GrayAreas Limited

Mount Olivet Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Mount Olivet is a care home, registered to provide accommodation and nursing and personal care for up to 30 people. Most of the people living at the home were older people requiring nursing care or those who may be receiving end of life care. At the time of the inspection there were 21 people living at the home.

The inspection took place on 12 and 13 October 2015 and the first day was unannounced. Two social care inspectors undertook the inspection on the first day, and one on the second day.

The home had previously been inspected in July 2014 and was found to be meeting the regulations.

The home had a registered manager. 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.

Summary of findings

Prior to this inspection we had received information that people's ability to be able to consent to their care and treatment had not been assessed in line with good practice.

A number of people living at the home had conditions that affected their ability to make decisions about their care and treatment, such as dementia or other neurological conditions. When people are assessed as not having the capacity to make a decision, a 'best interest' decision involving people who know the person well and other professionals, where relevant, needs to be made. Staff demonstrated a good understanding of the principles of the MCA and told us people were presumed to have the capacity to make decisions. The documentation relating to how the home assessed people's capacity to make decisions about their care and treatment was not always clear. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the time of our inspection some people were being deprived of their liberty to maintain their safety, as the home had a keypad lock on the front door to prevent people from leaving the home unsupervised and we saw that authorisation had been sought to do this legally.

People spoke highly of the care they received. They told they felt safe and were supported by kind and caring staff. Comments included, "yes, it's lovely here, I couldn't wish for anywhere better", "the staff are really nice, we have such fun" and "it's fantastic here; they can't do enough for you. It's the Ritz." People said they would speak with the registered manager, or any of the staff, if they had any concerns or wished to make a complaint. However, no-one had needed to do so as they were happy with the care and support they received

Some people were being nursed in bed due to their frail health and we saw they were treated kindly and with patience. Their care needs were well documented indicating their needs were being met and they were receiving safe care. We saw staff in pleasant conversations with people and it was obvious staff had genuine affection for people. When staff entered people's rooms we heard them explaining why they were there and what they were doing. Relatives told us they felt their relations were safe. One relative said, "I can relax; I know she's being cared for – it means a lot."

Care planning and risks to people's safety and well-being were assessed prior to people moving into the home, were well managed and regularly reviewed with the person and their relatives, should the person not be able to contribute to the review themselves. People had prompt access to their GP and other health care professionals as needed, such as occupational therapists and the community speech and language team. People's medicines were managed safely with only nurses administering medicines. People receiving care at the end of their life had medicines prescribed in anticipation of their needs to ensure they remained comfortable and pain free.

People told us they liked the food and had a good choice available to them. Comments included, "lovely food", "excellent food" and "I really like the food." During the inspection we saw people offered fresh homemade lemonade and fruit smoothies as well as hot drinks and biscuits, homemade cake and fruit. Some people required assistance with eating and drinking and we saw people were supported to eat in a manner that respected their dignity. Where people had been identified as at risk of not eating or drinking enough to maintain their health, records were maintained of how much they had eaten or had to drink during the day and these were reviewed daily by the nurses on duty.

There were sufficient staff on duty to meet people's needs. Staff were recruited safely and received training to ensure they were knowledgeable about people's care needs. They had received training in safeguarding vulnerable adults and they demonstrated a good understanding of how to keep people safe and how and to whom they would report any concerns to. They told us they enjoyed working at the home, one staff member said, "I love working here, we all work well together" and another said "I've been here a long time and I really enjoy working here." A nurse told us this was the "best" nursing home she had worked in.

The home had planned activities each week and these were either provided by the staff or people coming into the home, and included games, musicians and animal petting. Work was underway to provide Wi-Fi access for all rooms to enable people to keep in touch with family and friends via computers.

People and their relatives as well as the staff told us the home was well managed. The relatives we spoke with

Summary of findings

told us there was good communication with the home and they were kept fully informed of any changes in their relative's condition. The registered manager regularly met with people and their relatives individually to discuss in private their views and how well they felt they were being cared for.

