

Anchor Hanover Group

Israel Sieff Court

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

The inspection took place on 19 December 2018 and was unannounced. The last inspection of this service was on 16 and 17 May 2016 and we found the service to be good in all areas. The service is run by Anchor Hanover Group.

Israel Sieff Court is a care home located in the Crumpsall area of Manchester. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and support for up to 35 people, some of whom are living with dementia. On the day of inspection, 35 people were living at the home.

The home is divided into three floors. There is access to each floor via a passenger lift and stairwells.

At this inspection we found the evidence continued to support the overall rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. At this inspection we found the service remained good overall.

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a deputy manager. The registered manager was not available on the day of our inspection and the inspection was facilitated by the deputy manager.

People felt safe living at Israel Sieff Court. Staff were aware of their responsibilities to keep people safe and felt confident they could report any concerns they had to the registered or deputy manager and they would act upon the concern.

Staff members were recruited safely to ensure they were suitable to work with vulnerable groups. Staff members received an induction to the service and were given suitable training to allow them to undertake their job role effectively.

The safety of the home was well managed with regular internal and external checks of equipment. A fire risk assessment was in place and personal evacuation plans to assist people to leave the building in an emergency, safely.

Medicines were safely managed and monitored. Staff received regular training and competency checks of medicines administration to ensure they were following best practice.

Accidents and incidents were monitored for patterns and themes. Any learning from accidents and incidents

were shared for learning.

People received a full assessment of their needs prior to moving into the service. This fed into care plans and risk assessments to enable people to be supported in a person centred and safe way.

The service worked in line with the Mental Capacity Act, however, we made a recommendation that any conditions made in from authorisations in connection to deprivations of liberty safeguards were fed into care plans.

People were supported to eat and drink. We noted records for eating and drinking were being completed some hours afterwards. Changes to ensure records were completed in real time were actioned on the day of inspection. People were complimentary of the food and told us they had lots of choice. Meals looked appealing people could choose what they wished to eat and drink.

People had their health care needs met by various health care professionals. We saw people could see a GP when they needed to, and health conditions were monitored.

People felt cared for and told us staff were kind. Our observations were that staff knew people living at Israel Sieff Court well and there were friendly interactions between people and staff. A relative told us that they couldn't find anywhere better.

Care plans captured peoples support needs and we saw people and their families had been able to contribute to the plans. Peoples likes, dislikes, preferences and choices were recorded, and care plans were reviewed to ensure they remained accurate.

People were able to join in activities in and away from the home. While people enjoyed the activities, there were periods of time of when people were unsupported and lacked stimulation. We made a recommendation for this to be reviewed.

People were supported to remain at the home at the end of their life. Decisions made in respect of end of life care were clearly recorded and staff were aware of peoples wishes.

People and staff felt supported by the registered and deputy manager. Staff received regular supervision and the opportunity to attend staff meetings. People told us they knew who the registered manager and deputy manager was and told us they were always "Popping in."

The registered and deputy manager completed audits to monitor and improve the service. Further audits were completed by the district manager to ensure the service was compliant.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Israel Sieff Court

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.

The inspection was unannounced, and the inspection team consisted of two adult social care inspectors.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Israel Sieff Court, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

We contacted Manchester local authority, and Healthwatch (Manchester) to obtain their views about the quality of this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received were reviewed and used to assist and inform our inspection.

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.

During the inspection we spoke with four people who lived at the home. We spoke with five members of staff including the deputy manager, two team leaders and two care assistants. We also spoke with the district manager. We also spoke with a health professional who visited the home regularly and one relative.

We looked at training and supervision records for the staff team, staff rotas and the staff files for three staff including their recruitment records. We looked at four medicines administration records in the medicines treatment room and three people's care files. We also looked at records of staff meetings and training, quality monitoring records, medicines adults, fire safety records and health and safety records relating to

legionella, maintenance of the home and servicing of equipment.

Is the service safe?

Our findings

At our previous inspection we found that the service was safe. At this inspection the service continued to be good in this area.

People living at Israel Sieff Court told us they felt safe. One person told us, "Oh yes, I feel safe here, the staff are good, they look after us." Another person said, "Safe as houses, yes, I am safe here, I feel the staff look after me."

Staff had received training about how to safeguard people from abuse. They demonstrated a good understanding of what signs would alert them to suspect an issue and knew how to escalate this. They were able to give examples of safeguarding concerns in the past. Team leaders understood how to notify the relevant authorities of safeguarding concerns and all staff had confidence the registered or deputy manager would listen fully to their concerns. A whistle blowing policy was in place and staff confirmed they were aware and understood the policy. A whistle blowing policy allows staff to report concerns without fear of reprisals.

