Nightingale Hammerson

Hammerson House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 12 January 2016. The inspection was unannounced. Hammerson House is a Jewish care home registered to provide accommodation and nursing care for up to sixty eight people. At the time of our inspection there were thirty eight people living at the residential and nursing care service. There were an additional nine people living in the supported living wing of the building, where people lived independently without any care provided by staff. This inspection was of the residential and nursing care services only.

The service was located in a purpose built block, on two floors with access to a front and back garden area.

We previously inspected the service on 4 July 2013 when the service was found to be meeting the regulations we looked at.

Hammerson House had a registered manager at the service. 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.

During the inspection there was a calm and pleasant atmosphere. People using the service informed us that they felt safe living at Hammerson House.

All the people we talked with confirmed they were treated with dignity and respect, and we observed staff interactions with residents during the inspection day and noted them to be warm, engaging and reassuring.

Care records including risk assessments and care plans were up to date and detailed. People were supported to maintain good health by the nursing staff at the home and through regular access to community healthcare professionals such as GPs and local hospital services.

People had their medicines managed safely. People received their medicines as prescribed and on time. Nursing staff ensured safe storage and management of medicines.

Staff had been carefully recruited and provided with training to enable them to care effectively for people. Staff felt supported and there was always a nurse on duty. Supervision was due every second month, but this has not always taken place for all staff. Training was up to date for staff for mandatory courses with the exception of food hygiene, however, the registered manager had dates for the course later in the month.

People told us the management was a visible presence within the home. Staff talked positively about their jobs telling us they enjoyed their work and felt valued. The staff we met were caring, kind and compassionate.

Staff knew how to recognise and report any concerns or allegations of abuse and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated. We saw there were enough staff to meet people's needs.

There was a very full and varied programme of activities at the service and we saw there were a range of trips for shopping or cultural events people could sign up for. There was a café on site with a small shop staffed by volunteers. There was also access to a physiotherapist on site five days a week.

People's religious needs were actively facilitated by staff, and staff were able to tell us how they responded to people's cultural needs.

The home had arrangements in place for quality assurance. Regular audits and checks had been carried out by the registered manager.

We found the premises were clean and tidy. Measures were in place for infection control. There was a record of essential inspections and maintenance carried out. The building was fully accessible and maintained to a good standard.

The service had plans for renovations in the near future so the service was not admitting people permanently to the service at the time of the inspection, however people could be admitted for a short term respite placement.

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. Staff recruitment was effective and all checks were completed prior to people starting work, so staff were safe to work with people living at the service.

There were effective food hygiene and infection control procedures in place.

Medicines were safely administered and stored.

Safeguarding incidents were dealt with appropriately and promptly.

The premises were accessible and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective. Not all staff were regularly supervised although staff said they felt supported in their role and were skilled to do their job.

Staff were knowledgeable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Food was of a good quality and choice was offered to people living at the service.

Access to health care was good both within the service and through access to community health practitioners.

Is the service caring?

Good

The service was caring. There was a massage service available for all, and staff carried out reminiscence work with people with dementia.

Staff interactions were kind and caring with people living at the service. People were treated with dignity and respect.

Staff knew people's personal histories and related well to them. People's cultural and religious needs were met.

Is the service responsive?

Good

The service was responsive. Leisure activities were extremely varied, interesting and available to all.

Nursing requirements relating to skin care was clear, responsive and well documented.

Complaints were dealt with quickly and appropriately.

Care documentation had evidence of involvement by people living at the service and staff ensured people's choices and interests were supported.

Is the service well-led?

Good

The service was well led. There was a clear philosophy for the service.

The registered manager showed good leadership and commitment to providing a good service.

Quality assurance processes were in place and trustees, relatives and volunteers were involved in the running of the home along with staff.

Hammerson 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 inspection took place on 12 January 2016 and was unannounced. It was undertaken by two inspectors for adult social care and the inspection team included a specialist nurse advisor and an expert-by-experience with experience of working with older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included information provided by the service, 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.