The premises and equipment were maintained to ensure people were kept safe and monthly audits were carried out to review health and safety practices. The environment was very homely and clean throughout with no unpleasant odours. The communal rooms and many of the bedrooms had beautiful views over the Bay. The conservatory had binoculars for people to use, however, the room was hot and one person said they rarely used it as it was often too hot.

Summary of findings

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 home was safe.

People told us they felt safe at the home. Relatives were confident their relations received safe care.

Risks to people's safety and well-being were well managed. Staff were knowledgeable about protecting vulnerable people.

Starr recruitment practices were safe.

People received their medicines as prescribed and medicines were managed safely.

Is the service effective?

Good

The home was effective.

Staff demonstrated a good understanding of the principles of the MCA and the presumption that people have the capacity to make decisions.

The documentation relating to how the home assessed people's capacity to make decisions about their care and treatment was not always clear.

Some people had their liberty restricted to keep them safe and this was done legally in the least restrictive way.

Staff received the training they needed to meet people's needs. They were knowledgeable about people's care needs and had the skills to support them.

People had prompt referrals to healthcare professionals, such as GPs.

Is the service caring?

Good

The home was caring.

People spoke highly of the care they received. People were treated kindly and with patience. Staff had genuine affection for people.

Relatives were happy with the care their loved ones received and had a good relationship with the staff, nurses and the registered manager.

People were supported to remain at the home and be cared for at the end of their lives if that was what they wished.

Is the service responsive?

Good

The home was responsive.

Staff were responsive to people's need and requests.

Care plans described people's needs clearly as well as their preferences in how they wished to be supported.

Leisure and social activities were planned to provide meaningful engagement for people, including those who were being nursed on their rooms.

Summary of findings

People said if they had concerns they were confident these would be listened to and dealt with promptly.

Is the service well-led?

Good

The home was well-led.

People, relatives and staff told us the home was well managed. There were clear lines of responsibility in the home and staff worked well as a team.

There were systems in place to assess and monitor the quality of care. The manager had audited records, policies, environment, and staffing.

People, relatives and staff were encouraged to share their views for improving the services provided at the home.

Mount Olivet Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 took place on 12 and 13 October 2015 and the first day was unannounced. Two social care inspectors undertook the inspection on the first day, and one on the second day. The inspection was carried out by one adult social care inspector. Before the inspection we had received a concern regarding how the home assessed people's capacity and supported them to make decisions about their care and treatment. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke with or spent time with all of the people living in the home and five visitors. We also spoke with eight staff, three nurses, including the clinical lead nurse, and the registered manager. We looked at the care plans for five people, the medicine records, three staff files, and the audits and other records relating to the management of the home. Following the inspection, we consulted with the local authority's quality and improvement team, who confirmed they have no concerns over the care and supported provided at Mount Olivet.

Good

Is the service safe?

Our findings

During our visit we spoke with everyone who lived at the home and asked if they felt safe. Everyone who was able to share their experiences with us told us they felt safe. One person said "yes I feel safe here" and another said, "yes, it's lovely here, I couldn't wish for anywhere better." Those people who were not able to tell us their views were being nursed in bed due to their frail health. We saw their care needs were well documented and their daily care notes were updated as the care was provided. These records indicated their needs were being met and they were receiving safe care. For example, where people were at risk of developing pressure ulcers due to no longer being able to change their position, we saw staff had assisted them to change their position frequently. Relatives told us they felt their relations were safe. One relative said, "I can relax; I know she's being cared for – it means a lot."

We spoke with eight staff members and three nurses, including the clinical lead nurse, who told us they had received training in safeguarding vulnerable adults and certificates were held in their training files. They demonstrated a good understanding of how to keep people safe and how and to whom they would report any concerns to. The policy and procedure to follow if staff suspected someone was at risk of abuse were available in the office and telephone numbers for the local authority and the Care Quality Commission were clearly available for staff.

There were safe recruitment practices in place that included completed application forms, previous employment history and references as well as Disclosure and Barring checks, to ensure as far as possible only suitable staff were employed at the home. Records showed the registered nurses had their registration with the Nursing and Midwifery Council checked prior to their employment and then annually.

