Jewish Care

Hyman Fine House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Hyman Fine House is a large building in a residential area of Brighton, close to the sea, public transport, local amenities and shops. The service is owned by the charity Jewish Care and is one of their homes in the United Kingdom. The home provides accommodation, personal and nursing care for up to 45 older people. Some people had disabilities such as limited mobility, physical frailty or lived with health problems such as heart disease, diabetes and strokes. Some people lived with dementia. There were 39 people living at the home at the time of our inspection.

Hyman Fine House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

This comprehensive inspection took place on 16 October 2018 and was unannounced.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Hyman Fine House had a registered manager who had been working for Jewish Care since 1999 and in post as registered manager at this home since January 2011. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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's risks around food and nutrition were not always recognised and understood by all staff. Other risks to people and the environment had been identified and staff understood people well and how to manage risks to help ensure people were safe. People continued to be supported to receive their medicines safely by staff that were trained in administering medicines. People continued to feel safe. One person told us, "I feel safe here, the staff look after me well."

People remained protected from avoidable harm. There was a safeguarding policy and staff received training. Staff knew how to recognise the potential signs of abuse and knew what action to take to keep people safe.

People continued to be supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff understood best interest decision making where people lacked capacity in line with the principles of the

Mental Capacity Act 2005. Staff sought people's consent before giving personal or nursing care.

People were supported to maintain their health and had assistance to access health care services when they needed to. The home had a weekly GP's surgery. People were supported to attend other healthcare appointments. We saw people had access to services such speech and language therapists (SALT), diabetic team, chiropodists, opticians, dentists and physiotherapists. One person told us, "They're really on the ball, I see the doctor when I've needed to and they look after my health really well."

People continued to have access to an extensive and wide variety of activities and were involved in planning activities. People received compassionate and dignified end of life care that respected their wishes. People were proactively supported to maintain relationships with people who were important to them. One person said, "The best thing about the home is that they really care about the people." Concerns and complaints remained well managed and were responded to.

People continued to receive kind and compassionate care. People told us the staff were kind and caring and they were happy with the service they received. One person said, "The staff commitment to care is 24/7, you can't beat it." We saw positive interactions between people and the staff caring for them. Staff said they enjoyed working at the home and felt supported by the registered manager. A relative told us, "It feels like a home."

The home continued to be well-led. A relative said, "Everything runs smoothly." People, staff and relatives remained engaged and involved in the service provided. A member of staff said, "I love it here, everyone is supportive." Daily feedback was sought through people's engagement with staff, key worker meetings and care reviews.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service had deteriorated to Requires Improvement.

Risks to people were assessed but not all risks were understood by all staff.

Risks of the environment were safely managed

People were protected from possible abuse and neglect. Staff knew how to recognise the signs and they knew what to do if they suspected any abuse had occurred.

People received their medicines safely.

Is the service effective?

Good

The service remained Good.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Good

The service remained Good.

Is the service well-led?

Good

The service remained Good.

Hyman Fine House

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 comprehensive inspection took place on 16 October 2018 and was unannounced. The inspection team consisted of two inspectors, and inspection manager and an Expert by Experience. An Expert by Experience is a person who has a personal experience of using or caring for someone who uses this type of care services.

Before the inspection we reviewed information we held about the service including any notifications complaints or safeguarding alerts that we had received. A notification is information about important events which the service is required to send to us by law. We contacted the local authority and people who commissioned services from the provider to obtain their views. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke to the registered manager and a range of other staff including four care staff, a registered nurse, the chef manager, housekeeper, activities co-ordinator and maintenance staff. We spoke to 14 people who used the service, two of their relatives and one visitor. We looked at all areas of the building including the kitchen, people's bedrooms and bathrooms and the communal areas such as the lounge, dining room and synagogue.

