Barchester Healthcare Homes Limited

Hundens Park

Inspection report

Hundens Lane
Darlington
County Durham
DL1 1JF

Tel: 01325366000
Website: www.barchester.com

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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

Hundens Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection.
Hundens Park accommodates up to 47 older people in one building. People are accommodated over two floors, each of which have separate adapted facilities. The upper floor (Darnton Unit) provides support to people living with dementia. People with general nursing needs reside on the ground floor. On the day of our inspection there were 42 people using the service.

The inspection took place on 1 November 2017 and was unannounced. This meant staff did not know we were visiting.

We last inspected Hundens Park on 13 October 2015 and rated the service as 'Good'. At this inspection we found the service remained 'Good'.

The service had a registered manager who was on duty during the course of our visit. 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.

Accidents and incidents had been logged but we could not verify at the time of the inspection whether the registered manager had oversight of any trends or analysis since May 2017. The registered manager told us they had changed their recording system and there had been some miscommunication between the management team as to who had responsibility for this oversight. On the day of our inspection the management team agreed to revert to their previous system which they told us had worked well.

We saw that actions required from a fire risk assessment in July 2017 carried out by an external contractor were not clearly recorded for action or follow up. On investigation we found issues in relation to major building works were not clearly recorded on the service's ongoing action plan. This meant we could not see if it had been actioned or who was accountable. The regional director discussed this with the provider's health and safety director and it was found the service was not responsible but this was down to the provider's health and safety department not updating the recording system but the works had been actioned. This was rectified on the day of our visit by updating the service's action plan.

We have made a recommendation about the quality of oversight and action plans.

Staff and the management team understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding adults. People we spoke with told us they felt safe at the home. The registered manager shared learning from feedback and safeguarding events with the staff team through recorded

meetings.

Where potential risks had been identified an assessment had been completed to keep people as safe as possible. Health and safety checks were completed and procedures were in place to deal with emergency situations.

The home was clean, and we saw staff followed good practice in relation to wearing personal protective equipment when providing people with care and support. The environment in relation to the first floor had much improved and was much more homely, accessible and dementia focussed.

Medicines were managed safely. We saw medicines being administered to people in a safe and caring way. People confirmed they received their medicines at the correct time and they were always made available to them. We saw nursing staff working with community professionals to ensure end of life anticipatory medicines were available to people when needed.

We found there were sufficient care staff deployed to provide people's care in a timely manner. We saw that recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people. The registered manager shared learning from feedback and safeguarding events with the staff team through recorded meetings.

Staff received the support and training they required. Records confirmed training, supervisions and appraisals were up to date. Staff told us they were supported by the home's management but we saw that some staff meetings had lapsed over the busy summer holiday months. We saw the next staff meeting was scheduled within the next two weeks.

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.

People gave positive feedback about the meals they were served at the home. People received the support they needed with eating and drinking by the chef who was trained in the support of people with nutritional needs.

We saw people's healthcare needs were well monitored and records in relation to the monitoring of people's health, nutrition and pressure care were recorded.

People were supported by care staff who were aware of how to protect their privacy and dignity and show them respect at all times. We saw end of life care being provided with compassion and additional staff supported the person and their family.

People's needs were assessed before they came to live at the service and then personalised care plans were developed and regularly reviewed to support staff in caring for people the way they preferred.

An activities coordinator provided a range of activities and support for people to access the community.

People and staff were positive about the management of the home. Many staff had worked at the service for a number of years and this added to the feeling of a caring, well-run home.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint. Feedback systems were in place to obtain people's views

about the quality of the service. We saw the service had a duty of candour file where lessons learnt and feedback was recorded.

The service had good links with the local community and local organisations.

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 remains good.

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 was not always well led.

Accident and incident recording needed to have improved oversight to ensure trends were identified so that measures could be put in place to prevent repeat events.

The service's action plan needed to clearly record all areas of improvement to ensure they are identified and actioned.

The service had a clear management structure in place. Staff said they were happy working at Hundens Park.

People and staff were encouraged to express their views about the service.

Hundens Park

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 1 November 2017 and was unannounced. This meant the provider did not know we were coming.

One inspector, a specialist professional advisor and an expert-by-experience carried out the inspection. A specialist professional advisor is someone who has a specialist knowledge or background; in this case our advisor was a registered nurse. 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 the information we held about the service in order to plan for our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let the Commission know about.
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.