People and staff told us there were sufficient staff on duty to keep people safe and meet their needs. One the first day of the inspection, in addition to the registered manager, the home's clinical lead nurse and a further nurse were on duty with seven care staff, three housekeeping and laundry staff, and two catering staff: on the second day there was an additional nurse on duty. The registered manager confirmed staffing levels were arranged in accordance with people's care needs which were regularly assessed to identify changes in their dependency and their possible need for more assistance from staff. A relative said they knew they could leave their relation safely with staff because frequent checks were made. They said the call bells were always responded to in a reasonable time. One member of staff told us they "never have to rush, we are able to spend time with people" and we saw people being assisted unhurriedly and call bells were answered promptly.

Risks to people's safety and well-being had been assessed prior to their admission to the home and regularly reviewed to identify any changes. Risk assessments included the risk of skin breakdown and the development of pressure ulcers, poor nutrition, the risk of falls as well as the risks associated with health conditions such as diabetes. Where risks had been identified, people were consulted over how they wished to be supported to manage these. For example, one person had requested the use of bedrails to reduce the risk of rolling from their bed. The assessments also indicated what signs and symptoms to be observant for, such as red areas on people's skin, or a strong odour to someone's urine, to enable staff to alert the nurses for "early nursing intervention" to prevent deterioration in the person's condition.

Where necessary staff had sought advice from health care specialists to assist in managing people's risks. For example, one person had been assessed as at risk of choking due to swallowing difficulties. Records showed staff had consulted with the community Speech and Language Team. Their advice was clearly recorded in the person's care plan and staff were guided on how to support this person to eat and drink safely. Information also included, "signs of something going wrong with swallowing." This provided staff with information about how to recognise if someone had inhaled small amounts of food or drink and what action to take. Records showed risk assessments had been reviewed monthly or more frequently if people's needs had changed.

People's medicines were managed safely. We observed some medicines being administered and this was done unhurriedly. Medicines were administered by the registered nurses on duty.

Medicine administration records were clearly signed with no gaps in the recordings. The medicine administration records included information which protected people, such as any allergies, or any special instructions such the

Good

Is the service safe?

placement of medicated patches. Where medicines were prescribed with a varying dose, such as warfarin, this was managed safely, with staff receiving written confirmation from the GP of the forthcoming week's doses. For those people who were unable to express their needs, a pain assessment record was used to assess if someone appeared to be uncomfortable, enabling the nursing staff to provide pain relief. Anticipatory medicines were requested from the person's GP when they were identified as nearing the end of their life to manage their symptoms. These medicines helped people to experience a pain free and dignified death. We saw a number of people had these medicines prescribed to ensure pain relief was available to people when needed.

Medicines were stored safely and only the nurses and the clinical lead had responsibility for checking stocks, reordering and disposing of medicines no longer in use. They also undertook regular audits, daily, weekly or monthly, depending on the medicine, to ensure records had been accurately completed and the medicines received in to the home and administered could be accounted for. We checked the quantities of a sample of medicines against the records and found them to be correct. We saw medicine that required refrigeration was kept securely at the appropriate temperatures.

The premises and equipment were maintained to ensure people were kept safe. For example, checks had been carried out in relation to fire, gas, electrical installation, lifts and hoists.

Good

Is the service effective?

Our findings

Prior to this inspection we had received information that the home's assessment process to identify people's ability to consent to their care and treatment had not been managed well in relation to one person.

A number of people living at the home had conditions that affected their ability to make decisions about their care and treatment, such as dementia or other neurological conditions. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a 'best interest' decision involving people who know the person well and other professionals, where relevant, needs to be made.

Staff demonstrated a good understanding of the principles of the MCA and told us they presumed people had the capacity to make decisions. We heard staff seeking consent from people before entering their rooms or assisting them. Staff were heard saying, "Would you like some more? Have you had enough now?" and "shall I?" or "can I help you?" Care plans included guidance for staff to seek people's consent prior to assisting them with their personal care, including those who had limited communication abilities, with staff using visual clues that people were happy to be assisted.

