Pressbeau Limited

Greathed Manor 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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Greathed Manor nursing home provides care and accommodation for up to 32 people. The home is a Grade 2 listed building. On the day of our inspection, 25 people were living in the home. Many people needed nursing care and/or were living with physical disabilities. Some people were living with dementia.

The inspection took place on the 27 January 2016 and was unannounced.

A registered manager was in post. 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 and their relatives gave positive feedback about the service they or their family member received. People were very happy. One person said "They really look after me here."

People told us care staff treated them properly and they felt safe. One person said; "Yes, I have felt safe and I've never lost anything." Staff had written information about risks to people and how to manage these in order to keep people safe. One person had been assessed as being at risk of skin breakdown, we saw a skin risk action plan detailing actions for staff to undertake to minimise the risk to the person which detailed the appropriate pressure mattress settings, repositioning schedules, and reference to nutrition care plans to promote skin healing.

Incidents and accidents were fully investigated by the registered manager, and actions put in place to reduce the risk to people of accidents happening again such as people falling.

People received their medicines as they were prescribed and when they needed them. Processes were in place in relation to the correct storage, disposal and auditing of people's medicines.

People and their families had been included in planning and agreeing to the care provided. People had an individual plan, detailing the support they needed and how they wanted this to be provided. Staff ensured people had access to healthcare professionals when needed. The care plans for people did not show thoroughly their nursing needs as these were kept separately and we recommended that the plans were joined to provide continuity in both health and social care.
People were kept safe. Staff had received training in safeguarding adults and were able to tell us about the different types of abuse and signs a person may show if they were being harmed. Staff knew the procedures to follow to raise an alert should they have any concerns or suspect abuse may have occurred.
Care was provided to people by a sufficient number of staff who were appropriately trained and deployed. People did not have to wait to be assisted. One person said; "I do think there are enough staff about." Another person said "You never have to wait."

Staff recruitment processes were robust and helped ensure the provider only employed suitable staff to care for people.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Were they compliant with MCA, not clear here?

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. Related assessments and decisions had been properly taken.

Staff had the specialist training they needed in order to care for people who lived with epilepsy or needed support in end of life care. Staff demonstrated best practice in their approach to the care, treatment and support people received.

People were provided with a choice of freshly cooked meals each day and facilities were available for staff to make or offer people snacks at any time during the day or night. Specialist diets to meet medical or religious or cultural needs were provided where necessary.

People were treated with kindness, compassion and respect. Staff took time to speak with the people who they supported. We observed some positive interactions and it was evident people enjoyed talking to staff. People were able to see their friends and families as they wanted and there were no restrictions on when relatives and friends could visit. One relative said; "There are all sorts of nice things happening." Some activities were available. Some people enjoyed an activity on the day of the inspection. However, there were not enough activities provided for people specific to their needs or for those people who were nursed in bed. We have made a recommendation about this in the main body of our report.

People's views were obtained by holding residents' meetings and sending out an annual satisfaction survey. People knew how to make a complaint. Complaint procedures were up to date and people and relatives told us they would know how to make a complaint if they needed to. The policy was in an easy to read format to help people and relatives know how to make a complaint if they wished. Staff knew how to respond to a complaint should one be received.

The provider had quality assurance systems in place, including regular audits on health and safety, infection control and medication. The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

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 knew how to keep people safe and protect them from abuse.

Medicines were stored, managed and administered safely.

The provider ensured there were enough staff on duty to meet the needs of people. Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Assessments were in place to manage risks to people. There were processes for recording and monitoring accidents and incidents.

Is the service effective?

Good

Staff said they felt supported by the manager, and had access to training to enable them to support the people that lived at the service.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and specialist diets were supported where a need had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

People told us they were well cared for. We observed caring staff who treated people kindly and with compassion. Staff were friendly, patient and discreet when providing support to people.

Staff knew the people they cared for as individuals. Staff took time to speak with people and to engage positively with them.

People and their families (where necessary) were included in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person centred and gave detail about the support needs of people. People were involved in their care plans, and their reviews. However, care plans would benefit from linking with the nursing needs of people.

People had access to some activities that matched their interests. However, people who were nursed in bed did not receive any individual social stimulation.

There was a clear complaints procedure in place. No complaints had been made since our last inspection. Staff understood their responsibilities should a complaint be received.