We contacted the local authority safeguarding and commissioning teams. We also contacted the clinical commissioning group (CCG) and the local Healthwatch. We contacted community nurses and nutrition and infection control leads for care homes in the area. We used their comments to support the planning of the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We placed a poster in the reception of the service so that people and any visitors would be aware an inspection was taking place and who to contact to give feedback if they so wished.

During the inspection we spoke with five people who used the service and three relatives/visitors. 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 also spoke with the registered manager, deputy manager, the clinical lead nurse, one senior care staff, four care staff, one domestic staff member and the regional director. We looked at a range of records which included the care and medicines records for five people, recruitment and personnel records for six care workers and other records relating to the management of the service.

Good

Is the service safe?

Our findings

Accidents and incidents were logged. Information recorded the details of accidents, injuries sustained and whether relatives, or other required agencies had been notified. However, we saw that the oversight of accidents and incidents to look for trends had not been carried out since May 2017. We have addressed this omission in oversight under the key question of Well-Led.

People told us they felt safe living at the service. Comments included, "Yes, I am fine here. There is always someone here for me," and "The staff are nice." Three family relatives reported transferring their relatives from other services and told us they felt that their relatives were being cared for, and were safe at Hundens Park.

The provider had systems in place to make sure people were protected from abuse and harm. Staff had completed safeguarding training and were able to describe confidently what action they would take if they had safeguarding concerns. Previous safeguarding concerns had been referred to the local authority safeguarding team appropriately in line with the agreed local procedures. There were two safeguarding investigations ongoing at the time of our visit and we saw measures had been taken to instantly remove the risk of any potential harm to people and investigations were underway.

We saw staff using personal protective equipment such as gloves and aprons when dealing with people's personal care needs or when dealing with food. We saw that housekeeping staff had cleaning schedules they completed to ensure the service was kept clean and the potential for catching an infection was minimised.

Risks to people were identified and managed so people were safe. This included an assessment of the level of risk and action taken to mitigate the risks to the health, safety and welfare of people.

Risk assessments were completed for the environment, accessing other parts of the home, use of the nurse call bell, moving and handling, mobility, falls, use of bed rails, nutrition and hydration, choking, continence and skin integrity. There were specific risk assessments for distress and risks associated with behaviours that may challenge.

Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped identify the level of risk. The Waterlow scale is used to assess people's risk of developing pressure sores. Assessments were regularly reviewed and updated to ensure they reflected people's current level of risk.

Regular health and safety checks were carried out to help ensure the premises, environment and specialist equipment were safe for people and care staff. This included fire safety checks as well as checks of the electrical installation, gas safety, water safety, portable appliance testing and servicing of equipment used in care delivery. Health and safety checks were up to date when we visited the service. Specific health and safety related risk assessments had been completed where potential risks had been identified. We saw a

recent external fire risk assessment had been completed by an external contractor. This identified some issues for action and we addressed this in the Well-Led key question as some areas did not show that action had been taken to address the issues. We did receive confirmation on the day of the inspection from the director of health and safety for the provider that all actions were in hand and were being addressed. The provider also had up to date procedures to deal with emergency situations. Personal emergency evacuation plans (PEEPs) had also been written for each person to help ensure they received personalised support in an emergency.

Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Nurses and senior care workers had completed relevant training and had been assessed as competent. We observed staff explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken.

PRN (as and when required medicines) protocols were in place. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines such as pain relief medicines. Records showed that there was minimal use of medicines to manage behaviours for people displaying challenging/distressed behaviours and we saw that there was a record of diversional techniques to be used prior to administration of anti-psychotic PRN medicines.

Care staff confirmed staffing levels were sufficient to meet people's needs although some staff felt that on the downstairs nursing unit there was not always enough staff on a weekend. We spoke with the management team who told us they were aware of concerns from the ground floor team and they had arranged a staff meeting to explore this further. We saw the service was actively recruiting for additional support and nursing staff as the service was currently using agency nurses. On the day of our inspection there were eight care staff on the first floor and six care staff members on the ground floor as well as the deputy and clinical lead. There were also laundry, catering and housekeeping staff on duty. During our inspection call bells were answered in a timely manner.