We pathway tracked the care of ten people. Pathway tracking is where we check that the care detailed in individual plans matches the experience of the person receiving care. We looked at a range of documents including policies and procedures such as safeguarding, incident and accident records, medication protocols and quality assurance information. We looked at complaints and compliments and feedback from people who used the service. We reviewed three staff files including information about recruitment, supervision and training.

Requires Improvement

Is the service safe?

Our findings

Risks to people around food and nutrition were not always well managed. Risks to people had been assessed by speech and language therapists (SALT) where people had swallowing problems and guidance was in place regarding food texture and thickening levels for fluids. Despite this, while some people received their meals in the correct consistency for them, others did not. For example, we saw one person who had been assessed as needing specially prepared meals as they had difficulty swallowing. During lunchtime the person was given food in an unsuitable consistency for them. We bought this to the immediate attention of care staff who recognised the person had not been given the correct meal and it was removed to ensure the person's safety. The provider was in the process of transitioning to a new electronic care plan system. The instructions in the paper care plan were current, but the choking risk assessment had not been updated for five months. Care staff we spoke to understood people's preferences and those who had risks around food and required special dietary requirements, but the electronic care plan had not been updated to remind all staff of the risks. There was no process to ensure kitchen staff were aware of those people who had been identified as needing special diets. This meant that there was a risk people could be served food in a consistency that may not be safe for them to eat.

Nutritional risk assessments for some people had not identified potential risk of choking. For example, we observed one person during lunch who began coughing on their food while eating. The person was eating independently and was not eating in the main dining room. There were no staff in the immediate area. We reviewed the person's care plan which stated the person sometimes fell asleep during mealtimes and staff needed to prompt the person to stay awake. This had been recognised as a risk to the person in terms of weight loss if they did not eat enough, but their risk of choking on food if they were not fully alert while eating had not been recognised.

The registered manager had not ensured there was a robust process to ensure information regarding people's risks around food was consistently assessed, communicated to and understood by all staff. We discussed these issues with the registered manager during the inspection and subsequent to the inspection they discussed the immediate changes that had been made as they recognised this was an area of practice that needed improvement.

People told us that they continued to feel safe at Hyman Fine House. One person told us staff were "careful to make sure we are safe." Another person said, "I feel so relaxed and safe here because there is always people around I can ask for help. I am never alone which I like." Another person said, "I feel safe here, the staff look after me well."

People continued to be protected against the risks of potential abuse. Staff had received safeguarding training and understood safeguarding adults' procedures and what to do if they suspected any type of abuse. Staff demonstrated very clear understanding and knowledge of safeguarding principles. Staff told us they would not hesitate to report any bad practice they witnessed or suspected, and they would report it to a manager or external agency straight away. One staff member said, "I have no hesitation in making referrals, in fact no one does as we see it as an opportunity to learn." A safeguarding policy and

whistleblowing policy were available and staff were aware of it. Safeguarding referrals had been made appropriately.

Other risks to people's safety and welfare continued to be well managed. People who had moved into the home had a full needs assessment. The provider used a range of tools to assess specific risks to people, for example, a mobility care plan to manage falls risk and the Malnutrition Universal Screening Tool (MUST) was used to assess nutritional risks.

Risks associated with the safety of the environment and equipment continued to be managed appropriately. Regular checks were undertaken on equipment and the fire detection system was regularly checked to make sure they remained safe. Safety checks were regularly carried out and appropriate certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and where required, each person had an individual personal evacuation plan. The provider employed a dedicated facilities person who was responsible for overseeing the safety of the environment and premises.

There continued to be sufficient numbers of staff to meet people's needs. One member of staff said, "Of course you can always do with more staff, but I can't think of anything that we don't provide now that we could if we had more staff." One person said there were enough staff, "Generally yes, they respond as quickly as they can." Rotas confirmed the number of staff deployed was consistent. The provider had recruitment processes to ensure new staff were suitable to work with the people. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Records confirmed staff member's identities and nurses employed by the home had the appropriate clinical registrations in place. New staff completed an induction. We spoke with one staff member who had just completed their induction, and they told us they felt well prepared to do the job and they felt well supported.

