Burlington Care Limited

Maple Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 7 and 8 June 2017 and was unannounced. This meant the provider and staff did not know we would be visiting.

This was the first inspection of Maple Lodge Care Home since it was purchased by Burlington Care Limited.

Maple Lodge provides residential and nursing care for up to 60 people. At the time of our inspection 46 people were using the service. The service is divided into three separate units for residential, nursing and dementia care.

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. At the time of our inspection a manager had been appointed to the home and had applied to CQC to register. Immediately following the inspection the manager's application to become the registered manager was approved by CQC.

We found people had in place fluid charts to ensure they did not become dehydrated. Although we did not observe anyone at risk of dehydration there was no record of the amounts people needed to drink each day. The daily amounts recorded were not totalled. The manager explained they had recently put the fluid charts in place and agreed to take immediate action to improve them.

We found people lived in an environment where regular checks were carried out to keep them safe. These included checks to reduce fire risks in the home.

We saw that the provider had a staffing structure in place with rotas which showed consistent levels of staffing. We spoke with the manager about the staffing levels on a night time. Although we found there were no serious night time incidents relating to a lack of staffing we recommended the provider reviews staffing levels as a precautionary measure.

People's medicine was stored securely. All the staff who administered people's medicines had received training to ensure they could do this safely. People received their medicines in a safe way.

Staff had been trained in how to safeguard vulnerable adults. They told us they felt confident to approach the manager about any concerns they may have.

Recruitment procedures were in place and had been followed to ensure staff employed in the service were suitable for their roles. Staff employed in the service had all the required employment background checks, security checks and references taken up. They received appropriate training, supervision and appraisal to carry out their roles effectively.

The provider had started to make changes to the environment to ensure people with dementia type conditions were able to maintain their independence. We recommended the provider and the manager use best practice guidelines to further develop the home into a dementia friendly environment.

Staff were described to us as friendly and caring by relatives and people who used the service. We observed staff treated people with respect. Personal care was carried out behind closed doors to maintain people's privacy and dignity.

The service adhered to the principles of the Mental Capacity Act. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Complaints were taken seriously by the manager. These were documented, investigated and responses were provided to the complainants.

The service was well-led. The new manager spoke with us about the home being at low ebb when Burlington Care Limited bought the home. They were aware staff had been subject to a succession of managers and felt they had to work to gain the trust of the staff. Staff spoke to us in positive terms about the manager and told us they had made improvements to the home.

Quality checks and surveys were carried out by the managers to monitor the service. This had led to actions being taken and improvements made. Feedback on the service had been collated and reviewed by managers. This was largely positive. The manager had also introduced a "You Said, We Did" notice which showed people what steps had been taken in response to their wishes.

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

Regular checks were carried out in the home to ensure people lived in a safe environment. Staff were tested on their health and safety knowledge.

People were given their medicines in a safe manner by staff who were assessed as competent to do so.

Staff underwent pre-employment checks to ensure they were suitable to work with people living in the home.

Is the service effective?

Requires Improvement

The service was not always effective

Although we saw no one at risk of dehydration improvements were required to fluid charts to ensure staff were able to account for people's fluid intake. The manager agreed to take further action.

The service had in place a meal support list so staff could see at a glance which person required support at mealtimes.

Staff received appropriate levels of training and support to enable them to work in the service. Staff felt their training had improved since Burlington Care Limited acquired the service.

Is the service caring?

Good

The service was caring.

Staff were friendly and attentive towards people. We saw interactions between staff and people who used the service were positive.

Relatives were involved in the service to support family members. The relatives were asked for their views about people's care needs and their preferences.

People were respected in the home and their dignity and privacy were maintained.

Is the service responsive?

Good

The service was responsive.

People's care plans were up to date and regularly reviewed.

We found people's plans were person-centred and focussed on each person's individual needs.

The home had recently employed a new activities coordinator. An activities board was available to let people know what was happening each day.

Is the service well-led?

Good

The service was well-led.

Staff, relatives and people who used the service were complimentary about the manager.

The manager had introduced new systems and responsibilities into the service to increase accountability and demonstrate people's care needs were being met.

The manager and the regional manager conducted quality audits in the home. The audits resulted in improvements being made to the service.

Maple Lodge 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 7 and 8 June 2017 and was unannounced. This meant the provider and staff did not know we would be visiting.

The inspection team consisted of two adult social care inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had a background in nursing care.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events or incidents which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners and the local Healthwatch team. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work.

During the inspection we spoke with four people who used the service and carried out observations of people who were unable to speak for themselves. We spoke with seven relatives. We also spoke with 12 staff including the regional manager, the manager, nursing staff, the care home assistant practitioner, senior carer, support workers, activities coordinator and two ancillary staff.