The provider had effective recruitment procedures to ensure new care workers were suitable to work at the home. These included carrying out a range of pre-employment checks. For example, requesting and receiving two references and Disclosure and Barring Service checks. These checks were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with vulnerable people.

We saw that the registered manager had shared learning from feedback and safeguarding events with the staff team through meetings. The service also had a duty of candour file where lessons learnt and feedback was given to people in relation to the service being transparent about mistakes it had made. This showed the service was willing to listen and take on board feedback and to make improvements.

Good

Is the service effective?

Our findings

Care records contained social profiles, which included details about the person's life history and things that were important to them, such as particular events or family information. This allowed staff who had not supported the person before to familiarise themselves with that person's personal preferences.

Following an initial assessment, care plans were developed for people's daily needs such as physical well-being, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions.

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 saw that appropriate assessments were undertaken to assess people's capacity and saw records of best interests' decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. We discussed with the clinical lead on the ground floor nursing unit that in one person's care file decisions made in someone's best interest were not decision specific and the clinical lead reassured us that they would review this and include this detail in the DoLS care plan. All other files we viewed held decision specific assessments. Staff had all been trained in the MCA/DoLS and appropriate authorisations and requests for authorisations had been undertaken.

All staff we spoke with told us they were provided with training that enabled them to do their job and meet people's needs and that they had up to date training, including on line training and hands on moving and handling training. Staff mandatory training was up to date. Mandatory training is training the provider deems necessary to support people safely. This included moving and handling, health and safety, food hygiene, first aid, safeguarding, mental capacity, dementia, medicines, fire safety, infection control, and end of life care. One member of care staff reported she also had gained National Vocational Qualifications [NVQ] and a qualification in social care whilst working at Hundens Park.

New staff completed a comprehensive induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. Three new care staff stated they felt they had been supported within their training and discussions with colleagues, and their induction included reading individual people's care plans to support them to understand their individual care needs.

Staff informed us that they felt supported by the management team. Some staff raised a concern regarding the ground floor nursing unit when the clinical lead wasn't on duty as they felt leadership was not as visible

then. We fed this back to the registered manager who stated they would work with other nurses to develop their leadership roles. One staff member reported she had not received supervision since starting her job in July which we fed back to the management team who said this would be addressed promptly All other six care staff reported receiving supervision.

Records we viewed showed regular supervision sessions were carried out and staff had an annual appraisal. Supervision and appraisals are used to review staff performance and identify any training or support requirements. One senior staff member said, "I have supervision every two months with the manager, I've requested a bit more support as we've not been able to retain nurses and there were lots of care plans to do, I have started to distribute work for example to the nurse on nights and to the deputy manager, this helps. Manager helps with staff issues and decision making and we have 10 at 10 meetings daily [these are 10 minute meetings at 10am to discuss any issues of the day]."

People were supported to receive a healthy and nutritious diet. Information relating to any specific dietary needs was included in people's care and support plans. We spoke with the chef who was knowledgeable about people's nutritional support, likes and dislikes and had been trained in providing good nutrition for older people. The chef told us about using fortifying foodstuffs which is adding extra calories such as using cream and butter for those people who are at risk of weight loss.

The Malnutrition Universal Screening Tool (MUST) was used to complete individual risk assessments in relation to assessing the risk of malnutrition and dehydration. This helped identify the level of risk and appropriate preventative measures. Fluid intake charts were used to record the amount of drinks a person was taking each day and intake goals and totals were recorded. All charts were fully completed and analysed, which showed staff were effectively monitoring people's intake and taking action, as required.

People were generally positive about the food provided. We observed the lunchtime meals in two dining rooms where people were well supported and offered choices in a calm and sociable atmosphere. We observed a drinks trolley to be brought round with yoghurts as well as biscuits offered to people. Visitors we spoke with told us they could eat meals with people and that they felt welcomed and encouraged to do this.

Records confirmed that staff supported people to access healthcare services. We saw that handover records were good (although we noted many were not dated) and recorded people's current healthcare status so that nursing staff were clear on what people's needs were from one shift to the next. People also had their observations such as blood pressure, pulse and temperature recorded monthly as a matter of routine and more often where any concerns were found. We read in care records that people saw their GP, consultants, dentists, dietitian, opticians, podiatrists and speech and language therapists and behaviour support as and when needed and regular clinics were held in the home by the community nursing teams. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were met to maintain their health.