During the inspection we met and spoke with nine people who lived at the service, and following the inspection spoke with three relatives. We spoke with ten members of staff including a physiotherapist, nurse, a member of the kitchen staff and the registered manager.

We looked at ten care records related to people's individual care needs, two recruitment files and staff training records for the team. We carried out an audit of medicines stocks at the service and looked at records in relation to medicines management.

As part of the inspection we observed the interactions between people and staff, and discussed people's care needs with staff.

We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We checked fire safety including equipment, testing of the alarm, lighting and the regularity of fire evacuation tests, and information relating to incidents and complaints. We looked at minutes of residents'

meetings and staff team meetings. We also looked around the premises and viewed the garden.

Good

Is the service safe?

Our findings

People living at the service told us they all felt safe from harm or abuse. One person told us "Of course I do (feel safe). It's lovely knowing there is always someone close by to come cheerfully to my aid if needed." There was a calm and pleasant atmosphere throughout the service on the day of the inspection.

There was a safeguarding adults policy in place at the service and we viewed safeguarding records for the last year. There was evidence the service had acted appropriately and had liaised with the local authority and made notifications to the Care Quality Commission as required.

Staff had received training in safeguarding people. They were able to describe the process for identifying and reporting concerns and were able to give example of types of abuse that may occur. One care worker said "we need to be constantly alert, just in case there is something untoward going on. I look for changes in demeanour and explore this further." They explained that if they saw something of concern they would follow the service's safeguarding policy, including recording the issue and reporting it to the senior person on duty.

The service had a whistleblowing policy and staff understood how to whistle blow. They told us that they knew how to report any concerns and had confidence that action would be taken.

There were comprehensive risk assessments on each of the care records we looked at including those related to falls, moving and handling, pressure ulcers and nutrition using the Malnutrition Universal Screening Tool (MUST). The risk assessments we viewed were regularly reviewed and updated. All files examined had been reviewed within the last four weeks, or when there had been a change in a person's condition, in line with the policies and procedures at the service. We saw how amendments were made as issues arose, for example, where a person requested a hot water bottle, there was written guidance on how to support the person to fill the bottle without scalding themselves.

There was evidence of the development of appropriate care plans to mitigate the risks, with specific guidance provided on delivery of that care.There was evidence of responding to risk with referral to appropriate services e.g. tissue viability service, dietician, physiotherapist. Staff we spoke with demonstrated good understanding of a person's risks and how to mitigate against them.

We saw there was a Personal Evacuation Egress Plans (PEEP) on each record, specific to the individual's needs. This was recorded as a flow chart and there was a simplified master version available in the office.

We looked at sixteen medicine administration recording (MAR) charts. We found them to be appropriately completed, identify known allergies, and contain photographs of the residents. These had signatures and countersignatures, where medicines had been hand-written rather than printed.

There were processes and records for the safe return of unwanted medicines to the pharmacy. The medicines were appropriately and securely stored. The medicines were locked in a secure medicines trolley

and the trolleys were affixed to the wall when not in use by means of a chain and padlock. Medicines requiring cool storage were secured in a locked refrigerator and refrigerator and clinical room temperatures were recorded daily. No gaps were noted in the records and controlled drugs were stored in a separate locked cabinet.

Controlled drugs are prescription medicines that are subject to legal controls in relation to how they are stored, supplied and prescribed to prevent misuse. There was evidence of routine double signatures for all controlled drug administrations and checks. We checked the records of six random controlled drugs and found the stock to be correct. The controlled drugs were recorded as being checked twice daily. We reviewed signature initials for 20 residents and noted all routine prescribed drugs were noted to have been signed for. Where PRN (as needed) medicines were administered, the time was noted.

There was a clear process to enable residents who were able, to maintain and administer their own medicines. We looked at the MAR forms for four residents who were self-medicating and noted that there were risk assessments, care plans and protocols in place to support this process. One person living at the service told us proudly "I do my own medication, checked regularly. Not many people do their own."

