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The Pines Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an inspection of this service on 25 November 2015 at which two breaches of legal requirements were found. These breaches related to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment, and Regulation 17 Good governance. After the inspection, the provider created an action plan detailing the steps they would take to meet the legal requirements in respect of these breaches.

We inspected the service on 29 March and 3 April 2017 and found that they had taken appropriate action and were no longer in breach of these regulations. At the last inspection, we had found wardrobes were not secured to the wall so risked toppling onto people, windows were not restricted to prevent falls from height, and fire doors did not have the required seals to work effectively. There was also insufficient storage for medicines. At this inspection we found that wardrobes were secured, windows restricted including the replacement of some older style doors, and new doors had been provided which were compliant with fire safety regulations.

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.

We checked the management of medicines and found that the treatment room had been refurbished and a new bench, additional cupboards, and a new medicine fridge had been provided. Safe procedures were in place for the ordering, receipt, storage and administration of medicines including controlled drugs.

There were suitable numbers of staff on duty during the inspection. Recruitment procedures were in place which helped to keep people safe from abuse including carrying out checks on the suitability of people to work with vulnerable adults.

Safeguarding policies and procedures were in place. There had been no recent safeguarding concerns, and staff had received appropriate training. They knew how to report any concerns of a safeguarding nature.

Safety checks on the premises and equipment had been carried out, including gas and electrical safety checks, and fire safety equipment. The premises were clean and staff followed the provider's infection control policy to help to prevent the spread of infection. Closed circuit television (CCTV) had been installed in communal areas, to help to keep people safe. Attention had been paid to CQC's policy regarding the use of surveillance in care homes.

Staff received regular training and supervision and felt well supported by the manager and deputy. Annual appraisals were also carried out. Specialist training to support people with specific health or care needs was also provided.

The service was operating within the principles of the Mental Capacity Act 2005 (MCA). Applications had been made to deprive people of their liberty in line with legal requirements and a log was maintained of Deprivation of Liberty Safeguards (DoLS) granted and due for renewal. Decisions made in people's best interests were appropriately recorded.

People were supported with eating and drinking and feedback about the quality of meals was positive. Special diets were catered for, and alternative choices were offered to people if they did not like any of the menu choices. Nutritional assessments were carried out, and action was taken if people were at risk of malnutrition.

The premises were clean and tidy, and people and relatives told us they liked the homely atmosphere. There had been some improvements made to the design and adaptation of the premises to help to support people living with dementia who need additional support with finding their way around the home, and may also experience visual or perceptual problems. Further work needed to be done to improve the environment, and an action plan was in place. We have made a recommendation about this.

We observed numerous examples of kind, caring and courteous care. The privacy and dignity of people was promoted and maintained by staff. Explanations and reassurance was provided to people throughout the day, and staff and people displayed warmth and humour towards each other.

Person centred care plans were in place, and these were up to date and reviewed on a regular basis. Visiting professionals complimented the quality of care records, and told us that staff followed their advice and contacted them in a timely manner for support when necessary. People and relatives were involved in care planning and reviewing care.

A variety of activities were available, including group and individual sessions. An activities coordinator was in post and we received positive feedback about the activities that were available. Relatives and friends were invited to join entertainment or planned events in the home. Trips were arranged to the local community and to places of interest further afield.

A complaints procedure was in place. One complaint had been received although this did not relate to care in the home. This was dealt with appropriately by the registered manager.

People and relatives spoke highly of the registered manager. The registered manager carried out a range of quality and safety audits and the provider visited the service on a regular basis to monitor this. The registered manager advised us that they had resigned from their post and were working their notice period at the time of the inspection. The vacant post had been advertised. A deputy manager was in post.

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.

Risks to people were assessed and reviewed to ensure the safety and comfort of people living in the service. This had improved since our previous inspection. Steps were taken to mitigate risks. Safety checks of the premises and equipment were carried out.

Improved medicine storage facilities had been provided. There were safe procedures in place for the ordering, receipt, storage and administration of medicines.