We saw that the environment had greatly improved since our last visit especially on the first floor dementia unit. We saw that as well as improved access, people had lot of appropriate items to pick up and use and they were able to access appropriate domestic items such as a dining room and kitchenette so they could get drinks and help with jobs like setting the table. We were also told by the deputy manager that they planned to introduce a washing machine so people could help with laundry. There was a relaxation area with lights, music and a bubble tube that people could enjoy. As a result of this we saw people on this unit were much more relaxed and engaged with the staff team in activities no matter how small.

Good

Is the service caring?

Our findings

People and relatives were complimentary about the caring nature of staff. People we spoke with said, "They are all nice and kind," and "I like them all." We spoke with the staff team, one of the nursing team told us, "They are really caring staff and we have good team working."

We observed people being offered choices about what they wanted to do or where they wanted to go. People told us they were given choices by staff and comments included, "They ask me about what I want to do and what I want to eat." We saw people being asked before they engaged in activities with gentle encouragement. Staff encouragement included, "Let's have a look outside shall we? It's lovely out here," and "I'd really like you to try a little bit of this dinner, do it just for me." Bedrooms were individually decorated and contained people's own personal possessions such as family photographs.

Staff spoke with pride about the importance of ensuring people's needs were held in the forefront of everything they did. Staff were able to share with us lots of detail about people's lives, family and previous jobs and they clearly knew people well. Two staff members explained to us why one person carried out a repetitive action and how this was related to their former employment.

We saw positive interactions between staff and people. Staff were singing and reading to people and the atmosphere across the whole service was calm and caring. People using the service appeared very comfortable in the company of staff and we saw that many staff had worked at the service for a number of years which meant the support for people was consistent.

Staff were respectful in their approach. They treated people with dignity and courtesy. Staff spoke with people in a professional and friendly manner, calling people by their preferred names. We observed care staff assisted people when required and care interventions were discreet when they needed to be. We observed staff on the first floor Darnton unit supporting people with disinhibited behaviour in a way that was calm and which upheld the dignity of the person and those around them.

People and relatives were involved in the care planning process. The three relatives we spoke with stated that they were involved in making decisions for their loved ones and this was recorded within individual care plans. Meetings and reviews were carried out to involve people and their relatives in all aspects of people's care .This meant that people and their representatives were consulted about people's care, which helped maintain the quality and continuity of care.

Regular resident and relatives' meetings were held. Topics discussed at previous meetings included gathering people's views about care delivery, menu choices and activities. People were encouraged to express their views and actively supported to give suggestions to the staff team regarding their care, treatment and support.

We looked at the arrangements in place to ensure equality and diversity and to support people in maintaining relationships. We saw that relatives were welcomed at the home and during the course of our

inspection three relatives had their lunchtime meal with the person using the service and they told us they did this regularly. Relatives told us they were given regular updates about their relative and said they could visit and ring at any time and that visiting times were clearly explained to them. This showed the service supported people to maintain key relationships.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The management team were aware of how to contact advocates if they were required to support people but currently no-one had any advocacy support.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs. One person told us, "The staff are there when I need them." We observed staff anticipating people getting anxious or displaying disinhibited behaviour and quickly responding and diverting the people to a more appropriate activity. Staff were directed through care plans to offer support to resolve the problem by offering the person time, using verbal and nonverbal cues to communicate and to show they were listening to the person. This meant staff responded to ensure people remained calm.

There were systems in place to ensure the staff team shared information about people's welfare. A staff handover procedure was in place. Information about people's health, moods, behaviour, appetite and the activities they had been engaged in were shared. This procedure meant that staff were kept up-to-date with people's changing needs. We noted that a lot of handover documents weren't dated and we fed this back to the registered manager to ensure staff completed the document more fully so they could be audited.

We saw care plans were confidentially stored and well maintained and staff recorded daily communication notes. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported.

We looked at five care plans belonging to people who used the service. We found care planning and the provision of care to be person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. People had contributed to 'life history' documents in care files, which gave staff a good level of information regarding what and who was important to them. People's individual interests, preferences, as well as their anxieties were taken account of. For example, one person's care plan detailed the importance of the support from their very close family, together with the frequency of their visits. Their care plan also described how they liked to sit beside their bed to eat their breakfast.