We reviewed six people's care records in detail and six staff records. We also looked at other records used in the service including medicines records, people's food and fluid charts and staff competency assessments.

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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Good

Is the service safe?

Our findings

Relatives confirmed to us that people who used the service were safe. One relative said, "[Relative] feels very safe" and "Staff are excellent".

We asked relatives if there were enough staff on duty. One relative told us, "There is always someone around". One person said, "Sometimes I have to wait for the carers to take me to the toilet." A second person said, "It feels as though there is not enough staff as sometimes you have to wait a long time in the dining room for your meals".

We reviewed the staff rotas and found staff were allocated to set units each week of the rota. The manager told us this enabled continuity of care and levels of accountability in the home. We found staff were busy but people were responded to in a prompt manner. Staff told us they felt there were enough staff on duty but they could always do with an extra pair of hands.

We found the rota indicated on one of the units there was only one member of staff on duty on a night time when three people required regular checks during the night. We asked the manager what would happen if any person required more attention than a check. The manager told us the unit was supported by a senior carer and they would be summoned by the care worker if additional support was required. They provided us with a staff breakdown on each unit to show us how this worked. We found this then left the next unit with only one staff member. At the time of our inspection we found there were no night time incidents which caused us to be concerned about people's safety.

We recommend the service reviews the staffing levels required to keep people safe.

New staff were required to complete an application form detailing their past experience and learning. The provider also required the names and contact details of two referees from whom they had sought references. The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruitment decisions and also prevents unsuitable people from working with children and vulnerable adults. We saw the provider had carried out DBS checks on prospective staff members before they had commenced working in the home.

We found the home was clean and tidy and observed cleaning on-going throughout the day. The manager had in place cleaning records which demonstrated when the service areas had been cleaned. This meant the risk of cross infections was reduced.

Staff had access to a maintenance book to record any issues which needed to be addressed. These were completed on a daily basis. Maintenance checks were in place, these included hot water temperature checks which were regularly carried out for bedrooms and bathrooms. The recorded temperatures were within the 44 degrees maximum recommended by the Health and Safety Executive (HSE) to prevent scalding. Window checks were carried out monthly to ensure people were protected from falling out of the

windows.

The provider had a fire risk assessment in place and had arrangements in place to monitor fire alarms and fire extinguishers. Staff were given written tests to ensure they understood fire safety issues. They were also were required to undergo fire drills. This meant checks on risks were carried out to ensure that people who used the service lived in a safe environment. Personal Emergency Evacuation Plans (PEEPs) were also in place and available for emergency services should an evacuation of the building be required.

The service had risk assessments in place. Each person's risk assessment was based on their individual needs. We found these were well documented and included risks such as falls, skin integrity and choking. These demonstrated the provider understood the complexities of risk management.

The provider had in place a system for recording and monitoring accidents and incidents. These were reviewed at the end of each month by the manager. When a person had a fall staff continued to monitor them over a 24 hour period and recorded their observations. For example, staff had documented when a person continued to be "Alert and responsive." Actions were put in place to prevent re-occurrences. We observed if people had a fall in their en-suite toilets they would not have been able to alert staff as the emergency pull cords had been tied up. We drew this to the attention of the regional manager who immediately resolved the issue by arranging for the pull cords to be extended

Medicines were stored in a separate clinic area with locked cupboards and cabinets. We looked at the Medicine Administration Records (MARs) and found these were up to date. Each person had a medicines profile to which was attached a photograph to enable people to be identified. Staff had recorded where people had refused their medicines. We saw a best interest's decision had been put in place for one person who was unable to make informed judgements about their medicines. As a result the person was to be given their medicines covertly. Permission had been obtained from the person's GP to do this.

Controlled drugs are drugs which are liable to misuse and have stricter guidelines for storage, administration and disposal. We found the stocks of controlled drugs matched the records in the home. Care plans were in place for medicines which people required on an as and when basis (PRN medicines). Charts for the administration of people's pain patches documented the staff administering the patches on different parts of peoples' bodies, in line with the manufacturer's instructions.

We looked at people's topical medicine charts and found there were a small number of gaps in the records. We drew this to the attention of the manager who explained they had recently introduced the documents and would now review them to ensure staff were able to understand what was required. People's topical medicines for daily use such as barrier creams to prevent skin breakdown were stored in their bedrooms and were accessible to staff. At the time of inspection there was no one in the home whose skin integrity had been compromised.

Staff had received training in medicines management and had competency checks in place to demonstrate they were able to give people their medicines in a safe manner.