Safe recruitment procedures were followed which helped to protect people from abuse and there were suitable numbers of staff on duty.

Is the service effective?

Good

The service was effective.

The service was operating within the principles of the Mental Capacity Act (MCA) and applications to deprive people of their liberty had been made in line with legal requirements.

Staff received regular training and supervision and an annual appraisal. Specialist training was sought where necessary.

People were supported with eating and drinking and nutritional assessments were carried out. Appropriate action took place in the event of concerns about people's nutritional needs.

The premises were not fully adapted to meet the needs of people living with dementia although this work had commenced. We have made a recommendation about this.

Is the service caring?

Good

The service was caring.

We saw that staff spoke kindly with people and treated them with respect.

Dignity was preserved and personal care was offered discreetly and sensitively.

People were involved in decisions about their care and treatment and the day to day running of the service.

End of life care was provided at the home with support from district nurses who told us their experience of end of life care provided had been positive.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place and these were reviewed and updated regularly.

A range of activities were available including trips into the local community.

A complaints procedure was in place. There had been one complaint which did not relate to the care provided by the service and was dealt with appropriately by the registered manager.

Is the service well-led?

Good

The service was well led.

A registered manager was in post but was working their notice at the time of the inspection. The recruitment of a new manager was in progress. The manager was supported by a deputy manager. People staff and visitors told us the managers were helpful and approachable.

Regular audits to monitor the quality and safety of the service were carried out and issues identified were addressed.

Feedback systems were in place to obtain people's views such as surveys and meetings.

The Pines Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 March and 3 April 2017. The first day of the inspection was unannounced, which meant the provider did not know we would be visiting. The second day was announced.

The inspection was carried out by one inspector. We spoke with five people who used the service, two relatives, the registered manager, the deputy manager, a domestic and three care staff during the inspection. We contacted two relatives by telephone following the inspection.

We looked at four care plans, three staff recruitment files, and a variety of records relating to the quality and safety of the service. Prior to the inspection, we spoke with the local authority safeguarding and commissioning teams who told us they had no concerns about the service. We also spoke with a care manager, district nurse and member of the challenging behaviour team.

Before the inspection, the provider completed 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.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe living at The Pines. One relative told us, "They are very safe here. I have no worries about them at all now."

At the last inspection, we found that measures were not fully in place to maintain the safety of people that used the service. Windows were not restricted, and wardrobes were not secured to the wall risking toppling onto people. Door seals did not comply with fire safety standards. Risks were not always fully assessed and mitigated.

At this inspection we found that windows were restricted and a number of older style windows had been replaced. Wardrobes were secured to the wall, and doors had been replaced to ensure they met fire safety standards. At the last inspection there was insufficient space for the safe storage of medicines. At this inspection we found new medicines cupboards had been provided, and the treatment room had been refurbished including the addition of a bench. A new digital fridge had been provided to store medicines. The temperatures of the medicines storage room and the fridge were checked regularly. This is important as some medicines can become ineffective if stored at the incorrect temperature. Suitable arrangements were in place for the ordering, receipt, and administration of medicines. The number of medicines audits carried out had been increased, and these were carried out by the registered manager and the dispensing pharmacist. A running total of the quantity of medicines was kept, and we checked that these were correct.

There were suitable procedures in place for the management of controlled drugs (CDs). CDs are medicines that are liable to misuse so subject to more stringent controls. We checked the balance of one CD and found it to be correct. Medicines applied to the skin such as creams or patches were administered correctly. Creams were applied by team leaders and recorded in the medicine administration record (MAR). Body maps were in use which showed the location of the medicine patches to the skin, to ensure the site of application was rotated to prevent irritation. We checked MARs and found there were no gaps in the records we checked.

There were suitable numbers of staff on duty during our inspection. Staff were constantly available in the communal areas of the home, which meant they were able to supervise people and were accessible. We spoke with one person who told us they could feel a little isolated due to the location of their room, but also liked it as it was quiet and private. They said they felt very reassured that when they rang their call bell one or two staff members appeared quickly. A relative told us they thought there were sufficient staff and we observed that call bells or alarms were responded to quickly by staff.