We looked at three staff personnel files. These included a fully completed application form, proof of identity and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work. The DBS identifies unsuitable people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

People had sufficient numbers of staff caring for them. We observed that there were enough staff on duty to safely support people with their care. However, we observed when people were in communal areas there were no visible care staff for long periods. Staff said there were enough staff to care for people safely, but they rarely had time to sit and talk to people or offer emotional support. Staff were also expected to meet people's social needs and manage planned daily activities. On the day we visited there were two team leaders and three care staff on duty. Staff said this was the expected number of staff and rotas confirmed this, although it was often one team leader and four care staff during the day. A visiting nurse said they informed staff in advance when they were coming and who they would be seeing so they could ensure people were ready. They said there were always enough staff available to help them if they needed them.

Staffing levels were regularly reviewed using a dependency tool. People's dependency levels were reviewed at six monthly intervals unless there had been a noticeable change in which they were reviewed more often. Dependency levels were rated at high, medium or low and staffing levels were worked out from the differing levels of dependency.

Comprehensive risk assessments had been completed for all people living in the service. They included assessments of risk of malnutrition, pressure ulcers, falls and mobility. Risk assessments had been reviewed each month. Assessed risks fed in to care plans to give guidance to staff to keep people safe.

Accidents and incidents were recorded on an internal computerised system which could be accessed by the management team. We saw accidents and incidents were clearly monitored with lessons learned recorded to prevent future occurrences.

People's records were accurate, complete, legible, mostly up-to-date, securely stored and available to relevant staff so that they could support people to stay safe. Food and fluid records for people at risk of malnutrition or dehydration were not completed until several hours after meals or drinks which meant they maybe not be accurate. We raised this with the deputy manager who advised they would change the process to enable the information to be recorded immediately.

Staff sought to understand, prevent and manage behaviour that the service finds challenging. People living with dementia had an assessment and situations that caused might cause them distress had been recorded so staff could mitigate triggers. People were supported when their behaviour challenged. Incident records included what the person was doing before the behaviour, exactly what they had done or said, how staff had responded and the outcome. This aligns well with best practice. Senior staff can use the information to determine triggers and direct care staff how best to support people.

Medicines were managed safely. The service's role in relation to medicines were clearly defined and described in relevant policies, procedures and training. Staff who administered medicines had been trained to do so, both through the dispensing pharmacy and via eLearning. Annual competency checks were completed with team leaders to ensure their capabilities in administering medicines.

A system was in place to ensure medicines were available when people needed them. The manager or deputy ordered medicines each month, so they were delivered in time for when people needed them. Emergency, new or changed prescriptions were obtained promptly, usually on the day they were prescribed.

Medicines were stored securely in locked trolleys, fridges and cupboards in two locked rooms. Temperature checks had been recorded daily for the rooms and fridge to ensure medicines were stored within safe temperature limits.

Medicines were checked by two staff when they were delivered, and remaining stock count was added to supplied counts. The count of tablets and volume of liquids was audited by team leaders each month.

We viewed medicine administration records (MAR) for three people and found they were stored securely.

Each MAR included an up to date photograph of the individual person to aid identification of the right person. Any allergies people had, were noted and GP contact details were on each person's MAR. Staff said people were all encouraged to register with the same GP but were able to remain with their existing GP if they preferred. Having a single GP meant care staff had a single contact to discuss medication with.

We observed morning medicines administration for five people. The team leader washed their hands before commencing administration and prepared a trolley with small trays, medicine pots, tea spoons, glasses and water.

People were given time to take their medicines and assisted when they needed to be. We observed the administration of eyedrops which was done in a safe and professional way. Medicines were signed for after they had been administered.

Some people had been prescribed medicines for use 'when required' (PRN). When medicines had been

prescribed PRN, the carer asked people if they wanted the medicine before preparing it. Protocols in place for each PRN medicine so staff knew what the medicine was for, what dose and how often it could be given, when a person might need it and how the person communicated. The exact time PRN medicines were given was recorded.

We checked the count of four medicines and found stock levels to be correct.

Topical medicines were stored in people's bathrooms and applied by staff when delivering personal care. There were protocols and body maps in place for these so staff knew when and where to apply them.

The service had a stock of homely remedies such as Paracetamol for minor ailments. Homely remedies are medicines that can be bought over the counter, which people might need occasionally. Protocols were in place for these and records showed use was recorded. Staff said they were rarely used and if a person needed more than three doses, they would consult the GP.

