Galleon Care Homes Limited

Queen Mary's and Mulberry House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Queen Mary's and Mulberry House Nursing Home on 22 and 23 October 2018. The first day of the inspection was unannounced.

Queen Mary's and Mulberry House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Queen Mary's and Mulberry House Nursing Home provides accommodation and nursing care for up to 72 older people and younger people, some of who had physical disabilities. At the time of the inspection there were 59 people living at the home. Queen Mary's and Mulberry House Nursing Home is run as one and the home is divided into two units. Queen Mary's provides nursing care for people living with healthcare needs such as stroke, heart disease diabetes and dementia. Mulberry House provides nursing care and support for people living with an acquired brain injury. This can be because of an accident or following a health-related condition, such as a stroke or Parkinson's disease. There were also some people, with a learning disability, living at the home. Most of whom also had an additional nursing need.

There were some people at the home living with a learning disability. CQC have developed guidance for homes who look after people with a learning disability. This is called Registering the Right Support. We have written to the provider to ask how they will develop the service to ensure it embraces the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. This is so people with learning disabilities and autism using the service, can live as ordinary a life as any citizen.

There was 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.

We had previously carried out an inspection in April 2016 where we rated the service as good, although we asked the provider to make improvements in relation to the recording and management of wounds. At this inspection we found improvements had been made in relation to wound management and the evidence continued to support the rating of Good. We found improvements were needed to some aspects of record keeping. However, 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.

Improvements were needed to ensure people's records always reflected the care and support they needed and received. Staff knew people well and had a good understanding of them as individuals and the care and

support they needed. People received care that was person-centred and met their individual needs and choices. Activities were developed to meet each person's needs.

People were supported by staff who were kind and caring. They treated people with kindness, understanding and patience. People were supported to make decisions and choices about what they did each day and their dignity and privacy was respected.

People's safety was maintained because staff had a good understanding of the risks associated with the people they looked after. Risk assessments were in place and provided guidance.

People's medicines were ordered, stored administered and disposed of safely. They were protected from the risks of harm, abuse or discrimination because staff had a good understanding of safeguarding procedures and their own responsibilities. There were enough staff working to provide the support people needed. Recruitment procedures ensured only suitable staff worked at the home.

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.

There was a training programme for staff and they received regular supervision and appraisals.

People were supported to eat and drink a choice of food that met their individual needs and preferences. Their health and well-being needs were met and they were supported to have access to healthcare services when they needed them.

Complaints had been recorded, investigated and responded to appropriately. There were effective systems to assure quality and identify if any improvements to the service were needed.

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 has improved to Good.

People's safety was maintained because staff had a good understanding of the risks associated with the people they looked after. Risk assessments were in place and provided guidance.

People's medicines were ordered, stored administered and disposed of safely.

People were protected from the risks of harm, abuse or discrimination because staff had a good understanding of safeguarding procedures and their own responsibilities.

There were enough staff working to provide the support people needed. Recruitment procedures ensured only suitable staff worked at the home.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service has deteriorated to requires improvement because people's records did not always reflect the care and support they needed.

The registered manager was well thought of and supportive to people and staff. They were continually striving to improve and develop the service.

Quality assurance systems helped to identify where improvements were needed across the service.

Queen Mary's and Mulberry House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 22 and 23 October 2018 and the first day of the inspection was unannounced. This meant staff did not know we were coming. The inspection was carried out by two inspectors and two experts 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.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. 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 reviewed the records of the home. These included five staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information regarding the upkeep of the premises.

We looked at four people's care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' three people living at the home. This is when we check that the care detailed in individual plans matches the experience of the person receiving care. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving

care.

During the inspection, we spoke with 25 people who lived at the home. Some people were unable to speak with us verbally. Therefore, we used other methods to help us understand their experiences. 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 spent time observing people in areas throughout the home and were able to see the interaction between people and staff. We watched how people were being supported by staff in communal areas.

We spoke with nine staff members and the registered manager. We also spoke with five visitors and one visiting health and social care professionals. Following the inspection, we contacted nine health and social care professionals who visit the service to ask for their feedback.

Good

Is the service safe?

Our findings

At our inspection in April 2016 we asked the provider to make improvements in the way they recorded and managed wound care. At this inspection there had been changes to the care planning system, which was now electronic. Records of people's wounds included a description and where the wound was in the healing process. Where necessary there were measurements and photographs of the wound. The record also included information about the dressing used and when the dressing should next be changed. In addition, there was information about wound on the white board in the nurses' office. This acted as a reminder to the nurses about when dressing changes were needed.

