The Autumncare Group Limited

Northlands Care Home (Northumberland)

Inspection report

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Morpeth
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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

Northlands is situated in a residential area close to the centre of Morpeth. The service provides accommodation and personal care, including nursing for up to 35 people some of whom are living with dementia. On the day of the inspection there were 29 people using the service.

The inspection took place on 7 and 11 April 2016 and was unannounced. At the last inspection on 22 and 24 October and 3 November 2014, we found two breaches in regulations we inspected at that time, Regulation 13 medicines, and Regulation 20 record keeping. We asked the provider to take action to make improvements. At this inspection we found that appropriate action had been taken in relation to both breaches.

A registered manager was 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.

People told us they felt safe and there were policies and procedures in place relating to the safeguarding of vulnerable adults. Staff were clear about the action they would take if abuse or neglect was suspected.

Medicines were managed safely. The service was changing pharmacy provider due to some quality issues which they felt compromised their ability to respond quickly when medicines were added to a prescription.

Safe recruitment procedures were in place. Checks had been carried out by the Disclosure and Barring Service. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with elderly or vulnerable people.

Suitable numbers of staff were on duty during the inspection. Staff told us they found their work easier due to a slightly reduced number of people living at the service at that time, and a reduction in the dependency levels of people. The registered manager told us that staffing would be adjusted in response to any increase in numbers and complexity of people's needs.

Risk assessments in relation to the physical and psychological needs of people were in place. Some risk assessments lacked detail in relation to particular conditions and the nurse said they would amend these to provide more specific instructions to staff. There were audits relating to clinical safety including wound and catheter care audits and the safety of equipment was also checked.

Accidents and incidents were recorded and analysed for any trends or concerns by the registered manager. Serious accidents had been notified to the Care Quality Commission (CQC) in line with legal requirements.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental

Capacity Act 2005 (MCA). These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. The registered manager had submitted DoLS applications to the local authority for authorisation. A list was available of applications that had been authorised, those awaiting authorisation and those due to be resubmitted upon expiry. Consent to treatment policy was available and where people lacked capacity, best interest's decisions were appropriately recorded.

People were supported with eating and drinking and told us they enjoyed the meals. Assessments were carried out to identify any dietary problems and care plans were in place to address these.

Staff told us they felt well supported and records confirmed they received regular training, supervision and appraisals. This meant their development and support needs were met.

People had access to a range of healthcare professionals. Nursing care was provided and advice sought from appropriate specialists where necessary.

We observed that staff were caring. We saw that staff spoke kindly to people and were respectful and courteous. People and relatives told us that staff were caring. Privacy and dignity were promoted and confidentiality of information was maintained.

Person centred care plans were in place which took into account people's personality, behaviour, likes, dislikes and previous experiences when planning care.

A complaints procedure was in place and we saw that records of these had been kept including copies of responses by the registered manager and actions taken to prevent reoccurrence.

The quality of the service was monitored and the views of people, relatives and staff were sought through regular meetings and customer satisfaction surveys and audits. Staff and relatives told us they thought the service was well led.

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.

Safe recruitment procedures were followed which meant people were protected.

Risks to people were assessed and reviewed to ensure the safety and comfort of people living at the service.

Medicines were managed safely and a procedure was in place to ensure the competency of staff administering medicines.

Is the service effective?

Good

The service was effective.

People's capacity levels had been considered and the Mental Capacity Act (2005) (MCA) was applied appropriately.

Staff had received regular training and supervision.

People were supported with eating and drinking and appropriate systems were in place to identify and address any dietary problems.

Is the service caring?

Good

The service was caring.

We saw that staff spoke kindly with people and treated them with respect.

Dignity was preserved and personal care was offered discreetly and sensitively.

People were supported and encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place and these were reviewed and updated regularly.

We saw that the personal choices and preferences of people were respected and supported.

A range of physical and sensory activities were available and planned to meet the needs of people that lived at the service.

Is the service well-led?

Good

The service was well led.

People's, relatives and staff views were sought through questionnaires and meetings.

The registered manager carried out a number of audits relating to the clinical safety and comfort and quality of the care provided to people in order to ensure they were safe and well cared for.

Northlands Care Home (Northumberland)

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.

This inspection took place on 7 and 11 April 2016 and was unannounced. It was carried out by one adult social care inspector and a specialist advisor. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection and have specialist knowledge in a certain area. The specialist advisor during this inspection was a registered nurse with experience of working with older people.

