Oak Park Healthcare Limited

Oak Park Care 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

Summary of findings

Overall summary

This inspection took place on 16 and 18 May 2017. The care home was registered with the Care Quality Commission in May 2016 and this was the first inspection of the service.

Oak Park Care Home is a purpose built care home on the outskirts of Dewsbury. The home provides accommodation for up to 66 people on three floors. The care provided is for people who mainly have needs associated with those of older people; this includes a dedicated unit on the first floor for people living with dementia. There were 44 people living at the home on the first day of our inspection.

There is a registered manager in place who has been registered since the home first opened. 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 living at the home. There were systems and processes in place to protect people from the risk of harm. Assessments identified risks to people and management plans were in place to reduce the risks and ensure people's safety. Staff we spoke with had been trained and were knowledgeable about safeguarding people. They were able to explain the procedures to follow should an allegation of abuse be made.

Medicines were stored safely and procedures were in place to ensure medicines were administered safely. We saw people received their medicines in a timely way from staff who had been trained to carry out this role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The registered manager had complied with their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They had a good understanding of when a person might be deprived of their liberty.

People we spoke with said they were very happy with the meals provided and were involved in choosing what they wanted to eat and were offered alternatives to the set menu if they preferred. Mealtimes were a relaxed and enjoyable experience for people at the home and staff supported people with dignity and respect.

Staff interacted with people with warmth and respect and we saw the atmosphere in the home was friendly and supportive. Staff were able to spend time chatting and laughing with people. People spoke highly of the staff who cared for them and felt able to raise any concerns with staff.

Care files were person centred and evidenced people were involved in their care planning when appropriate. Families had also been consulted with to ensure preferences and views were considered when devising support plans.

The management team provided visible leadership and their vision was to provide a high quality service. Staff told us how supportive management were and told us they enjoyed their roles as carers. The registered provider was actively involved and visited the home regularly to ensure they could support the registered manager to develop the home and recognised building a home from new had its challenges.

The home was well maintained and regular audits were undertaken to benchmark the service and highlight where improvements were required.

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.

People and their relatives told us they were safe and there were enough staff to respond promptly to call bells.

Medication was managed well and was administered in a safe way by staff that had been trained to do so.

Risks to people were assessed and measures were in place to reduce risks.

Is the service effective?

Good

The service was effective.

Staff had received appropriate induction, training, support and supervision to enable them to provide effective care and support to people.

Assessments of people's mental capacity was in accordance with the principles of the Mental Capacity Act 2005.

People received support to access health care services and to meet their nutrition and hydration needs.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs, preferences, choices and personal histories.

We observed people making choices in their everyday lives and staff supported people to make choices when required.

Complaints were well managed and were used to improve the service.

Is the service well-led?

Good

The service was well-led.

Staff told us they were supported by the registered manager and they felt the service was well-led.

The registered manager held regular meetings with staff and people who lived at the home.

Regular audits and quality checks took place and these resulted in continued improvements to service provision.

Oak Park Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 16 and 18 May 2017 and was unannounced. The membership of the inspection team included two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service with expertise in dementia care.

We reviewed information we had received from the provider such as statutory notifications. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority commissioning and monitoring team, infection control teams and reviewed all the safeguarding information regarding the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the lunch time meal experience in two of the communal dining areas and observed care interventions throughout the inspection process. We reviewed six care files and daily records for people living there. We also reviewed the maintenance and audit records for the home and records relating to staff and their training and development.

We spoke with 12 people who lived at Oak Park and four relatives who were visiting during our inspection. We spoke with the director, the registered manager, the deputy manager, two care staff, the chef, and the activities coordinator.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe living at the home, and this was confirmed by the relatives we spoke with. We received the following comments; "I feel safe here yes I do", "I get my tablets on time, they're very good. I don't have to worry", "I know my belongings are safe here" "The staff are lovely." "I have a call bell, staff come when I ring it" and "Night staff are good. They come to help me as well."

The registered provider had developed and trained their staff to understand and use appropriate policies and procedures to safeguard people from abuse. The staff we spoke with knew the procedures if they suspected abuse and they could describe the signs of abuse they might see in a care home. The registered manager understood their responsibilities in promptly reporting concerns and taking action to keep people safe and they had reported incidents to the local authority in line with protocol and notified the Care Quality Commission (CQC) in line with their regulatory responsibility. Staff told us if they had any concerns about a colleague's practice they would feel confident to report this to the manager and if necessary to CQC.