We found the documentation relating to how the home assessed people's capacity to make decisions was not always clear and did not reflect the good practice demonstrated by staff. For example, we saw one person's capacity assessment to make a decision about receiving assistance with personal care was fully completed. The decision had been clearly identified, the outcome of the capacity assessment was described well, and the best interest decision recorded. While for other people, these documents had not been completed accurately. We saw two consent assessment forms in use for the same person, consent form 'A' for people with capacity and consent form 'B' for people who lacked capacity. The decision to be assessed had not been identified and the outcome of the capacity assessment had not been recorded. We also saw the home had received conflicting opinions from health care professionals regarding a person's capacity to make decisions, and the home had sought additional advice from other health care professionals involved in this person's care. This had led to a delay in deciding the outcome of a best interest decision for that person. Training relating to the MCA has been planned for November 2015 and will include the principles of the MCA and DoLS as well as other legal issues around making best interest decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. At the time of our inspection some people were being deprived of their liberty to maintain their safety, as the home had a keypad lock on the front door to prevent people from leaving the home unsupervised. We saw evidence that guidance had been sought from, and applications made, to the local authority's Deprivation of Liberty Team for authorisation to legally deprive people of their liberty.

Staff were knowledgeable about people's care needs and had the skills and knowledge to support them. People told us they had confidence in the staff and spoke positively about the care they received. One person said "all the staff are very good. I have everything I need" and a relative said "(name) is very well cared for, she's very comfortable."

People told us they saw their GP promptly if they needed to do so. On the second day of the inspection, one person said they had told staff they felt unwell and we saw their GP had visited them at the staff's request later that morning. Care files contained records of referrals to GPs, and other health care specialists such as occupational therapists or the community mental health team. The outcomes of these referrals were documented with changes to care needs transferred to the care plans.

People told us they liked the food and had a good choice available to them. Comments included, "lovely food", "excellent food" and "I really like the food, I can always ask for more, or for a snack or another drink." During the inspection we saw people being offered fresh homemade lemonade and fruit smoothies as well as hot drinks and biscuits, homemade cake and fruit. Some people required assistance with eating and drinking and care plans gave clear guidance to staff in how to support people safely. For example, one person's care plan said "all fluids must be thickened to a syrup consistency" with a picture detailing what this looked like. The plan went on to say "(name)

Good

Is the service effective?

needs to eat slowly from a teaspoon" and staff told us this was how they supported this person. We saw people were supported to eat in a manner that respected their dignity and at an appropriate pace. Staff sat at the same level as them to enable them to hold a conversation. Fold away chairs were available in people's bedrooms to allow staff to sit comfortably while assisting people with their meals and drinks.

People were able to take their meals where they chose and we saw staff asking people where they would like to eat, in their rooms, the dining area in the lounge or the conservatory. We saw people enjoying their lunchtime meal: people were offered choices and the mealtime was pleasant and unhurried. One person said they felt unable to eat their meal, saying "I just fancy bread and butter and some cheese" and we saw this was brought to them.

Care plans included nutritional risk assessments and people's weight was monitored regularly to assess for any changes that might indicate further support and advice was required. Where people had been identified as at risk of not eating or drinking enough to maintain their health, records were maintained of how much they had eaten or had to drink during the day. These records were reviewed during the day and each evening by the nurse on duty. Any concerns were reported to the person's GP.

All the staff at the home had either achieved or were working towards a Diploma in Health and Social Care at levels 2 or 3. They received regular training in issues relating to people's care needs as well as health and safety topics to ensure they could meet people's needs and provide safe care. Staff told us they had "lots of training" and could request training in topics they were interested in or to have updates if they felt they needed them. For example, staff said they could have updates in moving and transferring people safely using a hoist upon request. The home was supported by the local hospice who provided training in caring for people at the end of their lives.

Training records identified the training each member of staff had undertaken and when updates were due. The registered nurses were provided with additional training to maintain their professional registration and also to ensure their specialist skills were kept up to date such as administering medicine through a syringe driver, taking blood samples and catheterisation.