Staff told us they felt confident to raise any concerns about the safety of people in the service with the manager. We found staff had been trained in safeguarding. The provider had in place a whistle-blowing policy which guided staff on how to tell someone if they were worried about something in the service. The manager told us there were no on-going investigations into whistle-blowing.

The provider also had in place a staff disciplinary policy to address staff behaviour and practices, should

they be of an unacceptable standard.

Requires Improvement

Is the service effective?

Our findings

The manager told us they had introduced a weekly weights matrix for people who fall in the 'at risk' section on the Malnutrition Universal Screen Tool (MUST). People were weighed weekly and each person's weight was reviewed by senior staff. We saw appropriate actions had been taken, for example people had been referred to dieticians. During our inspection we checked people's care plans and found these had not always been updated when dieticians had given advice. In two people's plans we found a dietician had given advice and the advice had not been transcribed onto the plan. The manager found a diet sheet for one person in the kitchen. However both people had started to gain weight. Following the inspection the manager confirmed that both care plans had been reviewed and rewritten adding in the information from the dietician's letter and the care plans had also been shared with staff to ensure that the requirements and recommendations were followed and recorded in each person's records.

The home had in place a one page checklist for different checks people needed to ensure they were well cared for. One of the checks was on people's hydration needs. We found people who required checks on their fluid intake did not have a daily target fluid level. Staff were not totalling people's daily intake and were therefore unable to ascertain if each person was being offered enough fluids to prevent dehydration. We spoke with the manager about our concerns who told us they had recently changed the documentation and immediately suggested how they could improve fluid charts to address the concerns. They agreed to take action.

One person told us "The food is "good." Another person told us they were "Trying to be a vegetarian" and were offered alternative choices. The service had a meal support sheet and staff were able at a glance to see people's dietary requirements and the type of support each person in the home required to be able to eat and drink. Kitchen staff kept records of which people needed fortified or pureed diets and were aware of the person who was trying to be vegetarian. They told us they ordered the food people wanted and had not been constrained by limits put on the food budget. We found the kitchen areas to be clean and tidy. Staff checked the fridge temperatures on a daily basis. Foodstuffs in the fridge had dates of opening and stored food was rotated.

Relatives confirmed to us that if people needed a doctor the local surgeries were contacted immediately. One relative told us they found the communication was, "Good". They told us they were kept informed of events in their family member's life. Another relative told us they were, "Kept informed of their [relative's] care" and were "Given an update on their daily activities".

There was evidence that other health professionals had been contacted appropriately, for example, Speech and Language Therapy teams (SALT), dietician, tissue viability nurse, GP's and community nurses. One professional told us the home was much improved and they felt there was good communication between them and the staff.

The service had in place handover sheets to aid communication in the home. The sheets provided information between each staff shift and acted as a reminder to staff about whether or not a person had a

DoLS in place, the type of dietary care they needed and their medical history. Staff recorded brief comments about each person and offered prompts to the next shift such as, "Shower required" to remind the next shift coming on duty what was required. Diaries were also used in the service to remind staff of people's appointments. In addition, staff wrote daily notes on each person. This meant staff starting a new shift had communication systems in place to ensure they were up to date with regard to people's care needs.

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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the manager had made the appropriate applications to the local authority to seek authorisation to lawfully deprive people of their liberty. Staff were trained in MCA and DoLS. Where people were unable to consent to their care we found family members had signed consent documents and people had decisions made in their best interests recorded on file.

People received care from staff who were well supported to undertake their role. We saw the manager had in place a training matrix which demonstrated which staff had received training and when training required updating. The manager was able to keep a track of staff training and if it was up to date. The regional manager told us the provider delivered staff training on a face to face basis because they felt staff learn better through discussion with others in a training session. One member of staff told us they, "Liked the training and wanted to learn." They told us since the service had been acquired by Burlington Care Limited the, "Training was better."

Staff also received supervision from their line manager. Supervision is a meeting between a staff member and their line manager to discuss their progress, review their training and provide an opportunity for staff to discuss any concerns they may have. Since the manager had come into post a regular pattern of supervision had been established. The manager told us they had now
delegated supervision to heads of departments with a matrix for each manager to complete. For example, the home's deputy manager had been delegated the task of supervising nurses. Staff appraisals were in place.

The manager showed us around the home and the work which had been carried out so far by Burlington Care Limited to make the home more dementia friendly. This included ensuring some corridor hand rails were a different colour to enable people with dementia type conditions to differentiate the rails from the walls. Some signage was in place to direct people to toilets and bathrooms.

We recommend that the home use best practice guidance to enable them to further develop the home and meet the needs of people with dementia type conditions.