Care plans were comprehensive and contained up to date, accurate information. Plans contained a recent photograph of people and stated who their keyworker was. We found this system to be working well, with the relevant staff showing a good knowledge of people's needs. We saw care plans were reviewed regularly. Care plans were reviewed and updated at least once a month to ensure they contained relevant information. During one care profile review we saw that the person had been asked what had been good and they said, "Being with you". Relatives we spoke with confirmed they were regularly involved in people's care planning and were updated if there were any changes in people's conditions.

We found the provider protected people from social isolation. There was an activities co-ordinator employed by the service who provided support but they were not on duty on the day of our visit. Two staff members told us about activities and they stated they had armchair exercises within the communal corridor area the previous day, however they were not sure what activities would be arranged for the day of our visit. Many people on the first floor Darnton unit had support from staff on a 1:1 basis and we saw people going for walks, undertaking daily living tasks and enjoying games and books.

There was a complaints procedure in place. There were opportunities for people and staff to raise any concerns through meetings. We saw that there had been two complaints in 2017 which had been investigated and responded to by the registered manager in accordance with the service's procedure. We saw that the registered manager and regional director had visited someone at their own home to feedback a complaint investigation to them which was good practice and it was recorded the person was happy with the outcome.

Care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). In the care plans we viewed, one person did not have an end of life plan in place to record their preferences and we raised this with the nurse in charge who stated she would action it straight away. All other care plans had a detailed plan that showed the involvement of the person and their family to record people's wishes for care at the end of their life. We witnessed nursing staff liaising with community services to source a piece of end of life equipment called a syringe driver which may be used to provide pain relief medicines in a steady flow under the skin. We witnessed nursing and care staff providing care to a person at the end of their life in a compassionate and dignified manner. Staff spoke with family to ensure they understood the situation and we saw a care staff member was allocated to provide 1:1 support to the family.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. On the day of our inspection we met with the registered manager, deputy manager, clinical lead and regional director.

Accidents and incidents had been logged but we could not verify at the time of the inspection whether the registered manager had oversight of any trends or analysis since May 2017. The registered manager told us they had changed their recording system and there had been some miscommunication between the management team as to who had responsibility for oversight. On the day of our inspection the management team agreed to revert to their previous system which they told us had worked well.

We saw that actions required from a fire risk assessment in July 2017 carried out by an external contractor were not clearly recorded for action or follow up. On investigation we found issues in relation to major building works were not clearly recorded on the service's ongoing action plan. This meant we could not see if it had been actioned or who was accountable. The regional director discussed this with the provider's health and safety director and it was found the service was not responsible but this was down to the provider's health and safety department not updating the recording system. We saw that all outstanding works had either been addressed or were planned to take place.

We recommend the service reviews its oversight monitoring and action plan to ensure that all areas for improvement and trend analysis are recorded with clear actions, the person responsible for completing the task and timescales.

Staff we spoke with on the first floor Darnton unit told us they were happy in their role and felt very supported by the management team. They all stated they felt they could talk openly about any concerns and that they were supported by their colleagues and clinical leads. Some staff we spoke with on the ground floor nursing unit reported mixed views about the support they received from the management team. We shared this feedback with the senior management team who agreed and stated they were aware of the issue and they were developing the whole nursing team to improve leadership practice.

Staff were regularly consulted and kept up to date with information about the service and the provider. We also saw a recent staff survey had been carried out and the provider was currently analysing the responses before sharing this for learning and any actions.

We looked at the arrangements in place for quality assurance and governance. The clinical lead told us of various audits and checks that were carried out on medication systems, the environment, health and safety, care files, catering and falls. We saw clear action plans had been developed following the audits, which showed how and when the identified areas for improvement would be tackled.

We saw the service worked closely with healthcare professionals such as establishing a regular review programme with the community psychiatric nurse and the GP service.

The provider carried out annual questionnaires for people using the service and visitors to obtain their views. The results of surveys were analysed and actioned. These were just being collated and analysed by the provider for the 2017 results. We saw the service displayed a board in the main reception showing, "You said, We did" showing how feedback from suggestions and meetings with people and visitors and relatives had been actioned by the home.

The service had good links with the local community. We saw there were visitors to the home during the day who told us they felt welcomed by the service.

We saw that records were kept securely and could be located when needed. This meant only staff from the service had access to them; ensuring people's personal information could only be viewed by those who were authorised to look at records.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law. The provider had also displayed its CQC rating at the service and on its website as required.