Care and support was planned and delivered in a way that promoted people's safety and welfare. We reviewed the care records for six people at the home, both the electronic and paper records. These evidenced the registered provider utilised a range of risk assessments which underpinned a plan of care for each person. We found standardised risk assessments such a Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition.

Each person had a personal emergency evacuation plan (PEEP) which detailed how the person would need to be supported in the event of an emergency. The home was newly built with up to date fire safety features and the registered provider operated a horizontal evacuation policy where people would be evacuated to the opposite side of the building if a fire broke out. They practised regular fire drills including with night staff to ensure all staff would know how to act in the event of a fire.

We looked at the number of staff on duty on the days we visited the home and checked the staff rotas which showed planned staffing levels were met and there were enough staff on duty to meet people's needs in a timely way and keep them safe. We had been contacted prior to the inspection in relation to concerns about staffing levels at times when people wanted to go to bed. As a response to these concerns the registered manager had increased the staffing numbers by one to cover the period between 4pm to 10pm. People and their relatives told us there were enough staff to care for them during the week and staff were attentive, although one relative we spoke with had observed staffing levels were lower at the weekend. The registered manager and deputy manager told us they worked during the week which might have accounted for this observation of less staff at the weekend. The week prior to our inspection the registered provider had installed an audit tool on their computer system to be able to monitor the call bell response time. At the time of inspection, the registered manager had not yet reported on this.

As part of our inspection we reviewed the accident and incident records. The registered manager had a system in place for recording and analysing any incidents. Staff told us they reported all incidents to the

registered manager and recorded as per the home's protocol. The registered manager reviewed all accidents and incidents to determine themes and measures were put in place to reduce further accidents. For example, people who had been identified at risk from a fall from their bed were provided with profiling beds which lowered to the floor. This reduced the risk of harm from a fall from the bed and was less restrictive than bed rails.

We reviewed three staff files and found the necessary recruitment checks had been made to ensure staff suitability to work in the home. We found the files contained all the essential pre-employment checks required. This included an application form, interview records, two written references, (one being from their previous employer), and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The registered provider had a medication policy which outlined how medicines should be safely managed and we saw senior care workers were responsible for administering medicines. All the medication administration we observed during our inspection was undertaken professionally and sensitively. Prior to our inspection, we had been contacted with concerns in relation to how medicines had been administered to one person at the home, and the registered manager told us how the carer responsible had been supported to ensure this did not happen again, which demonstrated the registered provider was acting responsibly. Staff had their medicines competency checked once a year once they had been trained to administer medicines. No formal spot checks were carried out on staff by the registered manager or deputy manager. They told us they observed staff administering medicines as part of their daily checks.

Storage of medicines was provided in up to date clinic rooms on each floor and regular checks of the fridge and room temperatures were kept to ensure medicines remained at their optimum efficacy. Boxed medicines were all dated upon opening but we found eye drops were not. We raised this with the senior and the registered manager who thought this was unnecessary as medication is recycled every 28 days, so in their view the eye drops would not be opened longer than their opened expiry date but they agreed to ensure this was actioned.

The medication administration records (MAR) included a photograph of the person, which reduced the risk of medicines being given to the wrong person. Records were clear and easy to understand. We counted random samples of medicines and the balance remaining reconciled with the records.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely, as required, and the drugs that were required to be logged in the register were recorded as such. This showed controlled drugs were managed appropriately. We checked a random sample and found the amount of medicine remaining was correct, according to the register.

People's care records contained detailed information about the signs and symptoms to look out for, particularly when the person was unable to ask for pain relief. Although it was clear in people's care records when "as and when required" medicines were to be administered, the protocol for some medicines were not held with the medicine administration record (MAR) which posed a potential risk that a member of staff would not know what signs and symptoms to look for in relation to people who could not verbalise their needs, although at the time of our inspection were able to advise staff so the impact was minimal. The registered manager rectified this immediately.

We reviewed the maintenance certification for the home such as electrical and fire testing information, lift maintenance information and LOLER testing which were all in order. The registered provider had

implemented effective systems to check the environment was safe, such as fire extinguisher checks, room checks, fire alarm checks and water checks. This meant people living at Oak Park were protected from the risk of harm from an unsafe environment.

Good

Is the service effective?

Our findings

People told us how much they enjoyed the food at the home. Comments included, "The food is good. It's tasty. I like it." Another person said, "The menu choices are given each afternoon; you choose from it what you want."

The registered provider had a rotating four week menu detailing what was on offer for breakfast, lunch and tea. Options included a full English breakfast and we observed people enjoying this during our inspection. We observed the lunchtime experience on the dementia friendly unit and the residential unit. It was clear from the chatter and laughter at lunch time that mealtimes were relaxed and informal. People told us, and we could see for ourselves, they could choose what to eat from a choice of freshly prepared food. Tables were laid nicely with table cloths, condiments and wine glasses and staff supported people when required. We observed people were offered alternative choices to the menu when they preferred this.