Other risks were managed safely and people told us they felt safe living at the home. Staff understood the risks associated with the people they looked after and were able to support them appropriately without unnecessarily restricting their freedom or limiting their independence. There were a range of risk assessments, these included health, mobility, skin integrity, and behaviours that challenge. Information from these were used to develop care plans. There was information about how to reduce people's risk of developing pressure wounds. This included regular repositioning and the use of pressure relieving equipment. Where air mattresses were in place there was information about the setting requirements and these were set correctly. People were supported to move safely with the use of the appropriate equipment and support. Care plans included information about what equipment was needed and for example what sling size should be used for each person who required a hoist. A visitor told us their relative was safe. They said their relative was unable to walk, "But staff hoist her in a safe and comfortable way. They have acquired a new wheelchair which is more comfortable and safe. And she has a mattress which moves so does not get pressure sores." Some people displayed, on occasions, behaviours that may challenge. Staff supported them appropriately and with kindness. Staff de-escalated occurrences professionally and with kindness. Following an occasion of challenging behaviour records were completed and then analysed to identify any triggers or themes.

People were protected against the risk of abuse, harm and discrimination. Safeguarding concerns were taken seriously at the home. Staff received safeguarding training, they could tell us about different types of abuse and what actions they would take if they believed someone was at risk. They understood their own responsibilities in ensuring any concerns were reported appropriately. Staff told us how they would report their concerns to the senior person on shift, the registered manager or if appropriate, to external organisations. When safeguarding concerns were raised, the registered manager worked with relevant organisations to ensure appropriate outcomes were achieved. Information about safeguarding concerns and outcomes were shared with staff.

Before the inspection we had received concerns that there were not always enough staff working. At the inspection we found there were enough staff working to support people. One person told us, "I feel very safe because of the staff, you are never alone 24 hours a day." Another person said, "They come as quick as they can when you call the bell." Staff told us there were enough staff working. One said, "If someone goes off sick we might be a bit short but that's only a couple of hours until they can get someone to come in." Where people needed one to one support this was provided. The registered manager told us that a number of staff

had left and whilst this had left the home with a reduction of regular staff agency staff were used to ensure there were enough staff working each shift. During the inspection we spoke with one agency staff member who had worked at the home for four months. Agency staff were supported by regular staff. In addition to the nurses and care staff there was a housekeeping and maintenance team, a chef and kitchen assistants.

Recruitment was ongoing and we saw more staff were due to start work on the completion of appropriate checks. People were protected, as far as possible, by a safe recruitment practice. Staff files included the appropriate information to ensure all staff were suitable to work in the care environment. This included disclosure and barring checks (DBS) and references.

People received their medicines safely as prescribed. One person said, "My medicine is on time and fully explained." Medicines were ordered, stored, administered and disposed of safely. Medicine administration records (MAR's) were completed and showed people had received their medicines as prescribed. There was information in the MAR that showed how each person liked to take their medicines. Some people had been prescribed 'as required' (PRN) medicine and only took this when they needed it, for example if they were in pain or anxious. Where PRN medicines had been prescribed there were individual protocols in place to ensure people received these appropriately and consistently. During the inspection people were given their PRN medicines when they needed them. One person had some discomfort and the nurse spent time talking with them to determine the reason, and then pain killers were provided. PRN protocols included information about ensuring alternative approaches, including positive behaviour support, distraction techniques, reassurance and comfort were provided before people were given PRN medicines for anxiety or behaviours that may challenge.

Registered nurses were responsible for the medicines on the Queen Mary side of the home and assistant practitioners were responsible for Mulberry House. Assistant practitioners are senior care staff who have received extra training and had their competencies assessed to take on additional roles to support the nurses and this included medicines. Where people's medicines where complex due to their health needs these were always managed by a registered nurse. Only staff who had received medicine training and had their competency assessed were able to give medicines. Staff had good knowledge and understanding of the medicines people needed and received. Where tests were needed to support medicines these had been taken, for example blood sugar levels for people who were living with diabetes and needed insulin injections.

The home was clean and tidy. Housekeeping staff were responsible for the day to day cleaning of the home. There was an infection control policy and Protective Personal Equipment (PPE) such as aprons and gloves were available and used during the inspection. Hand-washing facilities were available throughout the home. The laundry had appropriate systems and equipment to clean soiled linen and clothing.

There was ongoing maintenance and a maintenance program. The registered manager was aware of areas where improvements and re-decoration were needed. This included the kitchen area in Mulberry House. A maintenance book was readily available for staff to enter issues. An additional one had been provided for visitors next to signing-in book. This was in response to finding from a complaint that an issue reported to a member of staff had not been passed on to maintenance team. This demonstrated how improvements were made following an incident or a concern. Jobs were signed off when they had been addressed.