Good

Is the service caring?

Our findings

One person told us they did not feel "Cut off" if they preferred to stay in their own room and that staff would, "Always chat and say good morning". Another person said, "Staff do care a bit but have a lot of other patients to look after". Relatives told us the staff were, "Friendly" and "Caring."

We saw the manager held relatives and residents meeting each month and involved people who used the service and their relatives in discussions about the care provided in the home, laundry issues, activities, fundraising and the summer fete. From these meetings the manager had instigated a "You said, we did" notice on the wall. We saw people had asked for exercises and found these had been introduced into the service. This meant the service had listened to people's reviews. A monthly newsletter had been devised to give people information about the service. The manager explained that this was intended to improve and enhance communication within the home and allow everyone to be involved in the running of Maple Lodge.

Relatives were consulted about the care needs of people who used the service. This meant people's needs were informed by those who knew them best. Relatives commented to us they felt they had been included in their family member's care and were able to tell staff about people's needs. A kitchen was provided for relatives with tea and coffee facilities to enable relatives to have social times in the home.

People's care plans gave staff guidance on how to promote each person's independence. For example they described the kind of assistance people needed for dressing so they could do as much as possible for themselves. We saw staff seek permission to support people when they thought they needed additional help and they chatted to people about what they were doing.

We observed kind and patient interactions between staff and people who used the service. People were supported in a warm, friendly and respectful manner.

We carried out observations throughout the home and found people responded to staff with smiles and friendly gestures. Using our SOFI we observed interactions between staff and people who used the service in the large lounge. The interactions were positive. This meant people's well-being was supported by staff.

During our inspection we observed staff giving explanations to people about what was going to happen next. This was particularly apparent when people were being assisted to the dining table and needed assistance from staff using a hoist. Staff provided reassurances to people and chatted as they transferred people from their chair to their wheelchair.

We did not observe any actions by staff which compromised people's privacy or dignity. All personal care was carried out by staff behind closed doors which promoted each person's privacy.

The manager demonstrated an understanding of the need for advocacy. At the time of our inspection the manager told us there was no one in the service who required an advocate. It was clear from the records relatives were acknowledged by staff as natural advocates for people who used the service and had been

asked for their views about people's histories, care needs and preferences.

Staff understood confidentiality and were aware of the security requirements of documentation. During our inspection they ensured people's personal information was secure.

Although there was no one receiving end of life care in the home during our inspection we saw staff had discussed people's end of life preferences with them and their relatives. The home had worked with medical services and had instructions such as, "Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)" in people's files. This means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These documents were readily available to give staff guidance on the care people wished for at the end of their lives.

Information about local services and health conditions was also provided to people and their relatives using pamphlets set out in the reception area and using a notice.

Good

Is the service responsive?

Our findings

We observed relatives being involved in people's care. Other relatives confirmed they had discussions with staff to inform their relative's care needs. One relative said, "Oh yes, they asked me lots of questions" and they confirmed if they asked questions about people's care, the "Manager and staff can always answer them."

Before people were admitted to the home we saw the provider carried out a pre-admission assessment. This document guided staff to discuss with each person and their family members people's needs which allowed the home staff to make a judgement about whether or not the home could meet their needs.

We reviewed people's care plans and found these were person centred. This meant people's care plans were individual to them and focused their own needs. Care documents contained a good level of detail regarding people's past lives, their employment, family members and interests. These documents enabled staff to be conversant with each person's history.

Each person's care documents included assessments and plans which varied according to each person's needs. One person, who was at significant risk of falls, had a very detailed plan in place to guide staff on actions to take to prevent falls. In another person's care plan we saw they experienced communication difficulties and were able to use, "Thumbs up and thumbs down" to express their preferences. Plans detailed if people were able to use the nurse call system and what checks were in place if people were unable to call for help. This showed the service had taken time to get to know people and their needs.

Staff had in place individual daily statement (IDS) charts for each person. These statement charts were divided into sections where sections were ticked to state if a person required for example catheter care. Staff were therefore given daily guidance on the care each person required.

In one person's care plan we saw one person sometimes shouted out during the night and called out for their relatives. The care plan required staff to document these incidents to see if there was a pattern. We found staff had continued to document the incidents. At the time of the inspection there was no discernible pattern. We found staff also monitored aspects of people's care needs and used advice from an on-line service to seek advice and support. The online service had the facility to use a video line to examine people's injuries. This meant staff were supported via a backup system to consider and review people's needs.