We found people's initial assessments provided information about their food preferences and any special dietary needs, and we spoke with the chef during our inspection who confirmed they had a system in place to ensure people's special requirements were met. On the dementia friendly floor there were snacks for people to help themselves. We observed these were not readily available on the residential unit but when we raised this we were told it was an oversight by the kitchen staff. One relative we spoke with told us their relation had been losing weight, but due to the staff input was now gaining weight and said they "had to bring in new trousers as others don't fit anymore." They told us they felt fully involved in their relations care by the staff at the home.

We found staff had the right skills, knowledge and experience to meet people's needs. The staff we spoke with told us they had undertaken a structured induction when they started to work at the home. This had included completing the company induction booklet and essential training, such as moving people safely, fire awareness, dementia awareness and health and safety. All staff new to care undertook the Care Certificate in addition to the registered provider's induction. The Care Certificate is a set of minimum standards that should be covered as part of induction training of new care workers dependent on their past experience and qualifications in care. This meant the home was using the recommended standard for new care workers to attain.

We were shown a training matrix which provided an overall view of staff training. This was well organised and showed staff had received training in the registered provider's mandatory subjects. They used an external training provider and each subject required staff to pass an externally marked test of knowledge. Staff that had not met this requirement were required to re-sit the test. Training which was required to be refreshed had been booked in. Staff told us they felt they received a good level of training for their roles and those that had been at the home since it opened said they had completed two months of training after they had been employed before people were living at the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Nine applications under the DoLS had been authorised, and the registered provider was complying with any conditions applied to the authorisation.

The registered provider had an electronic version of the two stage capacity assessment. The two stage test is defined by the Act to determine people's capacity to consent to how their care is delivered. However, the on line records we reviewed did not relate to every decision to be made and related to one overall decision of capacity. Each section of the care plan described how people should be supported to make their own choices and most people at the home could make simple day to day decisions such as what to wear and what to eat, so the impact at the time of inspection was minimal. We discussed this with the registered manager who agreed to contact the registered provider's technology support to build this into the system to clearly evidence they are following the two stage test in compliance with the Act for every decision that needed to be made.

The registered manager showed us they obtained written consent to care from people able to consent and we saw staff sought consent from people throughout our inspection.

The home's décor and furnishings were of a high quality and the home had been built in line with recognised design for environments for people living with dementia. There was a very small garden area but outside space was generally restricted.

Good

Is the service caring?

Our findings

We observed staff interacted with people with warmth and respect. The atmosphere in the home was friendly and supportive and we saw staff were able to spend time chatting and laughing with people. People told us staff were caring. One person said, "Staff are lovely here. Like home from home." Another said, "Very happy here, lovely people." People told us staff involved them in decisions and one person said, "I'm always asked what I want, I'm never told" and another said, "Staff always check with me first." A further person said, "They (staff) don't do anything I don't want." People told us there were no restrictions on when visitors could call. One said, "My family come when they want." Another said, "My [relative] brings the dog in to see me. They don't mind."

We saw people chose where they spent their time, with some people choosing to stay in their rooms while others sat in communal areas, and staff respected these decisions. We observed staff supporting people into the dining area, providing gentle prompts on where to sit and how to navigate. People decided what time they wanted to get up and go to bed and this was recorded in their care plan and the registered manager told us this did not always accord with what a relative might want, but they respected the right of the person to make their own decisions when they were able to make this choice independently.

Staff told us how they preserved people's privacy and dignity by knocking on bedroom doors before entering, closing doors and curtains while providing personal care and offering visitors privacy when visiting. We observed this throughout our inspection. People using the service were well groomed and smartly dressed. Gentlemen appeared cleanly shaven and we saw some ladies were wearing nail varnish. A hairdresser visited the home regularly and the home had a dedicated hairdressing room to enhance the experience of a meaningful activity. Choosing clothing and accessories in keeping with their personal style helps to ensure people are treated with dignity and respect.

We saw in one person's care plan they required staff to ensure they were wearing their glasses and to ensure they were cleaned to promote the person to interact with others. We observed this person wearing their glasses during the inspection and observed a staff member had noticed they had a smudge on them. They asked if they could clean their glasses for them which evidenced the staff recognised the importance clear vision had to people's wellbeing.