Is the service well-led?

Good

The service was well led.

The service had a registered manager in place.

The registered manager regularly checked the quality of the service provided and made sure people were happy with the service they received.

Staff felt supported and able to discuss any issues with the manager. Senior managers regularly visited to speak to people and staff to make sure they were happy.

The registered manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Greathed Manor 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.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we undertook the inspection earlier than planned. The inspection was carried out by two inspectors and a specialist adviser. A specialist adviser is a person who has special knowledge and experience in caring for people with physical nursing needs and who uses this type of care service.

During the inspection we spoke with eight people who lived at Greathed Manor, five staff, three relatives, the registered manager, and one health care professional. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the different floors within the building and the main lounge and dining area. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We looked at a variety of documents which included five people's care plans, five staff files, training programmes, medicine records, four weeks of duty rotas, maintenance records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

The last inspection was undertaken on the 13 March 2015 where breaches in the regulations were identified. At this inspection we found that the registered manager and provider had made improvements to the

service and met the regulations.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe living at the home. Comments included; "I've no problems with my safety here" and "Yes, my relative has been safe and also when they move them using the hoist."

The registered manager and staff had taken steps to help protect people from avoidable harm and discrimination. The registered manager and staff were able to describe what they would do if they suspected someone was being abused or at risk of abuse. Staff told us they had received safeguarding training and were able to describe the procedures to be followed if they suspected any abuse. People told us they would approach the registered manager if they had any concerns.

The risks to individuals and the service; for example health and safety, were managed so that people were protected and their freedom was supported and respected. One person said; "I move around with a walking frame in my room, around the home I freely use my wheelchair." The registered manager ensured staff assessed the risks for each individual and recorded these. Incidents and accidents were reported appropriately and in a timely manner, the registered manager described to us the action they took to analysis each incident. They showed us examples of outcomes of investigations; this included an accident where a person had fallen. The registered manager had reassessed the risk and implemented new strategies such as alarm mats to alert staff sooner to the person moving about their room. Staff were able to describe risks and supporting care practices for people. For example, people with specific health care conditions and alcohol dependency had individualised risk assessments which staff were able to describe.

We checked a sample of risk assessments and found plans had been developed to support people's choices whilst minimising the likelihood of harm. The risk assessments included people's mobility risk, nutritional risk or specific health risks. One person's risk assessment detailed their assessed skin breakdown risk. The action plan detailed pressure mattress settings, repositioning frequency and nutrition support which should reduce the risk to the person of their skin breaking down or them acquiring a pressure wound. We saw that these actions were followed by staff.

People's medicines were well managed and people received their medicines safely. One person said; "I do get my medication when they are due", another person said "I get my tablets when I expect them" and "They give me painkillers when I ask for them."

There was an appropriate procedure for the recording and administration of medicines and medicines were stored securely. Each person had a medication administration record (MAR) chart which stated what medicines they had been prescribed and when they should be taken. We observed staff ensuring people had taken their medicines before completing the MAR chart to confirm that medicines had been administered. We looked at MAR charts and saw they were completed fully and signed by trained staff. People who were prescribed 'as required' medicines had protocols in place to show staff when the medicines should be given. The provider had in place procedures for the safe disposal of medicines.

People said that there were enough staff deployed to meet their needs. One person said; "I do think there

are enough staff about." Staff also said there were enough staff on duty. We saw people being attended to promptly. Care staff acknowledged people when they required assistance and phoned colleagues to help people when needed. One person said "The staff do talk to me; you get anything you ask for." The provider used a dependency tool to assess that staffing levels were in place to meet the needs of the people. The registered manager said that the staff levels were one registered nurse, the clinical lead, five care staff and the head of care in the morning and four care staff, two nurses and the head of care in the afternoon. We checked the rotas for a four week period which confirmed the staff levels described by the registered manager were maintained.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff members confirmed they had to provide two references and had a DBS check carried out before starting work. The provider had ensured that qualified staff had the correct and valid registration.

There were emergency and contingency plans in place should an event stop part or the entire service running. Both the registered manager and the staff were aware and able to describe the action to be taken in such events.

Good

Is the service effective?

Our findings

People and relatives told us they thought staff were trained to meet their needs or their family member's needs. One person said, "All the staff are very competent" another person said; "I'd say they were well qualified."