We displayed a poster to inform people that we were inspecting the service that day and invited them to share their views.

We spoke with eight people who lived at the service and two relatives during our inspection. We spoke with local authority contracts and safeguarding officers. They told us that they were not aware of any current concerns about the service and there were no ongoing safeguarding investigations.

We spoke with a community matron and a nurse from the challenging behaviour team who visited the service regularly.

We spoke with the registered manager, deputy manager (also a registered nurse), activity assistant and four care workers on the day of our inspection. We also spoke with kitchen and domestic staff.

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 to us.

We looked at the care records of eight people using the service, and four staff recruitment files. We also reviewed safety and maintenance records and records relating to the management of the service.

Prior to the inspection we reviewed all of the information we held about Northlands including any statutory notifications that the provider had sent us and any complaints we had received. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We took this information into account when planning our inspection.

We did not ask the provider to complete a Provider Information Return (PIR) before this inspection. 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

People told us they felt safe and well cared for. One person told us, "They are lovely with you. I fell 12 times before I came in and broke bones. I've only had one minor fall since, and they've got me up using this thing now (wheeled walking aid) and I feel safer."

There was a safeguarding policy and procedure which informed staff how to recognise and report suspected abuse or neglect in place. Information about safeguarding vulnerable adults was displayed on noticeboards throughout the home. Staff had received safeguarding training and were aware of what to do in the event of any concerns. One staff member told us, "I would report any concerns straight away. I have never seen or heard anything to worry me at all."

We looked at the way medicines were managed. At the last inspection we found that medicines were not managed safely as they had been left with people to take unsupervised. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. At this inspection we found that appropriate arrangements were in place for the administration, storage and disposal of medicines including controlled drugs, which are medicines which may be at risk of misuse. Systems were in place to ensure that the medicines had been ordered, stored and administered. They were audited every two weeks. Medicines were securely stored in a locked treatment room and only the nurse on duty held the keys. Medicines were transported to people in a locked trolley when they were needed. The service was in the process of moving to a new pharmacy service due to delays in receiving medicines prescribed in between receiving regular prescriptions. A relative told us, "(Name of nurse) is very good. She puts on a jacket which means don't talk to me I'm doing the medicines."

We checked recruitment records and found that appropriate checks had been carried out to ensure that staff employed were safe to work with vulnerable adults; including obtaining references and checks carried out by the Disclosure and Barring Service (DBS). DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with elderly or vulnerable people. This helped to protect people from abuse.

There were suitable numbers of staff on duty on the day of the inspection. There were no buzzers ringing for an excessive length of time and staff supported people in a relaxed unhurried manner. We spoke with the registered manager about staffing who told us there were no concerns about staffing levels as there were fewer people living in the service at the time of the inspection and that dependency levels of people (the amount of support people needed) had reduced. They told us that staffing levels would be adjusted to accommodate any increase in the numbers or complexity of people using the service. We spoke with the deputy manager;, also a registered nurse, who told us, "I do the dependency levels and the staffing is okay. That's the good thing about working on the floor; you know whether staffing is okay. I alternate the floors I work on so that I know everything that is going on and can check staffing." A member of care staff told us, "We're at a nice level just now. Four people after six pm is a happy medium and you can get everything done including bathing people and spending one to one time with them. It is nice to have time to sit and talk to people. I used to worry about getting everything done when we were really busy but I go home relaxed now,

knowing I've done my best."

Individual risk assessments were also carried out in relation to the physical and psychological well-being of people. These included risks associated with eating and drinking, moving and handling, mobility, falls, and skin integrity (risk of skin damage). Audits in relation to clinical risks were carried out including risks associated with the use of urinary catheters (a tube inserted into the bladder) and use of air flow mattresses to ensure these were correctly set. Air flow mattresses help to prevent the development of pressure ulcers and must be correctly set otherwise they do not work correctly. A monthly audit of pressure ulcers was also carried out which checked whether there were any new issues and whether appropriate care plans were in place.

Risk assessments in relation to the mental health of one person lacked detail which meant that staff may not have been aware of the symptoms to note that their mood had deteriorated for example. Similarly, people who had gone through Percutaneous Endoscopic Gastrostomy (PEG) procedures and had a PEG tube in place, had detailed care plans , but risk assessments lacked detail to highlight specifically the signs that complications might be developing. PEG tube is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines. We spoke with the registered manager and deputy manager who agreed to add this detail to the risk assessments.