Some people had been prescribed controlled drugs (CDs). These are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. There are legal requirements for the storage, administration, records and disposal of CDs. These are set out in the Misuse of Drugs Act Regulations 2001 (as amended). The service stored and administered these medicines in line with the regulations. When these were in skin patch format, body maps were used to record the application site to ensure consistent absorption and reduce the risk of skin damage. Counts of CDs were accurate, matching the expected count.

Two people received medicines covertly. Covert administration is the term used when medicines are administered in a disguised format, without the knowledge or consent of the person receiving them.

We saw mental capacity assessments had been made and these people had lacked mental capacity to make decisions about medication. For one person their GP had reviewed medication and made a best interest decision they should be given medication covertly, 'disguised in food or drink.' We saw they had supplied a letter including a protocol for administering medication covertly for the person. The person had a care plan for medication. We recommend the pharmacist or GP reviews what food or drink the medicines could be disguised in.

We discussed NICE guidelines as being current, relevant professional guidance about the management of medicines with the deputy manager on the day of our visit. Before we left the service, they had printed a copy of the guidelines out and spoken with the dispensing pharmacist and assured us they would ensure the guidelines were incorporated into their procedure for administering covert medicines

People who had been assessed by speech and language therapists as at risk of choking had been prescribed thickeners. These were individually labelled and stored safely. Care plans included the required textures of food and drink for these people and kitchen staff included these in a list of people's dietary requirements. Staff knew how much thickener different people needed and we saw drinks were prepared with thickeners appropriately.

Records showed that equipment and services within the home were maintained in accordance with the manufacturers' instructions. This included checks on gas safety, portable appliance testing, electrical safety, fire prevention and detection, inspections of the passenger lift and emergency lighting. The service has a fire risk assessment in place which was regularly reviewed, and weekly and monthly internal checks were completed of the fire escape route, the fire alarm system, call points, fire extinguishers, fire door checks and

emergency lighting.

The service had a legionella risk assessment in place. Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria that can develop in water systems. The guidance in the risk assessment was being followed with regular checks of water temperatures and six-monthly testing of thermostatic mixing valves (TMV). This meant the service had ensured the premises was safe for the people, staff and visitors.

Each person had a personal emergency evacuation plan (PEEP) in place. A peep gives guidance to staff and others to evacuate people in an emergency. Each peep was rated as green or red. Green for people who could self-evacuate to red which meant people would need assistance due to cognition or mobility concerns. This meant there were procedures in place to support people to leave the building in an emergency.

The service also had a business continuity plan in place. The plan contained details of what action needed to be taken in the event of an emergency or incident occurring such as a fire or utility failures. The plan also contained copies of the peeps.

The home was clean and well maintained. Housekeepers completed daily audits to ensure rooms had been cleaned. The laundry was managed by a laundry assistant. We saw personal protective equipment (PPE) such as gloves and aprons were freely available throughout the home.

Is the service effective?

Our findings

At our previous inspection we found that the service was effective. At this inspection the service continued to be good in this area.

People received a full assessment of their needs, prior to moving into Israel Sieff Court to ensure the provider could meet their needs. Care plans and risk assessments were formulated from the assessment.

The service worked with other services to deliver effective care and people had access to healthcare. Care records showed visits from GPs, community nurses, podiatrists, dentists and specialist nurses. During the day we visited we spoke with a nurse who regularly visited the service who said they had a good working relationship with staff and had supported them to learn new skills to support people's diverse needs.

We saw staff received regular training to enable them to fulfil their job role. Staff felt they had the skills, knowledge and experience to deliver effective care and support. Staff were encouraged to complete diplomas in health and social care and told us, the qualification had aided their learning. We saw 97% compliance for all trainings. This meant staff had the appropriate skills to support people in their care.

The induction process for new staff included completion of the care certificate. The care certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care over a 12-week period. This included written work as well as practical's and observations. New staff shadowed other more experienced members of staff prior to working independently.

Staff said, and we saw, they received annual appraisals with the registered manager or deputy and supervision meetings with their line manager. For team leaders this was every six weeks with the deputy manager. Other care staff said they had supervision with team leaders about every three months. Written and verbal handovers were given at the end of every shift. This meant communication between the team was effective.

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 make 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where there were concerns with people's capacity, a capacity assessment had taken place. We saw where people were unable to consent or make decisions, a decision had been made in their best

interests and included, where possible the views of the person and their representatives. DoLS applications were made to the local authority for review but when an application was granted with conditions to be met, this did not always feed into the care plan. We recommend this is reviewed. Staff we spoke with were aware of who had a DoLS in place and why.