We saw there were adequate numbers of staff on duty during the day and night. The care staff work a mixture of long and short shifts. Long shifts are 08:00 to 20:00hrs, short shifts are 08:00 to 14:00hrs and 14:00 to 20:00hrs with night shifts starting at 20:00 to 08:00hrs. There was always a nurse on duty. We heard the handover from night to day staff and it was very person centred. For example, when we entered the handover room staff were discussing how one person living at the service only really liked a particular type of fruit. As she was not eating much food currently, one staff member said she would go to the shops before returning for night shift to buy the particular fruit.

One care worker told us, "I feel there is enough staff; if I didn't, I would definitely bring it to the attention of the manager, because it is the people whose home it is who would suffer." Another told us how, "staffing levels are good at the moment."

We saw that all nurses had up to date PIN numbers which confirmed their professional registration with the Nursing and Midwifery Council.

We saw there were finance staff who held records for managing people's money if they could not do so themselves, and robust logs of expenditure and receipts were kept.

The home was clean and we saw the home being cleaned throughout the day. Infection control measures were in place and we saw staff using gloves and protective clothing appropriately. We visited the kitchen area, and saw how there was a regular cleaning schedule checklist completed. Temperatures of all fridges and freezers were checked twice daily and all food in the fridges was appropriately labelled and covered. Food was stored safely and in line with Kosher requirements. The service had achieved five stars for food hygiene by the Food Standards Agency in August 2014.

There was clear guidance for domestic staff regarding what they needed to clean and when throughout the building. This was checked by the housekeeper. Laundry facilities included a separate washing machine for heavily soiled items.

Thorough recruitment checks were carried out before staff started working with people. We looked at staff records and saw there was a safe and effective recruitment process in place. We saw completed application forms which included references to their previous health and social care experience, their qualifications and

their employment history. Each record had two employment references and Disclosure and Barring Service certificates. This meant staff were considered safe to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

Staff had the knowledge and skills to enable them to support people effectively. New staff received an induction that met the standards set by Skills for Care, and completed a probationary period before being confirmed in post.

Staff told us training was available, usually provided in-house by colleagues who took responsibility for certain areas of training. A care worker told us how this system of training "enables flexibility around shift times and is therefore much easier to ensure that all staff are trained."

The registered manager told us that mandatory training included infection control, safeguarding of vulnerable adults, manual handling, fire training and food hygiene. The training matrix evidenced the fact that most staff were up to date on their mandatory training. The registered manager drew our attention to the fact that people's food hygiene training was overdue in relation to the provider's standards. However, we saw an e-mail with suggested dates for people to do this training later in the month. All staff were expected to complete foundation training in Person Centred Care, at the time of the inspection 95% had done so.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. There were three applications that had been made for DoLS within the service.

Staff we spoke with were familiar with the MCA, and the need to obtain consent from those who used the service. One told us, "I never make assumptions about consent; I spend time making sure I have understood the person's wishes." Another told us "I offer choice in every possible way; for example, I will give time for choices to be made, display what is on offer or, speak with family members about previous preferences. We heard care workers offering choices to people on a range of matters during the course of our inspection. We saw care plans made reference to people's capacity to make different decisions in relation to medicines, finances and choices regarding their everyday lives, and people's signatures evidenced they were involved in care planning. There was evidence of consent to photograph for care files.

We looked at an additional training matrix and noted how this included training in the MCA. This matrix had only got three workers on it whose training was in date. the registered manager told us that within the organisation's training and development strategy for 2016, the MCA would be part of the mandatory training programme. To this effect, she had very recently completed a 'train the trainers' course and it was her

intention to "roll out this training to all staff as soon as possible."

Staff told us they received regular supervision, but were unclear about the frequency. One told us they thought it was "every six months" and another told us they had recently had it, but it had been some time before that since they last had supervision, "it's not regular." Another staff member told us they had received a detailed induction programme and had been supervised in practice before working in her own right. They told us they felt they had received adequate ongoing training support, including syringe driver management, medicines administration and end of life care, and that they had received supervision approximately every three months.