People continued to receive their medicines safely by staff who were trained and competent to do so. Staff followed policies and procedures to support the safe storage, administration and disposal of medicines. The home's GP reviewed medicines every six months or more regularly if needed. Medicines management practice was regularly audited. Staff received regular training and annual competency assessments, to ensure their practice remained safe. There was also guidance for administering medications 'as required' (PRN). People told us they were supported to receive their medication on time.

People remained protected by the prevention and control of infection. There was a detailed cleaning schedule and this included regular routines for cleaning of the premises. Spot checks were regularly undertaken to unsure cleaning standards were maintained. Equipment such as mattresses, hoists, wheelchairs and commodes were also regularly cleaned. One the day of inspection, the cleaner was present and the home was clean. People told us staff followed good infection control routines and we observed this in practice. One relative told us the home was "spotless, they are always cleaning"

The registered manager continued to ensure lessons were learnt from accidents and incidents. There was a system in place to record accidents and incidents with information about what had happened, and any action taken to prevent a further accident as far as possible. For example, the registered manager undertook a monthly analysis of falls and this highlighted one person's falls showed a pattern in relation to the time of day. This led to a request for increased funding to ensure the person had one to one support when they were at most risk of falls. Staff reported that learning from incidents was often through reflective practice. In another example, one person had sustained a fractured hip. Their case was reviewed as a team and

measures were put in place to try and reduce the risk of future falls. The person's care plan had been updated which reflected lessons learnt including ensuring the person used appropriate mobility aids.

Good

Is the service effective?

Our findings

People's care, treatment and support continued to be delivered in line with current legislation and standards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Under the MCA, 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. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care plans remained sufficiently detailed with respect to MCA and included whether people could make specific decisions for themselves. Consideration was given to whether people were supported by others to make decisions, such as an advocate or a person with legal authority to do so. Where best interest decisions were made for people who lacked capacity, this was documented and we saw people were consulted appropriately.

People under DoLS authorisation continued to have appropriate assessments. For example, one person had a DoLS authorised with a condition attached that required management of covert medication was to be reviewed by the GP every six months. Staff were aware and the condition was adhered to. When people had capacity to make decisions about their care or to exercise choices in everyday matters they were free to do so. Staff asked people for their consent before supporting them.

People continued to be supported to maintain a balanced diet. We observed lunchtime and saw people, their visitors and staff eating together. One person told us, "We always sit here and eat together, it means a lot being able to share a meal together." People told us they had enough to eat and drink and were satisfied with the food provided. One person said, "Oh the food is always very nice." People who needed assistance with eating were supported by staff who understood their needs well. The kitchen and menu was managed and prepared in accordance with the Jewish faith and cultural traditions. Menus were planned with consideration for seasonal produce and what people enjoyed. The chef followed current best practice by ensuring meals were fortified and snacks were available between meals to ensure sufficient nutritional intake. For example, one person had a poor appetite and the chef confirmed this person was given fortified meals. Their care plan recorded that their weight had been stable for the previous six months. Another person followed a vegetarian diet and confirmed alternative meals were always provided. There was a book available for people to comment on the food provided and feedback was overwhelmingly complimentary and reflected that people were given plenty of choice. During lunchtime the menu was discussed and shown to people, and people were offered a choice of meals and we saw this in practice.

People continued to be supported to maintain good health and received on-going healthcare support. The registered manager retained the services of a GP who ran a surgery at the home every week. People could

self-refer and we saw people accessing this service during our inspection. People had access to care, support and treatment in a timely way with referrals made to appropriate social and health services when people's needs changed.