People's needs were met by adaptation, design and decoration of premises which were 'dementia friendly'. This means signs helped people find their way to bathrooms and furnishing, colours and decorations were appropriate. People's rooms were referred to as 'flats'. Flat door's had people's names on and a letter box and the deputy manager showed us a memory box outside a person's bedroom and explained they had asked relatives to help complete these for everyone living in the home. Each flat had an en-suite toilet room, bed, wardrobe, drawers and side table and room for a comfortable chair and television and associated equipment. People could hold their own keys to their bedroom if they wished, however, staff could still access the flat in an emergency.

We observed lunch time which was a sociable occasion. People sat with their friends and were very complimentary of the food. We noted the tables were set with cutlery and condiments. People asked for more or less on their plates and juice and hot drinks were freely available.

People were supported to eat and drink enough to maintain a balanced diet. People said the food was good and there was enough choice. One person said, "There is plenty of choice, if I didn't like something, they [kitchen staff] will make me something else and whoever makes it, they are good." Another person said, "I can have a fried breakfast or four rashers of bacon on toast." Weekly menus were displayed in the dining room.

Kitchen staff maintained a list of all the people living in the home with details of their dietary requirements and preferences. When we visited, eight people required food and fluid charts because of assessed risks. We saw these were maintained, but not at the time people actually ate and drank. Staff said they were each responsible for a group of people and we observed they completed the charts between 14.30 and 15.00 for breakfast, snacks and lunch. Staff said they remembered what people had been offered and had taken. We suggested these records might be more reliable if they were completed at the time people ate and drank. The deputy manager actioned this at the inspection.

Is the service caring?

Our findings

At our previous inspection we found that the service was caring. At this inspection the service continued to be good in this area.

People were treated with kindness, respect, and compassion. We observed interactions between staff and people living at the home that were caring and respectful. Staff spoke with us about different people living in the home and showed they knew people well and cared about their wellbeing.

People felt well cared for while living as Israel Sieff Court. Laughing and joking could be heard between staff members and people supported and it was clear all were at ease with each other.

People told us the staff were kind and helpful. One person told us, "The staff are lovely, nothing is too much trouble," Another person told us, "The girls are lovely, they work so hard and are very helpful."

A relative told us, "The staff have the patience of a saint, they are fantastic, they notice things and they got [name] a comfortable chair to rest in, you won't find anywhere better."

Staff knew about people's lives, their families and their preferences as well as their care needs and risks. One person liked to sing and was encouraged to do this. Another had enjoyed drawing in the past and was given the opportunity to colour in books in the home. A staff member told us, "I don't know what it is about (person), has a lovely smile and I'm fond of them." They knew what the person enjoyed doing and food and drink preferences. Another staff member, "It breaks my heart to see people anxious or upset."

Staff described how they ensured people's privacy and dignity was respected and promoted when delivering personal care. People could choose to keep their bedroom doors locked. We observed staff knocking on people's flat doors and gaining permission to enter. Staff also told us that they ensured any confidential information was discussed privately and only after permission had been gained from the person.

People's care files and other personal related documented were stored securely in a locked cupboard. Staff personnel files and premises related records were stored securely in the registered managers office. This meant that the service was working to ensure people's personal information was kept safe and secure.

Records showed that staff had received training in respecting people's equality and diversity. The provider had developed a lesbian, bisexual, gay and transsexual plus(LGBT+) group to provide support and guidance to people from the LGBT community. Posters were displayed in the communal parts of the premises and staff were clear on their responsibilities to provide information and support to anyone who identified as LGBT. Nationally, the provider was working to become more inclusive and supportive to people from the LGBT community.

Is the service responsive?

Our findings

At our previous inspection we found that the service was responsive. At this inspection the service continued to be good in this area.

People received personalised care plans responsive to their needs. Care plans included information about people's needs, preferences and choices and described what actions staff needed to take to effectively support people. Care plans confirmed the support people required with mobility, nutritional support, falls, continence, skin integrity, communication, sleep and rest, personal care, emotional and psychological support, beliefs and religion and cultural needs. We viewed three people's care plans and saw each plan was fully completed and reviewed regularly.

Assessments and care plan documentation prompted assessors and reviewers to consider people's communication needs, preferences and characteristics protected under the Equality Act such as gender, religion, sexual orientation and disability.

People told us they were involved in their care planning and we saw detailed life histories were kept for people and staff used the information to talk to people about their lives. Care plans were person centred and contained information personal to each individual such as favourite toiletries to be used or how people preferred to be assisted with personal care. Staff told us they had time to read people's care plans and could describe people's preferred ways of being supported,

People were supported at the end of life to have a comfortable, dignified pain free death. Staff said no one currently in the home was at end of life but described how care plans were written if people reached this stage which included four hourly assessments. Staff said, and we saw they had received training in end of life care and told us, "The focus is on keeping them [people] comfortable, ensuring they can sleep and rest pain free."