Care plans detailed what people could do for themselves and areas where they might need support. For example, to support a person to dress one record stated "[name] is able to choose their own clothes if visually shown." And "[name] is able to brush their own hair." This ensured staff continued to maximise people's independence through this activity of daily living.

Staff were aware of how to access advocacy services for people if the need arose although no one at the home had an advocate at the time of the inspection. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so, or may need assistance in doing so, for themselves

People's end of life wishes were recorded in care plans and the registered manager told us no one at the

home had a living will. They worked to the principles of the Gold Standard Framework (end-of-life care scheme) although were not accredited to ensure people who were at this stage in their life could be supported to have a "good death."

A church service was held once a month at the home for all the people of that faith. The registered manager told us that although the home currently did not support people from different faith backgrounds, they could facilitate this. We asked how the service would support people to ensure equality and diversity needs were met. They said they employed staff from a diverse background which would enable them to support people in line with these preferences.

Good

Is the service responsive?

Our findings

People told us they felt involved in their care planning and had a choice in how support was provided. For example one person said, "I have a bath when I want and they're lovely with me, you know what I mean, it's hard at first, but they are lovely." Another person said, "If I don't like anything I say. I am listened to."

The registered manager told us they undertook preadmission assessments, and part of this assessment was to ensure they only accepted people to live at Oak Park whose needs they could meet. This included ensuring new people would not have a negative impact on the people already living at the home. The registered manager said compatibility and ensuring they could meet the needs of people was more important to the registered provider than a pure financial decision which demonstrated the registered provider's commitment to ensuring the care and welfare of people at the home. Staff told us information collated at the preadmission assessment had been used to help formulate the person's care plan.

We reviewed the care records for six people at the home, both the electronic and paper records The registered provider used computerised care records although some information was also held in paper form. The computerised records contained a care plan which was underpinned by a risk assessment for the following areas of need; mobility, skin integrity, advanced care planning, pain, continence, emotional needs, communication, activities, personal care and hygiene. The information we reviewed in care plans was extremely detailed and person centred, and contained information on how to care for people. We also saw regular evaluations of interventions, such as for one person who had regular fits, and these updates showed what staff had learned after each incident to enable them to improve the care they provided. Care plans also detailed what people could do for themselves to ensure care provision did not take away people's abilities to undertake tasks themselves.

We found care plans and risk assessments had been evaluated on a regular basis to assess if they were being effective in meeting people's needs. However, the information had not always been used from the evaluation to update the care plan if the needs of the person had changed. This posed a risk that inappropriate care could be provided, although we did not observe this at our inspection. We raised this with the registered manager who told us they were aware of this and were actively supporting staff to ensure care plans were updated to reflect people's needs.

We had been told prior to our inspection that agency staff did not have access to the computerised system. When we raised this with the registered manager they told us agency staff were always paired up with permanent staff so were able to access records with the staff. On the dementia friendly unit they had started to compile one page profiles for people to be used as a quick reference and the registered manager told us this would be extended to all floors to ensure staff had all the information they required to support people.

A record of daily care interventions was recorded on the electronic system. These contained information such as information about personal hygiene interventions, visits from families and professionals, activities undertaken and any incidents. Staff had not always recorded on the system whether people had received a bath, shower or oral hygiene although the registered manager had been made aware of this and a report

had been placed on the system to enable them to monitor this and to raise the standard of recording in this area.

We looked in some people's bedrooms and found these to be personalised to the individual. We saw photographs and other sentimental items displayed.

The home employed specific staff to facilitate social activities. We saw an activity schedule issued telling people what activities were arranged for that month. The schedule for May included: dominoes and a glass of sherry, reminiscence/life history, creative colouring and relaxation, quizzes, knit and natter, one to one chats, manicures and pamper, arts and crafts, entertainers, book and reading club, film show, a gardening club, and choir practice. People using the service were asked their view on the activities and what they would like to do at the residents' meeting. They informed the activity schedule which ensured activities were planned to suit the needs of the people at the home at that point in time.

We spoke with one of the activities staff who was very enthusiastic about providing stimulation to meet people's individual needs. We observed staff taking one person to the shop to collect their newspaper and a word association activity during our inspection. Piped music played in the background and into the communal areas and bathrooms. There was a pram on one corridor for people to use, although this was not in use at the time of inspection. The home had also started to compile 'rummage boxes' and 'twiddle muffs' to encourage sensory stimulation for people living with dementia. The activities staff facilitated people attending the Minster for a singing group and people told us they enjoyed this.

We asked people at the home what they would do if they were not happy with the service. One person said, "If I want to complain I will. I know who to. But I haven't. It's lovely." Another said, "We only have to say and something is done about it. No complaints."