Newly employed staff were provided with an induction to the home, working alongside experienced staff and undertaking training prior to being assessed by the clinical lead nurse as competent to work unsupervised. One newly employed member of staff told us they had worked at the home several times through an agency and had enjoyed it so much they had applied for a permanent job when one became available. Newly employed staff were also enrolled to undertake the Care Certificate. The certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.

Staff received regular one to one supervision where they were encouraged to share their views on the running of the home and their personal development and training needs. Staff said they found these meetings useful and felt listened to. Staff also received an annual appraisal where their work performance was formally assessed.

The environment was very homely and had a welcoming feel. The home was clean throughout with no unpleasant odours. The communal rooms and many of the bedrooms had beautiful views over the Bay. The conservatory had binoculars for people to use, however, the room was hot and one person said they rarely used it as it was often too hot. The conservatory opened onto a pleasant patio area with seating, and we saw people enjoy sitting in this area.

Good

Is the service caring?

Our findings

Those people who were able to share their experiences with us spoke highly of the care they received. They told us the staff were always caring and friendly: comments included “the staff are really nice, we have such fun”, “I’m very happy here, I’m well looked after” and “It’s fantastic here; they can’t do enough for you. It’s the Ritz.”

For those people who were unable to share their experiences of living in the home, we saw they were treated kindly and with patience. We heard one member of staff talking to a person who was being nursed in their room. They were assisting them to have a drink and we heard “I’ve got a cup of tea for you (name). Do you want to have some? Is it sweet enough?” After the person had taken a sip it was clear it wasn’t to their taste. The staff member said “I don’t think it is sweet enough is it? I will go and add some more sugar and come straight back”, which they did and the person then drank the tea.

We saw staff in pleasant conversations with people and it was obvious staff had genuine affection for people. When staff entered people’s rooms we heard them explaining why they were there and what they were doing. For example, one member of the laundry staff was heard describing to someone what clothes they were returning and what was still to be returned. One of the housekeeping staff announced their entrance to the person who was being nursed in bed, explained what they were doing, and told the person when they were leaving the room. People told us they were treated with dignity and respect and their privacy was protected. We saw staff knocking on people’s doors and waiting for a response before entering.

Relatives told us they were happy with the care their relations received and confirmed they had a good relationship with the staff, nurses and the registered manager. One relative said their relation was treated with dignity at all times, including when staff were assisting them using the hoist. They said the staff were “kind, respectful and polite” and confirmed they were welcome in the home at any time.

Each nurse within the home was an advocate for a small number of people and they, with the support of “buddy” care staff were responsible for reviewing people’s care with them to ensure their care plans accurately reflected their needs and their preferences. They met monthly with family members to include them in the care planning processes if this is appropriate.

Staff told us they enjoyed working at the home, one staff member said, “I love working here, we all work well together” and another said “I’ve been here a long time and I really enjoy working here.” A nurse told us this was the “best” nursing home she had worked in. Staff told us their caring role was about “treating people as I would like to be treated” and “taking care of people, making sure they are well cared for.”

People’s wishes regarding how and where they wished to be cared for at the end of their lives was described in the care plans. The home had received training and guidance from the local hospice in providing end of life care. The registered manager said relatives were supported to spend as much time as they wished with their loved one, to be involved in their care if appropriate, and “to say goodbye.” Relatives told us they valued this support. One relative told us the registered manager had arranged for staff to collect her from home should her relation’s health deteriorate as she was not able to drive.

Good

Is the service responsive?

Our findings

People told us they could choose how they wished to be supported each day and how they wished to spend their time. They said they could get up and go to bed when they wished. One person said "I wouldn't wish myself anywhere else; it's homely and friendly here". They said they had a choice with everything and staff would always do what they asked. A relative told us the home was "absolutely wonderful" and if anything was wrong, "they will tell me straight away, it took a weight off my mind her coming here."

We saw staff were responsive to people's need and requests. For example, one person told us they were unable to easily access items on their table due to the positioning of the furniture and their upper body weakness. Prior to us speaking to the registered manager about this, we saw staff showing this person another room which allowed for more suitable positioning of their furniture. This person was very pleased with the opportunity to change rooms.