Care plans documented discussions that had been held about how people wanted to be cared for at the end of life. The information included where people wished to be cared for at the home or in hospital and any wishes to be observed such as a religious requirement.

Some people living at the home had a do not attempt cardio pulmonary resuscitation (DNACPR) record in place. A DNACPR is a document that confirms resuscitation would likely be unsuccessful and the person, a medical professional - usually a GP or doctor and family members if they held power of attorney had agreed that resuscitation was not in the person's best interests. We saw the decision was regularly reviewed and staff were aware who had a DNACPR in place.

The home had a memory book in place where people, staff and family could record their memories of people who had passed away while living at the home.

People told us there were activities for them to join in with at and away from the home. There were regular trips

to the local Irish centre where tea dances and bingo were held. Staff were trained in 'Oomph' exercise which enable them to carry out armchair exercises. People told us they enjoyed this activity. Staff members had recently been appointed as iPad champions to introduce people to using iPads. Church services were organised for people to attend if they wished.

The home had its own Twitter social media page which displayed activities people had joined in, this included arts and crafts, baking, table top games, quizzes and watching films.

Groups and acts such as Zoolab and singers visited the home to meet and perform to people living at Israel Sieff Court. Special days such as the royal wedding were celebrated with big parties and each person we spoke with told us they enjoyed the parties.

Although we did see evidence of activities, there were long periods of time throughout the inspection, where people were left unsupported in communal areas and lacked stimulation. We discussed this with the deputy and district manager who told us, there had been changes to the way activities were offered and an activities organiser was no longer employed at the service and activities were undertaken by staff and this would be reviewed.

Staff we spoke with told us, they didn't always have time to complete activities with people due to supporting people with care needs. We recommend this is reviewed to ensure people received suitable stimulation.

We saw, and people told us they could get their hair attended to in the hair salon and enjoyed being pampered. We also saw that a mobile library visited the home and provided books, audio books and large prints for people to read at their leisure.

The service had a complaints policy in place. People told us they would make any complaints to the registered or deputy manager, the staff team or their family. We saw any complaints had been responded to in a timely manner. This meant the service was responsive in acting on complaints to reduce the opportunity of it escalating.

Is the service well-led?

Our findings

At our previous inspection we found that the service was responsive. At this inspection the service continued to be good in this area.

The service had a registered manager in place who had been registered by the Care Quality Commission (CQC). The registered manager was unavailable on the day of our inspection and we were assisted by the deputy manager throughout the day.

People being supported by the service and staff told us they felt supported by the registered and deputy manager. One person told us, "[Registered manager] and [deputy manager] are great, always popping their head in." Staff told us they felt supported by both the registered manager and deputy manager. Staff told us they were approachable and listened to.

The service had received a number of letters and cards thanking them for their support in caring for their relative or friend. Many of the comments related to the kind care staff had provided to people.

Feedback received by the service was reviewed to assist the provider to monitor and improve what it offered. The most recent feedback survey had received responses from 12 people living at the home and the findings were that 100% of respondents were happy living at the home and satisfied with the overall standard of the home. 100% of families and friends were happy with the overall standard of care at the home and said the staff were good at keeping them informed. Additionally, 100% of people and their family or friends said staff treat them with dignity and respect and kindness, the home is safe and secure and clean and tidy. There were no negative responses.

The district manager visited the home on a monthly basis to support the registered manager. During the visit, they reviewed information relating to the service such as staff training, premises safety, the management of medicines and to talk to people being supported by the service. We saw the most recent review showed that the home was compliant in these areas.

An excellence tool was completed by the registered manager and validated by the district manager on a quarterly basis. The audit was linked to the Care Quality Commission (CQC), key lines of enquiry which highlighted good practice and evidence for when a service is inspected. Additionally, the tool looked at how effective care planning was and if care plans were completed and reviewed, budgets and if the service was working within the CQC five key questions of safe, effective, caring, responsive and well-led.

The registered and deputy managers completed audits of the home to ensure compliance. This included the management of medicines, the safety of the premises and the management of accidents and incidents to look for patterns and trends. Any concerns raised we responded to in a timely manner.

The registered manager has submitted notifications to CQC of certain events that had occurred at the service. This was a legal requirement as part of the registration. We found all notifications had been received

in a timely manner.

We saw there were regular staff meetings held to cascade information to the team and share ideas. Staff told us they found meetings to be useful.