We checked staff recruitment and found that suitable checks were in place to help protect people from abuse. Staff completed an application form and we saw that any gaps in employment history were checked out by the registered manager. Two references were obtained, and we saw evidence that they chased up references that had not been returned, and sought them from an additional source if required. There were numerous handwritten notes demonstrating that the manager had checked information and spoken with referees. Checks were completed by the Disclosure and Barring Service (DBS). The DBS checks the suitability

of applicants to work with vulnerable adults, which helps employers to make safer recruitment decisions.

A safeguarding policy was in place, and staff had received training in the safeguarding of vulnerable adults. There had been no recent concerns of a safeguarding nature. Contact details of who to contact in the event of concerns were displayed, and staff we spoke with were aware of the procedure to follow. One staff member told us, "I have done the training and would report anything straight away. I have never seen anything to worry me here."

A number of checks of the premises and equipment were carried out. The registered manager carried out regular environmental audits to ensure the premises were safe and well maintained. A maintenance staff member checked water temperatures, the nurse call system, and carried out visual checks of equipment used for the moving and handling of people including wheelchairs and hoists. This equipment was also checked on a regular basis by a specialist company to ensure they were safe for use.

Gas and electrical safety checks were carried out. A Legionella risk assessment had been carried out and tests and measures were in place to prevent contamination of the water system by the bacteria. Fire safety training was provided and regular drills were held. Fire safety equipment was maintained on a regular basis.

The premises were clean and we observed cleaning being carried out throughout the inspection. We spoke with a member of domestic staff who told us they were also the infection control lead for the service. This involved attending infection control meetings at the local hospital and then cascading this information back to the staff team. They told us their role also involved reminding staff of the correct procedures to follow, and ensured they had completed effective hand washing training. We observed people using gloves and aprons when supporting people with personal care or meals, and staff were aware of the correct coloured apron for each task. Mops and cleaning cloths were also colour coded for cleaning designated areas of the home such as bathrooms or kitchens to avoid the spread of infection. Staff we spoke with were aware of the correct products to use. Cleaning materials were stored securely and were not left unattended. Staff had received training in the Control of Substances Hazardous to Health (COSHH).

Accidents and incidents were recorded and these were detailed and body maps were completed. Body maps are diagrams of a person's body used to show the location of an injury for example. Accidents were analysed by the manager for patterns or trends with a view to attempting to prevent accidents where possible. We noticed that staff were observant and spotted potential safety risks. A staff member offered to wipe a person's hands in case their hand slipped when holding their hot drink. The provider had installed closed circuit television (CCTV) in communal hallways in the home to monitor the safety and security of people using the service. They had consulted with people and relatives before installation and followed CQC guidance about the use of surveillance. People and their relatives told us they were happy with the cameras and had no concerns about their use. We found that they did not infringe people's privacy or dignity in any way.

Good

Is the service effective?

Our findings

We checked staff training records and found they had received training in topics considered mandatory by the provider such as moving and handling, safeguarding, health and safety, medicines and infection control. Specialist support and training was provided to staff about how to care for people experiencing behavioural disturbance or distress. A relative told us that they were involved in care, and sometimes made suggestions about new ideas to try and shared information they had picked up regarding best practice. They told us the registered manager and staff were very receptive to new ideas and suggestions and "Welcomed suggestions to improve care with open arms."

Care staff had also completed vocational care training qualifications up to level three. Staff received regular supervision with their line manager where they had the opportunity to discuss their performance, training needs and wellbeing. Staff told us they felt well supported under the supervision of the registered manager and deputy manager. Annual appraisals were carried out.

The health needs of people were met. Care records we checked showed that people had seen a variety of health professionals including; GP's, district nurses, podiatrists, audiologists, opticians, and dentists. One person was unwell during the inspection and appropriate medical advice was sought. Emergency Healthcare Plans were in place (EHCPs). These record people's pre-existing medical conditions and their preferences with regards to admission to hospital or staying in the home for treatment if possible. They included details of anticipated emergencies and instructions about the action staff should take. Do Not Attempt Cardiopulmonary Resuscitation (DNAR) orders were filed in a prominent location.