Nurses and care staff completed daily notes about each person. We found nurses had completed observations and handed over information to the next nurse on duty. The nursing team had a list of people's names for a weekly GP visit. The nurse on duty explained the list was for people who did not require emergency attention and they would ask for a community nurse or GP visit if a person became unwell. The daily notes completed by care staff documented the care given to people in line with their care plans.

Regular reviews of the care plans were carried out by keyworkers to ensure the plans were accurate and up to date.

A new activities coordinator had recently been appointed. There was an area of the home set aside for activities. An activities board gave people information about what was happening each day. During our inspection the activities had to be changed due to adverse weather conditions and people were occupied doing a variety of activities indoors. The manager told us they had introduced activities paper work which captured information about the activities people had completed. This included group activities to one to one activities and an individual activity record of any refusals of activities. This meant the home was able to monitor what people enjoyed doing, what worked and what did not go so well.

We saw the home brought in entertainers and experts in exercises to promote people's well-being. During our inspection people did handicrafts and were engaged in hand exercises. They were given choices about what they wanted to do. The activities coordinator turned on some background music and the volume was turned up as people started to engage in singing. We saw people were taken out for walks. Staff supported people with activities in the dementia unit where we saw a range of books and magazines. One member of staff posed for a person to draw them. We found the home had made progress in establishing activities for people which reflected people's interests.

The provider had in place a complaints procedure and the manager had documented when the service had received a complaint. We saw complaints were taken seriously and people or their relatives who made the complaint were given feedback following an investigation. Where necessary discussions were held with the complainant following the investigation and actions were agreed going forward. People and their relatives we spoke with did not have a cause for complaint. They told us they felt able to approach the manager.

Good

Is the service well-led?

Our findings

At the time of our inspection the manager had applied to be registered with the CQC and had an interview planned with us where we could assess their ability and determine if they were fit to become a registered manager. Immediately following the inspection their application as registered manager had been approved.

The regional manager told us, "The residents are at the heart of everything we do." We found the manager to be passionate and enthusiastic about the home. One person described the manager as "Very kind and pleasant." The manager explained to us the provider had taken over the service from another provider when the home was at a low ebb. They told us staff who had worked in the home prior to Burlington Care Limited taking over the home, had experienced a number of managers and staff had lost their confidence in the management of the home. Staff confirmed to us they had felt ready to leave the home, but they had gained confidence in the new manager and wished to stay. One staff member said, "[The manager's name] has made things better" and told us the manager could be found, "Talking to residents."

Since coming into post the manager told us about the number of changes and improvements they had made in the service. We found the manager had an improvement plan in place, although they were acutely aware that staff needed time to absorb and implement positive changes. The improvement plan included a range of issues which covered staff training, audits, use of slings for hoisting people, and the cleaning of wheelchairs. It also included issues which the manager thought required additional attention to help the staff put their learning into practice. For example the manager had spent time focused on DoLS and best interest decisions to help staff understand their purpose. We saw the manager was working their way through the action plan and had achieved many of the actions within timescale.

We found the manager had introduced roles in the service. Champions for Dignity, Dementia, Infection control, Health and Safety and Nutrition, together with key worker roles and a named nurse had been identified. This meant staff were given tasks to ensure the smooth running of the home and were provided with areas of responsibility for which they were accountable.

The manager completed a monthly report for the provider and was required to review the activities in the home. Each monthly review included, for example, if people had lost weight, hospital admissions, infections in the home, bed rail usage, care plan reviews and notifications to CQC. We cross referenced the notifications described on the report with those received by CQC and found they matched. This meant the manager maintained accurate records and was aware of their responsibilities in notifying CQC of events and incidents that occurred within the service.

The manager held staff meetings. We saw the manager had given staff guidance on the standards of practice they required in the home including the behaviour expected of staff. Similarly we found the manager in providing supervision meetings for staff, had been clear about staff roles in the home and their expectations on what staff should achieve.

We found the regional manager carried out monthly auditing of the home which resulted in actions to

improve the service. We saw feedback from relatives and people who used the service had been sought. The responses were largely positive.

People's documentation was accessible and easily retrievable for staff seeking information about people's care needs. Staff were aware of the need for confidentiality and the safe storage of people's information. We saw people's care plans were accurate and up-to-date. The manager provided us with a list of documentation changes they had made to the service to enhance the accuracy and accountability of staff. They appreciated these documents were new to staff and they needed time to successfully embed them in the service. The manager told us they were continually under review.

One professional visitor to the home told us staff worked well with them. The records held in the home facilitated good partnership working. Professionals were able to be given information about people from which they could analyse and form judgements about people's needs. Staff prepared for visits to the home by professionals. We saw the home had worked in partnership with professionals for example occupational therapists to keep people safe.