Position right for pneumonia posters (PROP) were in place. These advise staff to position people at the correct angle in bed to prevent pneumonia. We asked staff what the posters meant and they were able to explain the procedure to us and told us a nurse had provided training to them. This meant that staff were aware of best practice in this area.

Accidents and incidents were recorded and analysed on a regular basis by the registered manager to identify any trends or areas of concern. Where a person had fallen on a number of occasions, we checked that appropriate action had been taken. This meant that the registered manager sought to maintain the safety of people who used the service.

We looked around the building and found it was clean and well maintained. There was an area of uneven flooring which we pointed out to the registered manager who was aware of it and told us there was a plan in place for ongoing redecoration and refurbishment and that this would be addressed. We spoke with a member of domestic staff who told us they had received training in the prevention and control of the spread of infection, and how this was put into practice in their daily work. They told us, "We wash sheets and towels separately and at a certain temperature. We know how to separate laundry. I have done training about how to clean properly and how to store chemicals safely and have done COSHH training (Control of Substances Hazardous to Health)." The control of substances hazardous to health (COSHH) regulations are used by employers to ensure that staff are protected from hazards associated with the use of certain chemicals or substances.

An emergency contingency plan was in place in the event of a fire, power failure, water leakage, gas leak, lift failure or loss of heating. Gas and electrical safety inspections had been carried out and personal emergency evacuation plans were in place. These plans outlined the support people needed in the event of an evacuation.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received at Northlands. One person told us, "I'm happy here, I like being here very much."

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 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). The registered manager had submitted DoLS applications to the local authority. A list was available which included applications made and authorised, and those awaiting authorisation.

Capacity assessments had been carried out, and care plans contained details of specific decisions made in the best interests of people, but also detailed areas where the person would have capacity to make a decision and how they should be supported to do so. For example, one care plan explained that the person would have capacity to make choices about which meals they would like, but lacked the capacity be able to decide whether certain as required medicines should be taken. This meant that plans were not unduly restrictive and recognised abilities and limitations to capacity.

A consent to treatment policy was in place which stated that people should receive examinations, care, treatment and support they agreed to. It outlined that where consent could not be given, best interests decisions should be considered. Consent to care and treatment forms were in place, including in relation to the use of photographs on people's records to help identify people. One person was given their medicine covertly. This meant that their medicine was hidden in food or a drink because they lacked the capacity to understand the importance of taking the medicine for their comfort and safety. We checked that the best interests decision around the administration of medicine covertly was appropriately documented and recorded all of the people involved in the decision making process. This meant that the decision was recorded in line with best practice.

People were supported with eating and drinking. One person told us, "The food is excellent; first class! There is so much choice here, you don't have to take what is there, you can have anything. Today I had cereal and a banana then white bread and marmalade because (name of nurse) told me I am losing weight so I'm stuffing myself with bread and potatoes!"

We observed a mealtime experience and saw that people were sensitively and discreetly supported with eating. There were two staff in the dining room and one staff member attending to people who chose to eat their meal in their bedroom. A staff member came to speak to the nurse, as they were concerned about the

diet of one person and said, "(Name of person) has had a poor lunch but has asked for ice cream, so I am going to put on a bit of cream and some honey." This showed that staff were aware of how to fortify the meals of people at risk of losing weight. Another person was reluctant to eat and asked for a small bowl of chips. A staff member kept gently prompting and encouraging them to eat their chips and said, "You are doing really well" and jokingly, "Have you eaten those chips yet?" The person replied, "No, you can have a taste."". Staff told us the registered manager sometimes ate with people at mealtimes and had no objections to staff joining people for meals.

Food and fluid balance charts were in use where required and we saw that these were up to date and fully completed. We spoke with a member of kitchen staff who was aware of the special dietary needs of people. We saw that there were lists of special diets but also likes and dislikes, such as "No fish or peas", "No peas or prawns" and "No white bread or carrots". Kitchen staff were also provided with a weight loss monitoring list. The Malnutrition Universal Screening Tool (MUST) was in use. "MUST" is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nourished), or obese. It helps with the development of care plans to support people with these risks. We saw that a small number of MUST charts had not been completed, however monthly weights had been measured and recorded. The registered manager showed us the monthly weight audit that they completed to determine if there was any incidence of weight loss and to indicate the frequency of weight monitoring and the involvement of the relevant health care professionals, as appropriate. The deputy manager reassured us that they would instruct staff to update the MUST charts on a monthly basis.