People were accompanied to hospital by staff and the registered manager; including out of hours. On a recent trip to hospital with one person, the registered manager asked the ambulance crew about what the home could do to improve the information provided when people were admitted to hospital. They suggested that a 'hospital passport' type document and detailed the type of information to help staff support the person during hospital admission. The registered manager returned to the service and developed these. We saw a number were now in place and were in the progress of being completed for all people.

People were supported with eating and drinking. Meals were planned to ensure that people were appropriately supported by staff, and that the dining room did not become too overcrowded as it was quite small. Staff helped people being cared for in bed first, and then there were two sittings for lunch, although there was some flexibility within this to accommodate people's preferences. The dining area was staffed at all times. A second dining table was available in one of the lounges, and one person decided to eat there as they were feeling self-conscious at that time. Staff supported people to choose where to sit.

There were two choices at mealtimes and alternatives were offered if people did not want what was on the menu. A four week menu cycle was in place, and people told us they enjoyed the food. One person said, "The food is excellent, in fact the only problem is that there is sometimes too much of it!" Another person said, "The food is great, I can't fault it." Menus were written on a chalk board daily, and posters displayed

breakfast and supper choices available. A 'midnight munchies' menu was available which reminded people it was their home, so the kitchen was never closed. The service had an environmental health level five food hygiene rating which is the highest rating awarded.

Nutritional assessments were carried out using the Malnutrition Universal Screening Tool (MUST). These assessments identify people that may be at risk of malnutrition. Care plans were in place to support individual nutritional needs and people's weights were checked on a regular basis. One person had moved into the home shortly before our visit, and we found that their dietary needs and support they required to eat were recorded in their care plan. We spoke with kitchen and care staff who were aware of the contents of this plan. Depending upon risk, people were weighed on a monthly or weekly basis. All weights were monitored through weekly audits by the registered and deputy manager. We found that where people had lost a significant amount of weight, appropriate action had been taken by staff to seek professional advice. One person had lost weight and although their weight remained within a healthy range, we heard the registered manager discussing with staff that this might be due to them deciding to stay in bed longer and eating a lighter breakfast option rather than the full cooked breakfast they usually enjoyed. The person's care plan was amended to include that staff should offer the person a cooked breakfast in their room. This showed that the registered manager and staff considered other factors that might lead to weight loss and looked at pragmatic solutions. The plan also included that if this did not result in the expected weight gain professional advice would be sought.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Applications had been made to the local authority to deprive people of their liberty in line with legal requirements. DoLS that had been granted were highlighted and a record was maintained of people for whom a decision had yet to be made. The registered manager kept a record of communication with the local authority DoLS team which showed they regularly checked upon the progress of applications.

Individual capacity assessments were carried out and there were clear records about the decisions people were able to make for themselves. This included, for example, that they could make day to day decisions about what to wear or about personal care, but they might need support with complex care, medical or financial decisions. This meant that staff were encouraged to support people to make choices wherever possible. Decisions made in people's best interests were appropriately recorded and relatives and representatives were involved where necessary.

Some changes had been made to the décor in the home, to make specific areas more recognisable. 'Dementia friendly' design guidance suggests a number of adaptations that can be made to the environment to support people living with dementia, particularly with regards to the visual and perceptual difficulties people can experience. We noted that coloured lounge chairs contrasted with the cream coloured walls, which made chairs easier for people to see. The dining area had food related pictures which could act as a visual clue for people living with dementia, as to the purpose of the room. Further work was planned, including the painting of door frames to highlight bathrooms for example, and handrails to ensure

they contrasted with walls. There were patterned carpets in some areas of the home which can cause difficulty for some people with dementia. Flooring also contrasted at door thresholds, which goes against best practice in this area due to the potential for people perceiving changes in colour as a step or void. Bathrooms and toilets were also lacking in dementia friendly design features.