The registered manager told us the supervision policy was for staff to have supervision every two months but she was aware that this had not always taken place due to competing priorities so she was going to prioritise it in the coming months.

There were menus displayed in the dining room. We spoke with the assistant chef about people's cultural and religious needs. The home is a Jewish home and the chef showed us how food was prepared in accordance with religious law. We saw how there was a good supply of fresh produce and the dry store cupboard was well stocked. The assistant chef told us how people's dietary needs were communicated to her by care staff, and these were written on a board. We were also told that the kitchen tried to respond to special food requests where possible and alternative options to the menu were available.

People we spoke with were in general very complimentary about the food. One person told us "The food is excellent!", another told us "…the food is not bad and of course it is Kosher". Relatives spoke very highly of the food and there was a system for spot checking the quality of the food. However a couple of people told us they thought the food was not as good recently, and for some people there was perhaps a sadness they were no longer cooking themselves. We asked the registered manager about this, but there was no change of personnel in the kitchen. The registered manager said she would continue to get feedback on food provision from residents and relatives at their meetings and from quality assurances processes.

At the time of the inspection, people chose to have their breakfasts in their rooms and their lunch and dinner in the communal dining room. We saw there was a varied menu for lunch and food was well presented and plentiful.

Monthly weights were recorded and incorporated into the Malnutrition Universal Screening Tool (MUST). These were routinely recorded for the files that were reviewed. There was a process of Nutritional Audits, with guidance that residents are reviewed "on a monthly basis or sooner when a resident's care needs change or there is a clinical concern".It was also specified that residents with a "MUST score of 2 should be referred to the dietician" and there was evidence this had taken place. We noted from care records dietary supplements were provided where necessary, and we observed staff offering choices of drinks to residents during the day.

People we spoke told us they could access health care as they needed it. The GP visited weekly and the staff met with the manager following the GP round to get up to date information on people living at the service. We saw from records that people accessed a wide range of health professionals. Relatives told us that people's health needs were met very well and any concerns they raised in relation to health issues were dealt with swiftly by staff. One relative told us when she raised a concern regarding her mother possibly having an infection, her mother saw the GP and antibiotics had been prescribed and obtained within the day. One relative remarked that people were so well looked after in the home, many lived to a very good age.

People also told us they saw the optician and chiropodist as they needed. Positively, we noted in one person's room a notice stipulating that the batteries for her hearing aid were to be changed every Tuesday without fail. People using the café or wanting to go out into the garden were provided with pendants so they could call for assistance when they wanted to mobilise. In all the bedrooms we went into a large notice by the call bell noted " Don't Fall – Call!"

Each resident was assessed by a physiotherapist on admission, with regular physiotherapy provided as necessary (free to people permanently living at the service at the time of the inspection). The physiotherapists provide group exercises for residents, twice weekly, supported by an activities worker.

There was evidence of regular involvement of other professionals e.g. GP, tissue viability nurse and falls clinic. One record noted that a person had refused to co-operate with the advice from the falls clinic, but as she had mental capacity this was accepted by staff although staff still sought to protect and engage her. One entry noted "I don't want to join in any activities" but then reported, "As I said, I don't want to do much, but sometimes enjoy my Namaste (sensory therapy) sessions and find it relaxing".

We saw one record of a person who was admitted from hospital with Grade 2 pressure ulcers. The nursing response was appropriate. Skin risk assessments were implemented and regularly reviewed, Pressure relieving equipment was put in place, body mapping was completed and appropriate notification was completed. The wound was photographed and dated, a wound care plan was developed and involvement and support from a tissue viability nurse was provided. The care was delivered in line with best practice guidelines for pressure ulcer management. We noted from records that the pressure ulcer was healed within two months following admission. This suggested good and effective nursing care was delivered.

