintained and we saw that food safety procedures were followed. Daily checks of food storage temperatures had taken place and refrigerated and frozen foods were stored and labelled appropriately. the most recent food safety inspection of the home showed that they were rated at

level five which is 'very good.'

People were supported to maintain good health and had access to a variety of healthcare services which included GP's, opticians, chiropodists, physiotherapists, psychiatrists and tissue viability nurses. During our inspection we spoke with a GP who provided primary healthcare support to the majority of people living at the home. They provided positive feedback regarding their experience of working with staff at the service. Information about people's health appointments was recorded and outcomes of these were passed on to other staff. Care plans had been updated to reflect any changes subsequent to health appointments.

Good

Is the service caring?

Our findings

People spoke positively of the care and support that they received from staff. One person said, "The care is wonderful. They look after you well with caring, washing and food. I feel respected. They always knock on the door." Another person told us, "I am happy here. I can relax and 'drop my shoulders'. I leave my door open all the time and if I have a problem someone will hear and sort it out. They are respectful of my privacy."

During our inspection, we observed interactions between staff and people living in the home. We saw that people were relaxed with staff members who treated them with kindness, patience and respect. Staff members sat and chatted to people. We observed a staff member communicating with a person who was unable to communicate verbally and noted that they received a positive response from them. People we spoke with told us that they liked the staff at the home. However one family member told us that, "The carers vary." They went on to say that some staff members did not always communicate effectively with their relative. We raised the fact that staff members may not always communicate with people when providing care and support with the registered manager. They told us that they would ensure that the importance of positive engagement and interaction with people was discussed with all staff members at forthcoming team meetings.

The registered manager told us that they recognised that people had preferences in respect of individual staff members. They said that, wherever possible, people were matched to preferred staff members, particularly in relation to care tasks. During our inspection we observed that where a person requested support from a specific staff member who was 'on shift' at the time that the staff member was called to support them. However we also noted that all of the staff members that we observed providing care and support were familiar with people and their needs and could communicate with them effectively.

Staff members demonstrated a good understanding of people's needs, interests and preferences. The staff members we spoke were positive about their roles in supporting people. One staff member said, "It's important to make sure that we get it right for people and help them to be as independent as they can be." Another staff member told us, "We cater for all of their needs, make them feel at home as much as we can and ensure they have no reason to raise any issues or problems."

Some people living at the home were unable to communicate verbally. We saw that their care plans included detailed guidance for staff members on how best to communicate with them. This included information about body language and behaviours which would indicate if someone was happy or otherwise with the care and choices provided to them. We observed a staff member encouraging a person to go to the dining room to eat and saw that the person responded positively to the interaction. A staff member said, "Sometimes we have to try different ways to encourage people. If it doesn't work we leave them for a while and ask them again later."

We observed staff members supporting people to eat or take medicines. We observed that such supported was delivered in a caring way. People were asked for their consent to support and given the time that they

needed.

Information was available to people in easy read formats. The registered manager told us that, at the time of our inspection, there was no-one living at the home who required information provided in a language that was not English. They told us that the provider was able to interpret for people if required and that efforts would be made to recruit staff if the person's first language needs could not be met by staff members currently working at the home.

Good

Is the service responsive?

Our findings

People and relatives told us that the staff were responsive to their needs. One person said, "If you want to do something they try to make it happen." Another person told us that they had asked to have their lunch at a later time and that this had been accommodated.

People had care plans in place which identified their current care and support needs and provided guidance for staff members on how these should be met. These were person centred and had been reviewed monthly. Changes in people's needs were recorded as part of the monthly reviews. However, we noted that, for two people, this had not always led to an update of their care plan. We spoke with the registered manager about this. She told us that, since these were recent changes they would not have been identified during the home's quality monitoring processes, but that she would speak with relevant staff members about the importance of ensuring that plans were updated following any changes in needs.

The home provided a range of activities that met people's needs and reflected their interests. We spoke with the activity co-ordinator for the home who showed us pictures and videos of people participating in activities such as tea dances, arts and craft sessions, baking, outings to places of interest, visits from a local primary school and performances from a local ballet school. During our inspection we observed a bingo session followed by a lively discussion between people participating and staff members. We also observed an interactive music therapy session where people played percussion instruments and were each given an opportunity to choose the music that they wished to be played. The music therapist visited the home on a regular basis and had set up playlists for people based on their musical preferences which were used by staff in other one to one and group sessions. During our inspection we saw that the music therapist went from room to room engaging people who were unable to attend the group session. Hairdressing and beauty treatments such as massages, facials and manicures were also available at the home on a regular basis.

The activities co-ordinator told us that they visited people who were unable to leave their rooms to engage them in activities or discussions of their choice. She told us, "My goal is to keep everyone as active as possible so they don't give up on their hobbies and interests. I ask if there is anything we don't do that I can try and provide. I am always looking for new ideas." Some people were able to go out with support and we saw that individual shopping trips and visits to parks and other places in the local area had been arranged.