We spoke with the registered manager who had recognised this and had begun to address this issue. They provided us with details of their short and long term plans for these improvements immediately after our inspection. These included the replacement of toilet seats and handrails in a contrasting colour, and during on-going refurbishment and replacement of flooring, priority would be given to patterned or contrasting carpets.

We recommend that the provider follows best practice in relation to suitable environmental adaptations for people living with dementia.

Good

Is the service caring?

Our findings

People told us they felt well cared for and that staff were caring. One person said, "I'm happy here, this is a nice place." Another person told us, "The staff are lovely, I have never had any trouble with any of the staff; none whatsoever." A relative told us, "Everybody is very caring. They don't just care for people that live here; they care for us too"

We observed staff providing kind and courteous care throughout our inspection. There was an informal and relaxed yet professional rapport between staff and people using the service. A relative told us, "When I speak to staff about (name of relation) they tell me things that make me feel they really know them. (Name) is a person to them." We observed staff and people joking together, and an element of fun was evident. Some breakfast items on the menu displayed on the wall were given names, after kitchen staff and the registered manager such as "Suzie's scrambled eggs on toast." This added to a homely inclusive atmosphere.

Staff were observant and noticed someone looked tired, they said, "Are you tired? Why not have a nap after your dinner?" Staff went to support a person in bed with lunch, we overheard them explaining to the person what they were doing, and providing reassurance. When people were supported to move using mobility aids such as body hoists, staff took their time and explained what was happening to avoid startling people. We saw a number of examples of kind considerate care. We heard staff discussing a person who was unwell, and about how they might entice them to eat. They discussed thoughtful ideas about going out to buy their favourite brand of ice cream to tempt them.

Privacy and dignity was protected and promoted. Confidential care records were stored securely and staff closed doors when discussing private information and during telephone calls. A staff member told us, "Only people that need to know, should be told anything." People and relatives told us their privacy was respected. One person said, "They always knock before they come in" a relative told us, "They deserve dignity in their later years and they are absolutely getting that here." We observed staff offering support sensitively and discreetly. People were assisted to maintain their appearance following meals to preserve their dignity. We heard a staff member asking a person, "Would you like some help to change your top? I know you are a smart person." Staff also complimented people on their appearance, one person smiled and enjoyed being told, "I like your orange skirt, that's beautiful."

We observed staff supporting people to make choices throughout the inspection. One staff member told us, "After all these years I know what people take in their tea or what they prefer, but I still always ask people." People were asked about where they would like to sit, and how they would like to spend their time. Choices and preferences were recorded in care records, including people's preferred choice of GP or other care professionals. One staff member said, "We never force anyone to do anything they don't want to, such as personal care. We would come back and ask them later to see if they had changed their mind. We use a lot of support and reassurance."

People were also supported to be independent, including opening and dealing with personal correspondence, and the level of support they needed was recorded. One staff member told us, "We really

support people to be independent, we have a lot of people here with walking frames. I've been in other homes and they use wheelchairs a lot because it is quicker for staff. We check every step of the way if people need help and try to let people do as much as possible for themselves."

There was no one accessing any form of advocacy at the time of the inspection, and the registered manager told us they knew how to arrange this if necessary. An advocate supports people to make decisions and speaks on their behalf.

No one was receiving end of life care during our inspection. We spoke with a district nurse who told us they had provided support to staff when people were nearing the end of their lives, they said, "Our experience of end of life care here has been very positive."

Good

Is the service responsive?

Our findings

People told us their needs were responded to. One person said, "I am perfectly happy with things, I have no complaints at all." A relative told us that staff responded to their relation's needs and that they were always contacted promptly and kept up to date.

Care needs were identified before admission to ensure the provider could meet the needs of people before they moved into the service. Care records were person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. People were consulted about their care plans where possible and we saw that they were supported by relatives if necessary. One relative told us, "I joined staff in a group discussion and training from a professional about how to care for my relative. I felt I was part of a team that wanted to make things better for her."