The premises were accessible throughout for people with mobility needs. Whilst individuals had showers in their rooms that were not fully accessible, communal bathrooms on each floor had accessible bathing facilities and there were two walk in showers in the communal bathrooms.

Good

Is the service caring?

Our findings

People we spoke with living at the home were very positive about the service and the staff. One person told us "I had a bad fall. Up until then I'd been doing everything myself. After this accident I came to this home for respite and found that I loved it here and decided to stay. The food is excellent and the staff are intelligent and kind and most of all it's my choice." Another person told us "There is every comfort, we take part in everything, scrabble in the evenings, current affairs , bridge and lots of coach trips. We are so well looked after."

Other comments included "The staff are very kind and respectful although few of them are Jewish…" and another person described her care as being "thorough yet unobtrusive". All the relatives we spoke with spoke extremely well of the staff. We were told "they are delightful", "absolutely wonderful", "very patient and respectful." Many staff had worked at the service for a long period of time so were very familiar with people living there.

There was a religious service on a Friday and Saturday for people to attend if they chose. Staff were trained to understand the requirements for people with more orthodox beliefs eg some people would not turn on/off lights or carry out any activity on the Sabbath. Staff understood the importance of meeting these religious needs. Many people living at the service told us they were not very religious but were glad to have their cultural needs met.

We saw that there was a programme of Nameste daily for people to book in for. On the day we inspected the service one staff member was allocated four hours to provide this service. There was an allocated comfortable room for this therapy with facilities to listen to relaxing music. Staff were trained in providing this service and for people with memory problems staff used the time to also do reminiscence work. We saw boxes with personal effects eg family members had brought in family photos that were very important to the person or other items. One box contained a sweet tin from a person's childhood. Individual blankets were stored for regular users so they could be cosy when receiving the massage. This attention to detail illustrated a service where people and their past were valued and cared for.

A small shop and café were staffed by volunteers and located in an open bright space behind the reception area. Around the walls shelves were filled with books for people to borrow and there were newspapers at reception for loan. The space overlooked the garden which was well kept.

People were clearly involved in their care planning as evidenced by their comments on documents and their signatures. Files contained Do Not Attempt to Resuscitate (DNAR) forms, as required. Some were appropriately completed by their GP and confirmed discussions with the resident and/or relatives/staff. One DNAR was noted to have been removed as the resident had subsequently decided that he wished to be resuscitated. We found one DNAR completed by a hospital consultant. Best practice guidance states the main medical practitioner should be responsible (ie the person's GP). The registered manager committed to a full review in the coming months to ensure all DNARs were appropriately completed.

We saw that the staff team were thoughtful and promoted positive caring relationships between people using the service. Throughout the course of our inspection day, we noticed how staff took time to engage with those who used the service, and patiently answered questions. We saw staff stopping what they were doing to speak with people or assist them to another part of the building.

Staff knocked before entering people's bedrooms. We observed how they assisted a person to eat in their bedroom. Staff were patient and engaged with the person, giving them time to eat slowly and safely.

People's rooms had personal memorabilia in them and the service had collages and photos on the wall in the communal areas. We met a long term volunteer who organised collection of money for people's daily newspapers who told us they enjoyed working with people living at the service.

Good

Is the service responsive?

Our findings

The care files were comprehensive and provided core care planning based upon ten areas. These were medication and pain management, eating/drinking/nutrition, communications, moving about, toilet care, sleeping and night time care, washing and skin care, breathing, expressing sexuality and end of life preferences. The breadth of these care plans meant that all areas of a person's life were covered.

The section on people's personal histories was divided into three sections, early, middle and later years. This enabled people to tell their story if they chose and prompted people to tell their families generational history, which for some people had been traumatic and therefore significant. There was evidence of identifying likes, dislikes, wishes and aspirations to enable care delivery to respond to personal needs and wishes. This meant that staff had the information about people and from our discussions with them, knew people well and were attuned to the important people and things in their life. One staff member told us she was "very proud" of the care plans she had compiled with the people she was a key worker to. The registered manager planned to develop a summary care plan sheet in the event agency/bank staff are on shift and need summarised, concise information in the coming months.