Servicing contracts were in place, these included gas, electrical appliances the lift and moving and handling equipment. Where works had been identified through the servicing contracts work was on-going to address these. There were regular fire checks and work was being completed following a recent fire risk assessment. Environmental and equipment risks were identified and managed appropriately. One person told us,

Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs in the event of an emergency evacuation.

Good

Is the service effective?

Our findings

People's continued to receive care and support that was effective. Their needs were assessed and care and support was delivered in line with current legislation and evidence-based guidance. People's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow risk assessment. Peoples' nutritional risks were assessed using Malnutrition Universal Screening Tool (MUST) to identify if they were at risk of malnutrition through not eating enough or weight loss. Staff followed the latest guidance on the International Dysphagia Diet Standardisation Initiative (IDDSI). This helped to ensure choking risks to people were reduced by having the correct food and drink consistency.

Staff continued to receive training and supervision to ensure they were able to meet people's needs effectively. People told us their needs were being met by staff who knew and understood them. One person said, "The staff know me and they look after me very well." Staff demonstrated good knowledge of how to look after and support people. When staff started work at the home they completed an induction, some training, met people and spent time shadowing regular staff, until they were competent and confident to provide care unsupervised. Induction checklists were in place and these were signed when completed. One staff member told us the induction had provided them with the information they needed to support people.

The training program included moving and handling, infection control, safeguarding and mental capacity assessment. Staff also received training that was specific to the needs of people who lived at the home. This included diabetes, dementia and positive behaviour support. Staff were encouraged and supported to continue their learning and development through further training. This included Diploma in Health and Social Care in levels 2, 3 and 5. The assistant practitioners and some senior care staff had received further training and had been assessed as competent to undertake clinical roles to support the nurses. This included supporting people with enteral feeding. Enteral feeding is where food, drink and medicine is given through a tube in the stomach or small bowel. A percutaneous endoscopic gastrostomy (PEG) tube is passed into a person's stomach by a medical procedure and is used to provide a means of feeding or receiving medicines when oral intake is not possible. They also supported people to manage their diabetes, this included the administration of insulin.

Registered nurses received additional clinical training which included catheter care and wound care. Registered nurses told us before anyone moved into the home an assessment would take place to ensure they had the knowledge and skills to look after the person. They told us if they identified any training need this would be provided.

There was a supervision programme and staff received regular supervision. This helped identify any areas where further support or development was required. Staff who required it, had received extra supervision and support. Staff told us they felt supported and could discuss any concerns with their colleagues, senior staff and the registered manager.

Equality and diversity training was provided to staff who demonstrated their commitment to promoting people's rights to a good standard of care, independence and treating people with respect. Adjustments

had been made to the staff rota to allow staff who were fasting during Ramadan to work at night to reduce the physical impact of fasting during the day time.

People's nutritional needs were assessed including any risks such as dehydration or not eating enough. Staff liaised with services such as the speech and language therapist (SaLT) team to assess people at risk of losing weight and was followed. People's weight was monitored and where appropriate their food and fluid intake along with any outputs. People were supported to choose their meals, this included the use of pictorial support where people less able to make choices. Where people had specific dietary needs such as pureed diet or thickened fluids these were provided appropriately. Some people who lived in Mulberry House were younger and changes had been made to the menu to include their preferences. Some people had complex nutritional needs and required PEG feeding. People received support to receive their nutrition this way and staff had a good understanding of how to do this appropriately.

People were supported to maintain good health. They received on-going healthcare support and could see their GP or other healthcare professional when they wished or needed and when there was a change in their health. This was confirmed through records seen and conversations with people, visitors and staff. One visitor told us their relative, "Sees a GP when necessary and the chiropodist comes in regularly." One person said, "A doctor or dentist would be arranged by the manager, there are quite a few nurses here and the chiropodist comes in." Health and social care professionals told us they were contacted appropriately if there was a change in people's health needs. Advice and guidance was followed appropriately.

People's needs continued to be met through the design and adaptation of the home. There were passenger lifts which provided level access throughout. The corridors and doorways in Mulberry House were wide and people who used wheelchairs could access these areas independently.
There was a wide range of equipment to support people, this included hoists to assist with transfers, adapted bathrooms and toilets. People could move freely around the home as they wished. There was level access to the garden. Some people smoked and there was a smoking area outside which enabled people to smoke safely.