People remained confident in the skills of staff. One person told us, "The staff commitment to care is 24/7, you can't beat it." Staff had the skills, knowledge and competency to deliver effective care and support. There was a well-established training plan and a member of staff told us, "The training makes sure we do things safely both for residents and us." The registered manager had overview and awareness of the status of staff training. As well as essential courses, staff also received specialist training in dementia, including experiencing the Virtual Dementia Tour. This aims to deliver training in an environment that simulates what it is like to experience the world when a person has dementia. The registered manager had plans to repeat this training to include relatives.

Staff continued to work well together to deliver effective care to people. Staff had regular team meetings and they told us this was an opportunity for reflective learning and discussions. Daily communication to staff about the people they cared for, including any updates to care plans or changes to people's needs, was done at shift handover meetings and via the handheld electronic care plan devises. There was a further reflective handover meeting with staff every afternoon.

The registered manager continued to ensure staff received appropriate professional development and supervision to meet the needs of the people they cared for. Staff supervision was up to date. Staff told us they felt supported and recognised the part that regular scheduled supervision played. Staff said, "I feel secure and supported. I can go to my line manager if I have any problems. Outside of those times I receive supervision every six weeks."

The decoration and adaptation of the physical environment of the service continued to meet the needs of people. People moved freely around the home as they wished. Corridors were left clear and accessible to enable people who were independently mobile to move safely. Lifts were available to people to use to access bedrooms on the first floor. People had access to equipment to support their independence including hoists, individualised slings and wheelchairs when needed. For those people with more complex needs, the provider used specialist seating that allowed the person to be moved to different areas of the home to enable them to participate and be included in activities provided. Some doors were automated to make access easier for people in wheelchairs or with limited mobility, and we saw people using these independently.

Good

Is the service caring?

Our findings

People continued to receive kind and compassionate care and staff had developed positive relationships with people. One person told us, "They all do their best to make you feel happy." A relative said, "Yes, they are caring, just seem to be like that all the time…. I find it quite astonishing."

We observed warm, friendly interactions between people and staff and it was clear there remained a commitment to promoting a sense of community within the home. One person said, "The best thing about the home is that they really care about the people." Staff spoke affectionately about the people they cared for. A member of staff said, "I love it here, everyone is supportive. Being part of the Jewish community makes it like a family so everyone knows everyone and have done for many years." Staff knew the people they cared for well. For example, a member of staff interacted with another person who was displaying signs of agitation. The staff member took the person into a quiet area and played a game with them and this visibly calmed the person down. A visitor who had volunteered at the home for several years told us, "You could not wish for a better caring environment."

People continued to be treated with dignity and respect. Staff called people by their preferred name and maintained people's dignity during personal care. Staff knocked on people's doors before entering a room and waiting to gain people's consent before supporting them. We saw a staff member respectfully kneel to speak to a person who used a wheelchair, and then discretely helped them maintain their dignity when their underwear was inadvertently exposed as their clothes became entangled with a magazine they were trying to take from a table.

People continued to be supported to make choices about their care, where they went and what they did on a day to day basis. One person told us about a lunch club they went to every week. Another person told us they used the garden regularly and said, "You can come and go as you please." A group of people were playing a board game together with their relatives and volunteers. It was clear from the chatter and the screams of laughter that the group were having fun as they played and ate snacks. Those who needed help with playing were assisted by the volunteers. Other people spent periods of time sitting in chairs or watching television. One person chose to lay on a settee for much of the day in the lounge area. At mealtimes staff involved people in making the choice about where they wanted to sit in the dining room to be most comfortable and to be with people of their choice.

Staff continued to understand equality, diversity and human rights. Care plans included people's preferences, for example regards gender, religion and sexual orientation where they wished to discuss them. People's cultural and religious needs continued to be met in a proactive way. Staff received training to support their understanding of Jewish festivals and received cultural awareness updates that reflected the diversity of staff themselves, as well as learn about the cultural heritage of people they support. People's differences were respected and were supported to maintain their identity and personal and physical appearance in accordance with their own wishes. People were free to arrange their rooms as they wished, and many people's rooms were highly personalised with items that were important to them.