The registered provider had a complaints procedure which was available to people who lived and visited the home. We had been notified about some concerns prior to our inspection, and we checked the information relating to these concerns and the actions of the registered manager to address these. The actions taken demonstrated the registered manager had investigated and implemented actions to ensure they learnt from complaints and put measures in place to ensure the situation would not happen again. Staff told us they dealt with some concerns informally such as lost slippers although these informal complaints were not recorded which, although small and easily resolved, if compiled would provide a further opportunity to improve systems.

Good

Is the service well-led?

Our findings

There was a registered manager who had been at the home since it opened in May 2016. They shared their vision for the home with us; "I want it to be outstanding. I want to take the service forwards. I want to improve training, build on life history work, and develop the dementia service. I am happy with the staff I have now. I want people to be passionate and care for people." They told us their greatest challenge since opening was ensuring they recruited and retained staff who shared the values the registered provider required. There had been a high turnover of staff over the year, but the registered manager said of the staff, "Some weren't right and had to go."

People's comments, and our observations, indicated they were happy with the care and support provided. The registered provider had not yet sent out questionnaires to people and their relatives but this had been planned. We reviewed the minutes of the residents' meetings which had been held so people using the service and their family and friends could be consulted about what was happening at the home and share their views on how the service could improve. The registered manager had put a suggestion box at the entrance of the home for relatives and visitors to make suggestions for improvements at the home in addition to suggestions from people living there. The registered manager could evidence they were listening to people at the home to make improvements that mattered to people such as one suggestion from people who wanted a lectern outside the dining room to hold the menu and one person had suggested a pew to sit on outside one of the units, which had been facilitated.

Relatives' involvement and feedback was encouraged through open access to managers and the registered manager told us they encouraged relatives to raise any concerns with them to enable them to improve. They told us they completed a walk around at the unit every morning and between two to three times during the day to observe and speak with staff and people using the service. We observed the management team to be open and transparent, helpful and caring in their attitudes to people and to staff during our inspection. Staff told us how much they liked working at the home and how different it was to their previous experiences in care due to the time they had to chat with people.

We found staff to be confident in their roles and they all reported positive leadership and knew who to report to should they need to raise concerns. Regular meetings were held with each staff group such as night staff, senior staff, housekeeping and kitchen staff and these were recorded. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service and it was clear these meetings were achieving this objective.

Regular audits designed to monitor the quality of care and identified areas where improvements could be made had been completed. These included catering audits, including the laundry, kitchen and domestic areas. Accident and incident audits, nutrition audits, weights, care profile, and infection control audits. Medication audits were completed regularly for each person and were checked by the registered manager. However, these did not filter into an overall audit which would have provided the registered manager with information on the management of medicines without having to review each person's audit. When we raised

this with the registered manager they contacted the registered provider and had a system in place to provide an overview of the management of medicines at the home, before the end of the inspection. This demonstrated the registered manager was proactive in improving systems and processes at the home.

The registered provider was actively involved and visited the home regularly to ensure they could support the registered manager to develop the home and recognised building a home from new had its challenges. The registered manager provided the registered provider with regular management reports to ensure they were kept involved with developments at the home. The registered manager told us they were supported and encouraged by the registered provider who responded positively to suggestions to improve the delivery of the service.

The registered provider employed two maintenance officers who ensured the health and safety of the people living at the home and they undertook a maintenance and health and safety audit each month. Regular health and safety meetings were held to ensure staff were aware of their responsibilities in this area. The maintenance officer had highlighted staff were not always reporting maintenance issues as this meant coming to the office so had changed the system so staff would have a book on each floor to report issues which the maintenance team would review and action to prevent a delay. The maintenance officer also maintained a log of all the equipment in use at the home to ensure every item was checked at the required time frame. This meant the home could evidence they were ensuring the safety of people from harm from faulty equipment and keeping people safe in a well maintained environment.

The registered manager told us they kept up to date with best practice through the Nursing and Midwifery Council (NMC) guidance, and good practice information from the local authority. They told us they received alerts from The Medicines and Healthcare products Regulatory Agency (MHRA) which regulates medicines and medical devices and they ensured they were up to date with the latest National Institute for Health and Care Excellence (NICE guidelines). The registered manager could explain to us the process they used for putting guidance into practice.

We spoke with three visiting healthcare professionals who said they thought the home was well led by the management team. One said, "Whenever we come to see someone for a condition or ailment, they follow instructions that we leave and the condition is always managed well. I have no concerns or problems." Another professional said, "I have no concerns. People are all very happy living here."