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. Where people lacked capacity best interest decisions had been made through discussions with people, their representatives and appropriate professionals. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. At the time of the inspection there were nine DoLS authorisations in place and applications for others had been made for other people who did not have capacity and were under constant supervision. Copies of the authorisations and applications were available to staff. Throughout the inspection staff asked people's consent before providing care and support and supported people in making their own decisions.

Good

Is the service caring?

Our findings

People continued to be treated with kindness, compassion and care. One person said, "The staff are very kind and caring, they always treat me with respect and dignity; they give me enough time and treat me as an individual." One staff member told us about a person they were supporting. They said they had been able to, "Give the person their life back through the care and support provided."

People responded positively to staff presence. Staff greeted people warmly when they came on shift or when people got up and called people by their preferred name. People demonstrated they were pleased to see staff through smiles, greetings and hugs. When staff spoke with people they showed an interest in the response they received and demonstrated patience and understanding. Staff spoke about people with real affection. They knew people really well and had developed positive relationships with them and their families. One staff member told us, "We find out who people really are, this is their home."

People made their own decisions about what they did each day and were supported to maintain their independence. People and relatives told us they were involved in developing care plans and care records included details about people's preferences.

Staff responded appropriately to people when they were anxious or distressed. One person became distressed due to receiving bad news. The registered manager and staff supported the person. They provided reassurance and discussed with the person how they would support them. Another person also became upset at the news and staff were observed comforting the person through appropriate hugs and reassurances.

People were supported to maintain contact with families and friends and to develop new friendships. Visitors told us they were welcomed at the home at any time and this was evident throughout the inspection. Where needed people were supported to maintain contact through telephone calls and letter writing.

People were treated with respect and their dignity was maintained. When people displayed behaviours that may challenge they were supported by staff with care, sensitivity and patience. People were supported to maintain their personal hygiene. One visitor commented that their relative's continence was well-managed. When people needed support to use the facilities this was done discretely and promptly. Staff knocked on people's doors before entering their rooms and ensured people were comfortable before they left. People's bedrooms were personalised with their possessions such as personal photographs and mementos and arranged in a way that suited each person. For example, one person's bed had been moved to ensure they had a better view out of the window.

Staff had a good understanding of dignity, equality and diversity. They were aware of the need to treat people equally irrespective of age, disability, sex, gender or race. People were supported to maintain their life in the way that they chose. There was information in their care plans and staff were aware of people's spiritual and religious beliefs.

Good

Is the service responsive?

Our findings

People continued to receive care that was person-centred and responsive to their needs and choices. People told us they were involved in developing their own care plans and where appropriate, people's relatives were also involved. One visitor told us, "I was present with the nurse and deputy when they reviewed the care plan. It was drawn up and I was asked to sign it if I agreed."

Before people moved into the home an assessment was completed to identify people's needs and choices. It also helped ensure staff had the knowledge and skills to meet these needs. Information from this assessment was used to develop individual care plans and risk assessments. Care plans included information about people's physical, emotional and health needs and these were regularly reviewed. Staff knew people well and were able to tell us about each person, their care and support needs, choices and interests.

People were supported to remain active and had enough to do each day. There was an emphasis on developing individual activities and meaningful occupation for each person. Motivational occupational therapists (MOT's) had been employed to organise and facilitate activities for people. For people living in Mulberry House this included developing daily living skills to improve the person's independence, for example kitchen skills. The physiotherapist showed us photographs of how people had engaged in preparing food for World Physio day which was an event held at the home. This had involved people chopping vegetables which improved people's physical strength, dexterity and well-being through achievement.

Most people made choices about what they wanted to do on a day to day basis and were supported to do what they liked. Some people needed a more structured approach to activities and this had been developed with them and included support from external professionals. Where people were frail and less able to express their choices, staff used their knowledge of people to support them. The care plans for some people stated they liked to have objects of comfort with them, and we saw these were in place. Staff changed the television channel to play some music which they knew one person enjoyed, we saw the person engaged and listening to the music. There was also a range of group activities which people could take part in if they wished.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Communication care plans contained information to guide staff. This included whether people wore glasses or hearing aids. Staff communicated appropriately with each person and understood the importance of communicating in a way that met people's individual needs. This included using simple words and sentences and for some people the use of picture cards to assist. Staff were currently developing disability distress assessment tools (DisDat) for people who had a learning disability. These tools help identify distress cues in people, who because of cognitive impairment or physical illness, have limited communication.

There was a complaint's policy and records showed complaints raised were responded to and addressed appropriately. People told us they had no complaints but if they did they would discuss them with staff. The registered manager told us concerns were addressed as they arose. One person said, "I would go to the manager or her deputy with any complaint."