Care plans were in place for a variety of physical and psychological needs. These included information about whether people were able to communicate their needs or feelings verbally to staff. They were up to date and had been reviewed on a regular basis. A member of the challenging behaviour team told us that care plans were very good and necessary information was recorded. We spoke with a district nurse who told us people's needs were responded to. They said, "Pressure area and nutritional care is good. Staff seek timely advice and we are not called out unnecessarily."

Transition care plans were in place to support people if they needed to move to another setting, such as hospital. A transfer plan included information about risks to people, contact details, and information about sleep pattern, communication and abilities.

Personal profiles were in place which told staff at a glance what was important to people, and how they best liked to be supported. These were kept in people's bedrooms, and could be added to with a dry wipe pen to ensure they remained up to date and relevant.

A variety of activities were available, and an activities coordinator was in post. We observed a number of activities including group quizzes and one to one activities with people such as knitting or drawing. There was a planned trip to Beamish museum, where people could spend time in rooms decorated in 1940's and 50's décor. We observed staff making good use of distraction with one person who was becoming upset and restless, by giving them a photograph to carry with them. This helped them to relax and feel more settled. A relative told us they were happy with the activities available and the impact that social stimulation had on their relation. They said, "My relative is a different person since moving here. They engage with (relative) they don't just sit in their room. They talk and remember more now, they have brought (relative) back to life." Another relative told us, "The activities person is very good. They organise lots of days and all relatives are invited along and can get involved. There was a garden tea party last year and people came along with their families and friends. There were children there and it was a lovely atmosphere."

A complaints procedure was in place. There had been one complaint since the last inspection although this was not related to the quality or safety of the service or care provided. This was dealt with appropriately by

the manager in line with their complaints policy. People and relatives told us they knew how to complain but they hadn't needed to and said that the registered manager was accessible should they have any concerns.

Good

Is the service well-led?

Our findings

At the last inspection, we found that an effective system to assess and monitor risks relating to the health, safety and welfare of people and others was not fully in place. Timely action had not been taken to mitigate the risks which arose.

At this inspection we found that suitable systems were in place for the assessment and monitoring of risks, and action had been taken in response to the concerns we raised. A registered manager was in post, who had been registered with the Commission since October 2010. We were told during our inspection that the manager had resigned from their post to take up a position elsewhere and the recruitment of a new manager was underway.

A deputy manager had been appointed, who was going through a period of induction into their new role. People, staff, relatives and professionals told us that the manager and deputy were approachable and helpful. A member of the challenging behaviour team told us, "The manager, is fantastic and she drives the staff hard to deliver excellent care." A relative told us, "The manager is excellent. She put us at ease the first time we spoke on the phone and our experience of care here has been very good ever since. The home is very well run." We observed the manager spent time out of the office, checking staff and people were okay. The registered manager told us they were well supported by the provider who visited the service on a regular basis.

There were systems in place to monitor the quality and safety of the service. The registered manager carried out a number of regular audits and checks including audits of health and safety, infection control, care plans, medicines, weights, and accidents. We saw that where checks had picked up shortfalls, action had been taken to address these. An external quality monitoring visit by the Northumberland County Council commissioners had resulted in the service being awarded a level one quality rating. This was an increase of two points from the previous monitoring visit, and is the highest rating awarded. The registered manager was proud of this achievement.

People and their relatives were surveyed for their opinions regarding the service. Regular meetings were also held with people who used the service and their relatives. These included questions to prompt discussions including the approachability of the registered manager and staff, satisfaction with rooms and facilities, the quality of food and mealtimes and the activities available. Responses were displayed on a 'You said we did' board. People had asked for takeaway meals and two people had asked for fresh fruit in their rooms. We found that fruit bowls were filled up each week and takeaways provided. One person had asked to be moved to another room as they felt isolated, and this was done straight away. This demonstrated that the views of people were sought and acted upon.

Regular meetings with staff were also held. Minutes of these meetings showed that they were used to discuss quality and safety issues, and also to pass on praise and positive feedback to staff. This included praise from a GP who had complimented the service on their record keeping.

The last inspection report and rating was displayed in a prominent location, and statutory notifications had been sent to CQC in line with legal requirements. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.