Visitors remained welcome at the home. They sat with people in communal areas and private rooms. Relatives told us they could visit at any time and they were always made to feel welcome. A visitor said, "I get hugs from half of the staff, I feel part of the family." There was a synagogue within the building. The registered manager told us that it was used for Shabbat, the day of rest service, every week. Different branches of Judaism were practiced by people at the home and people choose whether to attend services or not. Some people came from the local community to worship there and all the Jewish festivals were celebrated.

People's private information remained secure. The provider had an electronic care plan system where information about people was stored and updated. Care documentation was held confidentially and systems and processes protected people's private information. Sensitive information was stored securely in the registered manager's office which was locked when they were not present.

Good

Is the service responsive?

Our findings

People continued to be supported to live as full a life as possible. Staff identified that activities were an integral part of people's lives and were led by people's choices. People had access to an extensive and wide variety of activities both inside and outside the home and were involved in their planning. For example, one person was very withdrawn when they first moved in to the home. The activities coordinator understood the person enjoyed animals and gardening and helping others. The home kept chickens and the person now looked after them and collected the eggs. They were also supported to keep budgies in their room and helped organise trips to the local garden centre with others to collect bird food. The activities coordinator told us," She is still quietly spoken, but it's different now. She engages with life, and others and is involved with activities that have purpose." There were regular scheduled activities for people. On the day of inspection, people were enjoying a regular visit from a creative artist, a puppeteer and some people went out to a lunch club while others were supported by volunteers to play games. One person told us about a regular fitness class, "I enjoy it, it's important to stay active." People were supported to take trips out to the shops or local museum. Staff supported people to be active in their local community and had put on an arts and crafts event as part of the Brighton Festival. The home was involved with a project to celebrate the links between Judaism and the local community by exploring people's life stories and local history through "active aging" to find physical and mental ways to address dementia.

People continued to be supported to maintain relationships with people who were important to them. For example, one person was being supported so that their spouse could come and live with them at the home. The person was being given regular emotional support by their key worker while this was being organised.

People remained at the centre of care planning and were involved in the process. Where appropriate, relatives and advocates were consulted. One person told us, "I'm happy here, if I want anything I get it." Staff were responsive to people's individual's needs and allowed them to live their lives how they wanted. One healthcare professional told us that staff "provide a high standard of individualised care." A relative told us, "The home staff are excellent respecting mum's wishes and providing a high level of care and attention to her."

Care continued to be person centred with respect to people's healthcare needs. Records of referrals to and visits from healthcare professionals in people's care files, such as speech and language therapists (SALT), diabetic team, chiropodists, opticians, dentists and physiotherapists. One person told us, "They're really on the ball, I see the doctor when I've needed to and they look after my health really well." One visitor said, "They respond quickly when a health problem is noted and doctor visits weekly so its dealt with quickly." Another visitor said, "They know their residents well."

The provider had incorporated the Accessible Information Standard (AIS) when assessing people's needs. This is the standard that aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Providers must identify record, flag, share and meet people's information and communication needs in line with section 250 of the Health and Social Care Act 2012. All organisations that

provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards. Care plans showed people's sensory and communication needs were being recorded and considered.

Where people needed to raise concerns, the provider remained responsive. The providers complaints procedure to was available for people and their relatives to view. Staff told us the management were responsive and "They will act on any concerns." People told us they knew how to raise concerns and had no hesitation in speaking to the registered manager. Complaints were managed in line with the providers policy and we saw any concerns raised were actioned. The registered manager also fully understood their responsibilities relating to duty of candour. Duty of candour is a regulation that ensures providers are open and transparent with people who live in the home when things go wrong

People continued to receive compassionate and dignified end of life care that respected their wishes and was in accordance with their religious faith. People were asked about their wishes with respect to end of life care at the time of their initial assessment and this was recorded in their care plan. Staff received training on how to care for people at the end of life and the service worked with a GP and local palliative care teams to support people. One healthcare professional told us, "They discuss advance care planning with all the residents, and provide good palliative care." The provider had been accredited for the previous three years with the Gold Standard Framework Award for end of life care. This provides structured guidance and training to those providing end of life care. The registered manager proactively looked for ways to improve end of life care for people. For example, a review after one person's death led to reflection for staff on being less reticent about asking people about their end of life preferences. At the time of this inspection the provider was not supporting people with end of life care.