As far as possible, people were supported to remain at the home until the end of their lives. Staff were aware of the support people needed to keep them comfortable in their last days. Care plans contained some information about people's end of life wishes. These had been discussed with people and their families. These wishes were respected. Some people chose not to discuss their end of life wishes and this was also respected. Staff liaised with healthcare professionals to ensure the appropriate support was in place and to develop the care plans. This included anticipatory or 'just in case' medicines which had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the key question 'Well-led' was rated good. At this inspection we found improvements were needed in some aspects of record keeping. There was information in care plans about what people liked to do each day, their interests and hobbies. However, care plans did not provide guidance for staff about how to support people to maintain these interests. Some people needed a structured approach to their activities, this was particularly relevant to people who were living with a learning disability. Staff gave us detailed information about how people were supported with their activities but this information was not in people's care plans. Daily notes demonstrated people had regular contact with staff. For some people this contact was task based and related to the care and support they received. However, we observed regular interactions throughout the day when staff had spent time chatting with people, these had not always been recorded. We identified these as areas that needed to be improved to ensure people's records reflected the care and support they received and required.

The registered manager told us staff were being reminded to record all interactions and 'meaningful interaction' forms had been developed. These included details of what the person had done, their level of engagement and enjoyment. There had been a reliance on the MOT's to complete these but all staff were now being encouraged. A new approach to activities had just being introduced. This was using the Pool Activity Level (PAL) assessment. This is a framework for providing activity-based care for people who are living with cognitive impairment such as dementia, learning disability and who have had a stroke. The PAL assessment identifies a person's ability to engage in activities which are then developed for each individual.

There were some people at the home living with a learning disability. CQC have developed guidance for homes who look after people with a learning disability. This is called Registering the Right Support. We have written to the provider to ask how they will develop the service to ensure it embraces the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. This is so people with learning disabilities and autism using the service, can live as ordinary a life as any citizen.

The registered manager worked at the home most days. They had a high profile at the home and knew people, their relatives and staff well. People, visitors and staff spoke highly of the registered manager and life at the home. One person told us, "Living here is like living at home, I have everything I want and need, nothing bad here at all." A visitor told us they could talk to the registered manager and staff at any time. They said, "They keep you informed of everything, from changes to the building, to staff changes they are ready to listen and help." A staff member told us there was, "Good supportive management, and we all support each other." The registered manager was working to improve staff well-being. Staff were provided with free fresh fruit daily and they had access to the physiotherapist to discuss and muscular problems.

There was a positive culture in the service. Staff told us they were happy in their work. They demonstrated a clear commitment to improving people's lives and ensuring the home was a place where people wanted to live. There was an emphasis on ensuring people had choices and enjoyed their lives. Staff told us they felt supported by the registered manager and other senior staff within the organisation. They told us there was

always someone available and approachable and this provided a supportive environment to work in. Staff were updated at a handover between shifts where they could to discuss matters relating to individuals and their care and support needs. There were regular staff meetings and these were used to identify any concerns, inform staff about changes and planned improvements. These meetings allowed for discussion and communication with staff.

The registered manager completed a range of checks and audits. These included medicines and health and safety. An audit had also been completed by an external consultant to help identify areas for improvement and development. Where issues were identified there was evidence that actions had been taken to address. The registered manager had a good oversight of the service. They were aware of areas where improvements were needed and how these would be achieved. This was reflected through our conversations and within the PIR. Since the last inspection the provider had introduced a computerised care planning system. The registered manager told us this was continually being developed and improved to ensure information was clear and easily accessible. During the inspection we identified that information about people's diabetes was not always easy to find. Following the inspection, the registered manager told us a bespoke diabetes plan had been developed and was being introduced.

The registered manager asked for feedback from people and their family and friends to develop the service. This was facilitated through regular meetings, satisfaction surveys and regular contact with people and their relatives. Meetings were used to update people on planned events and other activities, changes in staff and any works to be completed to the premises. Minutes from recent resident and staff meetings discussed suggested changes to the interviewing of staff. People and relatives had been asked for their feedback and were also being encouraged to take part in the interview process.

The registered manager was committed to their own development to support improvements of the home. They attended nursing and care conferences and attended the local care homes association meetings. The registered manager engaged with local stakeholders and with health and social care professionals to ensure they were up to date with changes in legislation and best practice. They received regular supervision from a senior manager within the organisation who also supported them on a day to day basis.

The registered manager had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. These notifications and the PIR were completed to a high standard and included all relevant information. There was a procedure in place to respond appropriately to notifiable safety incidents that may occur in the service.