The registered manager told us that all staff undertook an induction before working unsupervised to ensure they had the right skills and knowledge to support people they were caring for. One staff member said the service, "Provides training on regular basis I have just finished SG (Safeguarding) training, and completed dignity in health and social care."

The provider ensured that each staff undertook their personal Induction. The induction process for new staff was robust to ensure they had the skills to support people effectively. This included shadowing more experienced staff to find out about the people that they cared for and safe working practices. Staff had effective training to undertake their roles and responsibilities to care and support people. Staff were trained before they started to support people and received regular on-going training to ensure their skills where kept up to date. Training was given based on the support needs of the people that lived at the home. Training for PEG (supported nutrition) feeding / medication administration has been delivered by the Nutrition Nurse, to ensure staff had the necessary skills to do this safely and effectively.

Catering staff had undertaken training and were being supported to develop their knowledge and skills. The chef told us "One of the kitchen assistants was undertaking an NVQ 2 food preparation & cooking."

Staff said they had annual appraisals. The registered manager showed us records of appraisals and the dates of next staff appraisals. Staff also had regular supervisions which meant they had the opportunity to meet with their registered manager on a one to one basis to discuss their work or any concerns they had. One staff member said; "I had supervision last week, given a written record, discussion re team player, tasks, areas which weaknesses and strengths so can work with registered manager." We saw that nurses received clinical supervisions and undertook training to meet their continuous professional development programme.

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.

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. The provider had complied with the requirements of the MCA. Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were effectively followed. Detailed assessments of people's mental capacity for specific decisions such as not being able to go out on their own had been completed.

Where people did not have capacity, relatives with a Power of Attorney confirmed they were consulted by staff and involved in making decisions for their family member, or advocate. A staff member said, "A person was having long term difficulty in eating and drinking, as they found it hard to swallow. So we had a best interest meeting with the GP, parents, SALT (Speech and Language Therapist), dietician and the manager to decide the least restrictive option."

Staff had a good understanding of the MCA including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. One staff member said, "MCA is for people who are unable to make a decision regarding their money or medication, but they may be able to make a decision about their food and drink and what to wear." Staff asked for people's consent before giving care throughout the inspection. A staff member asked for a person's consent before beginning a massage. They checked all the way through that the person was comfortable continuing with it.

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 are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

People's nutritional needs were met. One person said; "The quality of the food is quite good" and another person said "I don't like fish and prefer to have cheese omelette which they do for me". The chef told us they created an excess of meals so if people changed their minds when the meal was served; they could be offered the alternative.

There was a list in the kitchen of people's dietary requirements. The chef was able to identify those people who were on specialist diets. The chef spoke about the needs of people such as people on soft diets, who had progressed from a pureed diet to a fork mash able diet. They said that referrals to the SALT (Speech and language therapy team) were made when needed.

One relative said "The food's excellent. X was on pureed meals and now they are on soft food" and "They eat well" and "My relative always has a jug of orange juice in her room" and "They record what she drinks."

We spoke with the chef manager who explained the daily menu, they said "The kitchen assistant goes round and asks people what they would like. We show people and tell them about the options on the day." The menu was displayed in the dining room and included the main meal of the day, together with the alternatives on offer including a vegetarian option. During the day people had drinks in front of them and tea and coffee was offered throughout the day. People were offered wine at meals (and also had beer available if the person preferred).We observed lunch in the dining room and for some people in their rooms. We saw one staff assisting a person with their lunch in their room, safe practice was noted in that the person had been assisted to sit upright (had a profiling bed for ease of positioning and safety rails in place) which reduced the risk of the person choking.

We sampled food and fluid charts for people who may be at risk of not having enough to eat or drink, that were kept by people's rooms. Staff told us these were referred to as people's 'mini care plans'. These 'mini-records' were kept in or by people's rooms for people who spent long periods in their rooms either due to their needs or because of their preferences. Records included fluid charts, elimination records, topical application of prescribed creams/lotions etc. We were told by the head of care that these records formed part of the overall recording for people.