Good

Is the service well-led?

Our findings

Hyman Fine House continued to be well led. A volunteer told us, "What makes it great is that it's all about the staff. They work hard, you cannot fault them. I visit many people here, and I have watched it improve year after year." A relative said, "Everything runs smoothly."

Management of the home continued to be robust and the registered manager understood the regulatory responsibilities of their role. Relatives, people and staff were complimentary of the registered manager. A member of staff said, "The registered manager is great, all the management team are. They are open to new ideas or if you have any concerns." We observed the registered manager to have a good rapport with people living at the home and people were comfortable and happy in their presence.

The culture of the home remained positive. The registered manager told us, "We see respecting people's differences and promoting independence as central to what we do and this ensures that our residents are at the heart of everything in the home" and these were the core values of Jewish Care. Our observations of how people were supported and enabled to live how they wanted and to be involved in the running of the home demonstrated this was embedded in practice. The registered manager told us that the culture at Hyman Fine House was family oriented and inclusive and they positively encouraged people to get involved with the running of the home. The registered manager told us, "We're a very active home" and "We like to think we're a homely home, we don't stand on ceremony." There was a relaxed and friendly atmosphere within the home. It was clear that people living at the home were the focus by the support they received. A member of staff told us, "It's like looking after family members, it's not like a normal job, we do it because we want to." A relative told us, "It feels like a home."

Systems and processes continued to assess, monitor and improve the quality of the service being delivered. These included regular checks of different aspects of the services provided including cleanliness and health and safety. For example, the registered manager undertook a monthly quality assurance process looking at number of aspects of care, including falls, referrals to GPs, accidents and incidents and nutritional screening. Trends and themes were analysed across all Jewish Care homes, and learning was shared. Any issues identified were documented, action taken and lessons learned. For example, one person was found to have unusual sleep patterns and preferred to sleep in a chair in the lounge, which the staff supported. Falls analysis identified the person was at risk of falling around breakfast time, when staff were busy supporting people. This resulted in a referral to the falls prevention team for specialist advice and raised awareness so staff were more aware of the person's risk at this time of day.

Staff continued to work in partnership with other organisations to ensure people's needs were met. The registered manager and staff had developed relationships with a variety of healthcare professionals including having a weekly GP surgery on site. The aim of this was to try and reduce the number of people becoming unwell, and empower people to be in control of their own health. The registered manager also had close links with other services such as local dementia specialists.

People, staff and relatives remained engaged and involved in the service provided. One person told us about

the residents and staff committee they were involved with, "It's a way of dealing with any problems or talking about ideas for new things. We have a lot of say in how things are run here." People were also involved in the recruitment process for new staff. Staff employed at the home were interviewed by people as part of the application process. People, or their advocates where appropriate, were consulted and involved in the service provided. A relative told us, "I also recently attended a Relatives Meeting chaired by the registered manager and found the content very useful, the patient and open way the meeting was handled was excellent."

Staff remained empowered to make decisions and staff meetings allowed them an opportunity to discuss any issues and suggest ideas to change ways of working. Staff meetings are held monthly and staff found the meetings interesting and informative and they told us it gives them chance to discuss any issues. A member of staff said, "The registered manager is great, all the management team are. They are open to new ideas or if you have any concerns. The team meetings are a real opportunity for reflective learning and discussions."