Staff received regular training. One staff member told us, "It's not simple to work here; you have to do lots of training!" Another staff member told us, "We get regular training. You always learn something new, mine is all up to date. Next week we are doing infection control training." We checked a training matrix and saw that staff had received training in key areas on a regular basis including where appropriate, the administration of medicines, infection control, end of life care, dementia care, equality and diversity, health and safety, nutrition, DoLS and moving and handling. Not all staff had received first aid training but the registered manager told us they ensured there were sufficient staff trained in first aid to cover the service at any given time.

Staff received regular supervision and appraisals. We spoke with one staff member who told us, "We have supervision with the manager three monthly and we have a regular appraisal." Regular supervision was recorded in staff records and staff said they felt well supervised and supported.

People had access to health care services and their records showed details of appointments with and visits by healthcare and social professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), community matrons, social workers, dieticians, the speech and language team (SALT), podiatrists, opticians and dentists. Care plans reflected the advice and guidance provided by external health and social care professionals. One person received a visit from a community matron on the day of the inspection which we were told was part of an ongoing treatment and care plan. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People and relatives told us that staff were very caring. One person said, "I have a fantastic relationship with the staff. We had a party recently and first thing we had to do was to say a special thank you to Northlands, we mentioned them in our speech." A relative told us, "The staff are fantastic. Nothing is a problem; in fact when I come in they say, "Good morning, what can I do for you?"

We observed that staff were cheerful during the inspection; some staff sang and whistled as they worked in an unobtrusive way. One person commented upon the cheerful approach of staff and said, "They would never mention for example that someone had died. They just carry on being cheerful. When you think of all they have to deal with, they are remarkable really."

There was a calm, positive atmosphere throughout our visit and we saw that people's requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. Our observation during the inspection was that staff were respectful when talking with people calling them by their preferred names. The dignity of people was promoted and we observed staff knocking on doors and waiting before entering, ensuring people's privacy was respected. At mealtimes people were offered clothing protectors but could choose not to wear them.

Confidentiality of information was maintained. Records were stored securely and we were asked by the activities coordinator to return records we were looking at to the cupboard as they were going home. This meant that staff ensured that private information about people was stored securely.

We observed that people were asked what they wanted to do and staff listened. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. One member of staff told us, "It is lovely to sit and listen to people. It is amazing to hear their memories."

One member of care staff told us they were conscious of the way that the environment might influence the mood of people. They told us, "I always teach new staff that the radio is for the people to listen to, and we usually just have quiet background music. Some people don't like the television or loud music and find it upsetting."

One relative told us they had been allowed to become involved more widely in the home, and had supported another person to make a small garden on a window sill in the corridor opposite their room. They had made a sign with the name of the person and helped them to water and care for the plants.

A hairdresser visited the service once a week. They told us, "People are always clean and tidy here. They have beads and accessories and if ever have a spill and need a change of clothing it is done straight away."

People were supported to make choices. We saw that this was reinforced in care plan documentation, and details of a local advocacy service were also displayed. An advocate is a person who supports people to exercise their rights and express their wishes.

Staff received training in end of life care and Emergency Health Care Plans (EHCP) and end of life care plans were in place which meant healthcare information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Good

Is the service responsive?

Our findings

People told us their needs were responded to. One person said, "Staff are all helpful, the younger ones help me with my computer. You have to see it to believe it, they are great."

At the last inspection we found that People who used the service were not protected from the risk of unsafe or appropriate care and treatment arising from a lack of proper information being held about them, as records were not appropriately maintained. This was a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations2010 Records.

A this inspection we found that person centred care plans were in place. Appropriate action had been taken by the provider and information was up to date and had been regularly reviewed. Each person's care plan contained a 'one page profile' which detailed what was important to the person, how best to support them, what people thought of the person. A narrative gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This was important information and necessary for when a person could no longer tell staff themselves about their preferences and enabled staff to better respond to the person's needs. People were consulted about their care and where appropriate, relatives were involved in the care planning process with care plans reviewed monthly.

We spoke with a community matron who told us, "The care staff are good. Care plans are followed through and they take up any training that we offer and contact me when they need anything. I have no concerns at all." We also spoke with a nurse from the challenging behaviour team who told us, "The staff always do what we ask them to do. Some of the care staff are particularly good. We held a mini formulation (a meeting facilitated by the challenging behaviour team but where the staff take a lead role in identifying unmet needs which might be driving certain behaviours). It was well attended and the staff were great."

Daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility, nutrition and activities and interests. This was necessary to ensure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences. Excerpts for one person stated, "Engaging well with staff, ate good supper, had good fluids overnight, watched sport on TV, small amount of conversation today, managing to eat by themselves today."