The registered manager said that they promoted collaborative care which is person centred care supported by other professionals. We were told the GP visited every Tuesday to see people who needed the support of a doctor. They could also be called at any point if a person needed to see them. Staff would call the Staff responded to changes in people's health needs quickly and supported people to attend healthcare appointments, such as to the dentist, doctor or optician. We saw, in individual care plans, that staff made referrals to other health professionals such as the speech and language therapist (SALT), the falls team, district nurses or the dementia nurse when required. One person said; "If I need to see the doctor or the chiropodist, I only need to ask" and "Hospital transport takes me to appointments and my daughter meets me there". Another person said; "I do see my GP from time to time."

We spoke to a visiting professional during our inspection who told us that staff made appropriate referrals in a timely manner. Another external health care professional told us that the technical aspects of the nursing care provided 'seemed ok' for example, in the provision of air mattress that were set at the right pressure to promote good skin care.

Good

Is the service caring?

Our findings

One person said "It's a privilege to be at this place, a lovely place." One relative said "I feel the staff here are dedicated and committed."

During the inspection we saw that staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff, smiling and communicated happily often with good humour. A relative said they thought the staff were caring and had no feeling that they were disrespectful or not caring to their family member. We had positive feedback about the caring nature of the staff. A relative said, "The best thing is the caring, they really do care for people in everything they do."

People looked well cared for, with clean clothes, tidy hair and were appropriately dressed. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. Staff were knowledgeable about people and their past histories. Care records recorded personal histories, likes and dislikes so staff were aware of people's backgrounds before they came to live at the service. This has enabled staff to plan the persons care to meet their needs. Throughout the inspection it was evident the staff knew the residents well. A relative said, "Staff are very friendly and caring to my family member." Staff were able to tell us about people's hobbies and interests, as well as their family life. This information was confirmed when we spoke with relatives, or when they showed us their bedrooms, as decorations and items matched with what staff had said.

Staff treated people with dignity and respect. People had a choice of who provided their personal care. A male staff member said, "I respect people's privacy; I will use a towel to cover them up. I will only support men with their personal care." Staff were very caring and attentive throughout the inspection, and involved people in their support. When giving personal care staff ensured doors and curtains were closed to protect the person's dignity and privacy. People had their own toiletries in the bathroom, clearly labelled so that they did not have to use the same as everyone else.

People were given information about their care and support in a manner they could understand. A staff member said, "We support people to make daily choices about what they wear, what clothes and items to buy in the shops; I will show them the item. I know people, they communicate through facial expressions, body language or noises." Information was available to people around the home. It covered areas such as local events, newsletters from the provider and which staff would be on shift. Information was presented using pictures and easy to understand text, for example, the staff on shift used staff pictures, so everyone could see who would be supporting them in their home. Information such as staff on shift, calendars, menus and activity planners were all current and up to date, so gave good and correct information to people.

People's rooms were personalised which made them individual to the person that lived there. People's needs with respect to their religion or cultural beliefs were met. Staff understood those needs and people had access to services in the community so they could practice their faith. Relatives told us they were free to visit when they chose to.

We saw positive interactions between staff and people. We observed a person being moved using a hoist in the communal lounge. Staff explained the process and constantly asked the person if they were comfortable. Two staff members came into the lounge and chatted with people cheerfully, displaying kindness and compassion. They spoke with people individually and assisted them if they needed anything. Staff who did engage with people knew them well and were able to refer to their likes and dislikes in general conversation to which people responded positively.

We asked people and family members if they had been involved by the staff in their care or the care of their relative. They confirmed that were included and kept up to date by the registered manager and the staff at the home.

Requires Improvement

Is the service responsive?

Our findings

One person said, "I feel I get the care I need" and "I am given choice and I choose not to take part in things." Another person said "The activities are not bad." One relative said, ""The care is person-centered."

People had access to some activities. We saw one person enjoyed someone to one time with the activity co coordinator supporting them to paint, in the main activities area. They told us that they enjoyed this activity. The activity coordinator told us they specialised in arts and crafts mainly. However, in the morning no other people were socially supported. We observed later in the afternoon the activity coordinator ensured that each person was aware of what was happening when an outside entertainer visited. However, we saw that staff were not sitting with people during the activity or supported the social needs of other people that were unable to come to the group activity by providing alternatives or one to one support.

We asked the activity coordinator about one to one time for people and they told us that they were not always able to organise this. We saw in the staff meeting minutes a note that stated 'Residents are frequently in the lounge with no interaction from staff, but staff are happy to congregate around the nurse's desk. This must stop and staff should sit & talk with the residents.'