We reviewed the complaints book over the last year. The level of complaints was low, and we could tell from records the issue, action taken and the outcome were recorded appropriately. All the people living at the service knew how to complain and who they could talk to. People living at the service and relatives we spoke with told us that if they raised any issue with the registered manager or staff it was dealt with quickly.

The activities provided by the home were exceptionally varied and catered for people's social, cultural and physical needs. There were exercise classes twice weekly as well as access to physiotherapy staff five days a week. In the month of our inspection, there were opportunities to join in silk painting, creative art and flower arranging. There was choir practice, a news review of the year, book/poetry readings, two films being shown as well as art talks on Frank Auerbach and Jane Eyre. There were trips out to a concert, Tate Britain and shopping trips to Brent Cross and other venues locally. There was an exhibition locally of art work created by people living at the service including photographs at a local community venue, as well as musical events at the service. Games activities took place regularly in the 'Activity Hub', a cabin specifically used for leisure activities and physical exercise. People living at the service and their relatives spoke extremely highly of the activities and the staff who facilitated them.

In the dining room there were kitchen facilities for people to bake cakes or cook a particular food they chose. One relative told us she was part of the 'tasting panel'. The panel was made up of people who would randomly turn up and taste the food to ensure it was of a good quality and presented well. She told us that she routinely asked people what they thought of the food and fed this back to the kitchen staff and the registered manager.

The views of people living at the service and their relatives were gained through regular meetings. This was evidenced by records we saw.

Good

Is the service well-led?

Our findings

Hammerson House is run by an independent Jewish charity whose philosophy is to provide holistic care in a safe and stimulating environment and to provide a home for life.

The registered manager showed good leadership and commitment to providing a good service. People who lived at the service and their relatives told us the staff team were very visible, proactive, and responsive when issues arose.

There was evidence that essential services such as gas, electricity, and portable equipment testing had been professionally checked within the last twelve months. Moving and handling equipment had been serviced recently. Fire drills were carried out regularly as was water testing. This showed that the registered manager had systems in place to ensure the safety of people in the service.

There was a comprehensive list of policies and procedures so staff knew what was expected of them. Care plans were regularly audited, weekly checks of medicines and pressure ulcer audits took place, and infection control and health and safety audits were in evidence. The registered manager regularly reviewed the level of need of people living at the service to adjust the staffing levels required. A new health and safety committee had been established with individuals studying for higher qualifications in health and safety.

It was evident from our inspection the registered manager provided good leadership to the staff at the service. Regular meetings took place with staff to gain their views and share information, and a weekly meeting took place in which two case studies were discussed to improve learning.

The organisation valued their staff, and people routinely told us many staff had worked there a long time. Long service staff (of 20 years) were rewarded with a significant bonus towards a holiday and annual leave increments increased with length of service. The organisation had a People's Strategy and a review paper was to be presented at a senior management meeting in January to review the current reward scheme.

There was a new person centred facilitator post within the organisation to promote best practice and a person with lead responsibility within the organisation for safeguarding adults issues. This person carried out incident analysis to identify learning from safeguarding incidents and promote preventative work across the organisation. Senior staff got involved at mealtimes to be visible to people living there and as part of their quality assurance process.

Relatives and volunteers were actively welcomed to be involved in the service, and volunteers and trustees formed part of the auditing and reporting structure. The development of a 'tasting panel' was one example of involvement by relatives in the quality assurance process.

Regular meetings took place with relatives and people living at the service in which people's views could be heard and information shared. There were some planned improvement works due at the service so there was some concern expressed to us by both staff and people living at the service at the possible impact of

this work. Due to the planned work, the service were not admitting new permanent people to the service at the time of the inspection. The registered manager told us senior management were committed to working closely with staff, people living at Hammerson House and their relatives to ensure openness and transparency regarding the options open to individuals as a result of these planned changes.