Care planning started before the person moved into the home, with one of the nurses visiting people either in their home or in hospital. They and their relatives, where appropriate, were involved in identifying their care needs and how these should be met. The care plans recorded people's preferences and provided staff with clear guidance. For example, one person's care plan indicated they were "always a very smart lady who likes to look feminine with her hair tidy." Another care plan guided staff on how to make a dining experience an "opportunity to stimulate (name's) senses of smell, taste and hearing" by engaging the person in conversation and listening to music while being assisted with their meal. It then went on to identify the interests the person had before moving into the home as suggested topics for staff to talk about.

These plans and associated documents such as risk assessments were reviewed each month and care plans were amended to reflect the changes in people's care needs. In addition to the daily care notes, an "intentional rounding care chart" provided information of people's night time care needs. Staff used this to record when and how they had supported each person, including their pressure area and continence care and their diet and fluid intake.

Staff knew people well and were able to describe people's preferences in how they wished to be supported. One staff member said that although one person could no longer speak, "we know she understands what we say" and their care plan guided staff to "talk to her about the garden" which they could see from their room.

The home planned several activities each week and these were either provided by the staff or people coming into the home, and included games, musicians and animal petting. Staff said they spent time with people who were being nursed in their rooms, in conversation or looking at photographs, or taking the animals into their rooms when they visited the home. The registered manager recognised those people who used computers needed Wi-Fi to stay in touch with their families and friends and work was underway to provide Wi-Fi access for all rooms.

There was a policy in place for dealing with any concerns or complaints. People said they would speak with the registered manager, or any of the staff, if they had any concerns or wished to make a complaint, but they had not needed to do so as they were happy with the care and support they received. One person said, "The gentleman in charge, he's a down-to earth, understanding man. I'd go to him if I was ever worried, but I am comfortable and happy. " A relative said, "I have no complaints. If I did I can speak to (clinical lead nurse) or anyone. I am so pleased with it (the home) in every aspect." Another relative told us the registered manager had listened to their concerns and had responded promptly to their satisfaction. The registered manager reviewed any comments, suggestions or complaints received each month and recorded the action taken in response to these. This information was included in a monthly report made to the company's head office.

Good

Is the service well-led?

Our findings

People and their relatives as well as the staff told us the home was well managed. The staff understood their roles and said the communication between themselves, the nurses and the registered manager was good. Staff said duties were allocated well and they knew what was expected of them during their shift. They said the views of all staff, including those not directly involved in providing personal care, were valued and listened to.

The registered manager was aware of their responsibilities relating to their duty of candour. The duty of candour places requirements on providers to act in an open and transparent way in relation to providing care and treatment to people. The registered manager said they had an "open door" policy for people, their relatives and staff to discuss any issues of concern or to make suggestions about improvements in the home. They regularly met with people and their relatives individually to discuss in private their views and how well they felt they were being cared for.

The registered manager said they regularly reviewed the comments made by relatives on the website www.carehome.co.uk as an indication of their satisfaction with the care and support provided at the home. The management of the home was described as "excellent" in comments made in September and October 2015, with one relative saying, "I cannot recommend Mount Olivet Nursing Home highly enough."

Staff said regular meetings allowed them to discuss with the registered manager how well the home was meeting people's needs, and to make suggestions for improvements. Minutes from a recent meeting identified staff were happy with the home's flexible routines with people being able to get up and go to bed when they wished.

Monthly audits were carried out to review health and safety practices such as fire safety, equipment checks, medicine audits and analysis of incidents such as falls to try to identify any trends and prevent them re-occurring. Any incidents were investigated and an action plan or additional support put in place where needed. From these audits a report was made to the company's head office detailing clinical issues, such as whether people were eating and drinking enough to maintain their health, whether anyone had been admitted to hospital or needed medical attention, and whether the home had received any complaints. The registered manager confirmed they met regularly with the registered provider to discuss these management issues.

The registered manager and clinical lead nurse attended care conferences and forums with other providers to explore new developments in care and legal matters and to share good practice. The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

The home had received a food hygiene visit in July 2014. They had been awarded a rating of five. This was the highest rating and showed the service maintained very good hygiene.