We recommend that the service seeks guidance on activities for people who may be at risk of social isolation.

Before people moved into the home an assessment of people's needs was completed with relatives and health professionals supporting the process where possible. This meant staff had sufficient information to determine whether they were able to meet people's needs before they moved into the home. Once the person had moved in, a full care plan was put in place to meet their needs which had earlier been identified. People were monitored for any changes. Full family histories were drawn up so that staff knew about a person's background and were then able to talk to them about their family or life stories.

Staff were responsible for a number of people individually which meant they ensured people's care plans were reviewed on a regular basis. We read that reviews were undertaken and staff discussed with people their goals for the future. A staff member said they got to know what people wanted, including what time they wanted to get up and how they liked to spend their day. Staff said they had handovers when they first came on duty. This was an opportunity for staff to share any information about people. We noted that care plans were written by the head of care and did not always contain information about people's physical nursing needs. These needs were recorded by the nurse and held separately to the main care plan and only used by the nursing staff. This could lead to information about people's nursing needs not being accurately handed over, and the person not receiving the appropriate care.
We recommend that best practice guidance such as NICE or SCIE in care planning including nursing and social needs is put in place to ensure continuity of care for people.

Individual care plans contained information which related to people's preferred name, allergies, family history, personality, the social activities they liked doing and their care needs. There were also details about

how they wished to be looked after if they became unwell. Staff showed us a file which recorded people's weights. People were weighed regularly and staff calculated people's body mass index (BMI), so they could check people remained at a healthy weight. We saw that one person had lost weight and staff had referred this person to the GP for a dietician referral and to the SALT team for further guidance on managing the weight loss and nutritional needs.

People told us they knew how to make a complaint if they needed to. One person told us "I've no major complaints but I'm sure they would respond to a grumble." We saw how the registered manager had dealt with previous complaints and had identified improvements or actions that needed to be taken. The complaints policy was displayed in the foyer and each person had a copy of it in their service user guide.

People felt they had a say in how the home was run. People told us that they remembered filling out a survey .We observed a residents meeting; one suggestion from people was for 'better communication about the delayed start to meals and activities. This had been agreed by the home registered manager who said that she would discuss with all staff. People and relatives said "There is a resident's meeting every month and relatives meet every two months" and "They do try to resolve issues brought up at the meeting."

Good

Is the service well-led?

Our findings

The home had a registered manager. People and relatives we spoke with all knew who the registered manager was and felt that they could approach them with any problems they had. One person said "I find the manager a nice competent person."

We observed that the registered manager interacted well with people. An external healthcare professional said "The registered manager is approachable." One care staff said "I can go to the registered manager and they listen." We observed on numerous occasions the registered manager sitting and chatting to people and asking if there was anything that people needed.

Staff were positive about the management and the support they gave to them. They told us they felt supported and could go to them if they had any concerns. One member of staff said "It was a good group of staff who worked well together and there was good communication." They had staff meetings in which they could speak openly and make suggestions. Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings and any concerns that staff had. For example; discussions around the handover forms and the need for daily care documenting to sustain a good quality in continuity of care.

The registered manager told us about the providers core beliefs which were "That we should endeavour to do everything we can to ensure you are reassured about receiving high quality nursing care." Staff we spoke to understood and followed the values to ensure people received kind and compassionate care. This was implemented during the staff induction process and reviewed regularly. We saw that the values were promoted in the 'Residents Guide', which anyone wanting to find out about the home or who lived there could read.

One member of staff said when new staff started they received training on the aims and objectives of the service. It was then up to senior staff to monitor them to ensure they put these aims into practice. Any issues identified would be covered in an individual supervision session. This helped develop consistent best practice and drive improvement.

The registered manager told us about the systems they used to ensure the delivery of high quality care. We viewed records of the quality assurance systems in place. We saw evidence of audits for health and safety, care planning, medication and infection control. This enabled the registered manager to identify deficits in practice and rectify these. The registered manager explained that regular health and safety meetings were held and we looked at the minutes of the previous meeting held. Best practice guidance was discussed during these meetings including communication skills and care plan reviews and how these should be put into practice during the staff working day..

The registered manager had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely within the home.