People spoke positively about the activities at the home. One person told us, "I get a visit from a dog every few weeks and I like that." Another person told us that they ran an arts and craft session for other residents every week. They also liked to use their art and crafts skills to help the home with, for example, posters and invitations. The registered manager told us that the person was recompensed for this through the purchase of items of their choosing.

The home provided wifi for people and we saw that some people used their own electronic tablets and computers. The resident experience manager described how a person had been supported to purchase and learn to use a tablet so that they could do their own shopping on line. The home had also supported a person to set up a system whereby they could use IT equipment to be more independent in their room, for

example to turn lights on and off and play music.

Visits from faith representatives took place regularly and the registered manager told us that staff members would arrange additional visits if a person so wished. Partners and other family members visited people regularly and they were given privacy during visits.

Although some people living at the home were unable to communicate verbally, we saw from their care plans that information in relation to their communication and cognition requirements were in place. Care plans provided guidance for staff members on how best to support people with communication and decision making. We saw from the plans that people understood information provided in English and were also supported by staff members who used pictures, signs and objects of reference to aid communication. The registered manager told us that if someone living at the home understood or communicated in a language other than English that they would seek to ensure that they were supported in their communication by staff who were familiar with their preferred language.

A person living at the home was receiving end of life care. Their wishes in relation to this had been recorded in partnership with the person, their family member and GP. Records showed that the home worked in partnership with the local palliative care service in relation to supporting people at the end of life.

The home had a complaints procedure which was available in an easy read format and was displayed in the home. We looked at the home's complaints records and saw that any complaints received had been investigated fully and appropriately responded to. Most people and relatives we spoke with told us that they had no complaints and were confident that any concerns would be addressed. A family member told us that they had made a complaint and, although this had been resolved, they hadn't received feedback. However other people told us that where complaints were unable to be resolved immediately the manager explained the reasons for this and told them what was being done.

Good

Is the service well-led?

Our findings

Overall, people and relatives were positive about the service they received and told us they thought the service was well managed. A person told us, "[Registered manager] is very approachable. You can talk to her about anything." Another person said, "The manager and the deputy come round. They pop in to say hello and ask how things are."

The registered manager was supported by a deputy manager who was responsible for clinical supervision and a resident experience manager. Lead nurses were responsible for the day to day running of each floor at the home.

At our previous inspection of the home on 31 May and 1 June 2017 we found that the provider's quality assurance monitoring systems had failed to fully identify and address failures in relation to the administration and recording of medicines provided to people. During this inspection we found that robust procedures were now in place for ensuring that the auditing and monitoring of medicines administration and records was effective.

We looked at the home's procedures and systems for managing safety and quality. Regular audits undertaken by the management team covered areas such as medicines management, care plans, infection prevention and control, health and safety, monitoring of call bell response times, unannounced night spot checks and quarterly audits of the service by the registered manager. A monthly "first impressions" audit was also carried out which looked at the internal and external environment and the levels of activity and care and support being carried out at the home. We saw that actions identified as a result of the audits and monitoring monitoring which took place at the home had been quickly addressed.

The home was also monitored by the provider who produced a monthly 'metrics' report that contained statistics in relation to reported activities and incidents, for example, in relation to pressure sores, medicines, care plans, hospital admissions, DoLS, safeguarding concerns and complaints. We saw a copy of the most recent report for May 2018 and noted that that this included a commentary from the registered manager on any specific concerns, changes and actions that affected this report. The provider also undertook quarterly visits to the home to review quality. Actions identified during these quality reviews were identified within the subsequent reports and checked on at the following visit. We saw that the staff team at the home had ensured that required actions had been addressed. Recent improvements had included, for example changes, to the decoration and facilities available to people living at the home and systems for record keeping.

Staff told us that they were happy in their roles and felt supported by the management team. One staff member said, "I've had lots of support since I started here." Another told us, "Staff morale is good and everyone 'pitches in' when necessary. The management is lovely and supportive and offer extra help and training when asked for." A visiting health professional told us, "I think that the home is very well managed. The management is very responsive to people's needs."

We saw that a monthly meeting took place between the home and the local multidisciplinary team which included consultants from the local hospital, mental health team, GP practice and pharmacy. People new to the service were discussed and appropriate referrals were made to, for example dieticians, speech and language therapists and occupational therapists.

We found that there was clear communication between the staff team and the managers of the home. Staff meetings took place on at least a quarterly basis for both day and night staff. There were regular weekly clinical risk meetings. Topics discussed at recent staff meetings included good practice in care and support, health and safety and quality assurance issues. Weekly clinical risk meetings took place where nursing staff could review any concerns about the support needs of people living at the home. The registered manager and/or deputy manager also undertook a daily 'walk round' of the home which included a 'take 10 meeting' on each floor. The take 10 meeting provided an opportunity for staff members to discuss any immediate issues facing people who live at the home.

There were systems in place to ensure that the service sought peoples and their relative's views of the home. Resident and relative meetings took place on a regular basis. Information about a planned refurbishment of the home was discussed at the most recent meeting. An annual survey of views about the home had taken place and the most recent report of this showed high levels of satisfaction.