Pre admission assessments were carried out before people moved into the service. We saw older care plans that had been archived but had been put into place immediately after admission, based upon the pre admission assessment. This meant that care plans were based upon identified needs and risks and were updated following a period of monitoring and ongoing assessment.

People were given opportunities to get used to the service gradually prior to moving in permanently. One person had not been in the home long. They were supported by staff who told us they had spent each day for one week visiting the service to get used to the environment and staff before moving in. We saw a staff member hug the new person who had become a little anxious and tell them, "Do you feel a bit lost? It's

alright, you'll soon get used to us you know. Would you like to come and help me to set the table?" This interaction acknowledged that staff recognised the needs of the person (validation) and then used distraction to divert the person to something more positive with good effect. The term validation in relation to person centred dementia care, is the acknowledgement of the persons feelings and emotions and responding to them.

A varied programme of activities was in place. An activities coordinator was in post, and people spoke highly of them. One person said, "She's very effective, she takes us for physical education. That's a laugh a minute!"

We spoke with the activities coordinator who worked three days per week. Activities were planned to be varied and meet the individual needs and preferences of people. Letters had been written to people or their family members asking for information about hobbies and interests. It also asked for families to provide music which was important to their loved one. Activities available included, crafts, physical and sensory activities, Tai Chi, and general knowledge or current affairs. People had been discussing whether to leave the European Union and the activities coordinator explained that she felt that helping people to keep up to date with what was in the news was very valuable. Activities were planned to suit a variety of tastes and while the activities coordinator was conscious not to stereotype people, they arranged different activities to suit men and women. For example, a beer and cheese afternoon had taken place to appeal to some of the men. Ladies had afternoon tea in the conservatory with china cups and topics for discussion including; politics, motherhood, fashion and the war. We spoke about the activities available to people who were nursed in bed, as some people had limited communication and were very frail. The activities coordinator had arranged for one person to have access to talking books, as they had been an avid reader. We saw that instructions about the favourite classical music of another person was displayed in their bedroom and the radio set to the correct station. The activities coordinator also read to people and recited poetry, and was looking at ways to provider greater visual stimuli, in relation to what people could see from their beds.

Records of activities which people had participated in were maintained. The service had links with a voluntary organisation called MIND Active. MIND active supports local volunteers to improve the lives of older people living in residential care homes and people living with dementia from their own homes in South East Northumberland.

A complaints procedure was in place. There had been three complaints since the last inspection. We saw that these had been recorded and responded to appropriately. A copy of the response from the registered manager was available including any action taken.

Good

Is the service well-led?

Our findings

A registered manager was in post who was supported by a deputy manager. One person told us they had a good relationship with them and said, "(Name of manager) can be very frank but she's great! I got a mild telling off because I was losing weight. It was light hearted and she said 'I'm watching you'."

We observed the registered manager walking around the home, and engaging with people, staff and relatives. She was aware of what was happening in the home and noticed things that needed to be attended to; for example, we overheard her comment to the deputy manager that a room was beginning to "look shabby" so needed to be redecorated.

Staff told us they felt well supported by the registered manager. One staff member said, "If I have any problems I can just go to the manager. I see her regularly." Another staff member said, "I like the manager, day to day the home runs smoothly." We spoke with a staff member who had previous experience of working in other care settings. They told us that they were very happy with the way the service was run and told us, "This care home is much better in every way, it is cleaner, tidier and well organised. I am happier working here."

The views of people and their families were sought. Regular meetings with people and relatives were held. We saw that the most recent one had taken place at the beginning of March and minutes were available. Questionnaires were sent and customer satisfaction surveys were in use.

The registered provider visited the service regularly and records of visits were maintained including a list of any actions to be carried out. The registered manager also carried out a number of safety and quality audits. For example, we saw an audit had been carried out regarding the quality of food. Care plans were also audited on a regular basis and we saw that where gaps had been identified, that these had been highlighted to staff to address. Audits relating to clinical safety in relation to medical conditions or specialist equipment, and infection control were also carried out. This meant that the registered manager sought to ensure the safety and comfort of people who used the service was maintained.

The service had developed links with the local community, including work experience students from the local high school, library, MIND active and children from the catholic school visited at Christmas. The service was also developing links with a local charity which supported the integration of children with older people, in recognition of the positive impact this can have on both groups.

The registered manager sent statutory notifications to CQC in line with legal requirements. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.