The Manor (Sussex) LLP

The Manor 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

The inspection took place on 23 November 2016 and was unannounced.

The Manor Care Home is a residential care home providing accommodation for up to 21 people. The home provides support to older people who have learning disabilities, some of whom also have physical disabilities and may also be living with dementia and therefore may require support with their personal care needs. On the day of our inspection there were 21 people living at the home. The home is a large property situated in Selsey, West Sussex. It has two communal lounges, two dining rooms, a separate activities building and a garden.

The home was a family run home and was the only home owned by the two providers. The management team consisted of one provider, a registered manager and a team leader. A registered manager is a '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 home is run.

People were protected from harm and abuse. There were sufficient quantities of appropriately skilled and experienced staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. When asked what they would do if they suspected abuse, one member of staff told us, "I'd speak to my manager or CQC". People's freedom was not unnecessarily restricted and they were able to take risks in accordance with risk assessments that had been devised and implemented.

People received their medicines on time and according to their preferences, from staff with the necessary training and who had their competence assessed. There were safe systems in place for the storage, administration and disposal of medicines.

People were asked their consent before being supported and the registered manager had a good awareness of legislative requirements with regard to making decisions on behalf of people who lacked capacity. Records showed that best interest decision meetings had taken place with external professionals and that the registered manager had sought advice from the local authority to ensure that any decisions that were made were in people's best interests.

People and their relatives, if appropriate, were fully involved in the planning, review and delivery of care and people were able to make their wishes and preferences known through regular meetings with their key-workers or residents' meetings. Care plans documented people's individual needs and wishes in relation to their social, emotional and health needs and these were reviewed and updated regularly to ensure that they were current.

Staff worked in accordance with people's wishes and people were treated with respect and dignity. It was apparent that staff knew people's specific needs and preferences well. Positive relationships had developed amongst people and staff. A comment within one person's key-worker meeting, stated, 'I am pleased with

the staff that are working here, especially my key-worker'.

People's health needs were assessed and met and they had access to medicines and healthcare professionals when required. One visiting healthcare professional explained that if people were unwell then healthcare professionals were contacted promptly, they told us "Some people here struggle to communicate their needs but I don't have any concerns, I feel comfortable that they are okay. We've made a plan today for a couple of people and I'm confident they'll carry it out". Another visiting healthcare professional told us, "I enjoy coming here, people are really well looked after. When I ask them to do something for someone, for example, obtain a urine sample, it is done".

People's privacy and dignity was respected and maintained, when offering assistance staff did so in a respectful way by knocking on people's doors before entering and using privacy screens when assisting people with moving and positioning. People had a positive dining experience and told us that they were happy with the food. One person told us, "I really enjoyed it today".

The registered manager welcomed feedback and used this to drive improvement and change. There were quality assurance processes in place to enable the registered manager and provider to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. People, a relative, staff and visiting healthcare professionals were complimentary about the leadership and management of the home. The home had a warm, friendly and homely feel and this was echoed in the comment made by the registered manager, who told us, "We try to work to it being 'our residents' home' rather than just a home. They can say whatever they want, when they want. We try our best to ensure that they have the same life here as they would choose to have in their own homes".

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 home was safe.

Sufficient numbers of staff ensured people's safety. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People received their medicines on time, these were dispensed by trained staff and there were safe systems in place for the storage, administration and disposal of medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure people's safety and people were able to take risks to promote their independence and quality of life.

Is the service effective?

Good

The home was effective.

People were asked their consent before being supported. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity and had worked in accordance with this.

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff that were kind, caring and compassionate.
Positive relationships had developed between people and staff as well as between each other.

People were involved in decisions that affected their lives, care and support needs and staff respected people's right to make decisions.

People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Good

The home was responsive.

There were meaningful activities for people to participate in and people were not at risk of social isolation.

Care plans documented people's individual social, emotional and health needs and enabled staff to care for people in accordance with their specific needs and preferences.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback.

Is the service well-led?

Good

The home was well-led.

Quality assurance processes ensured the delivery of high quality care and drove improvement.

People, relatives, staff and visiting healthcare professionals were positive about the management and culture of the home. The registered manager maintained links with other external registered managers and healthcare professionals to share good practice and maintain their knowledge and skills.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

The Manor 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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 23 November 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. Before the inspection we asked the registered manager to complete a Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the home, what the home does well and improvements they planned to make. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with three people, one relative, five members of staff, one of the providers, the registered manager and two visiting healthcare professionals. We reviewed a range of records about people's care and how the service was managed. These included the individual care records for five people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. A majority of people had limited or no verbal communication and were unable to speak to us. Therefore 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 observed care and support in the communal lounges and dining rooms during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

The service was last inspected in May 2014 and no areas of concern were noted.

Good

Is the service safe?

Our findings

People and a relative told us that people felt safe and that the home was a safe place to live. One person told us, "I feel safe because they care about me". A relative told us, "I believe they are safe because of how the girls look after them".

Appropriate pre-employment checks had been carried out and people were cared for by staff that the registered manager had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained. Staff's suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

There were sufficient staff to ensure that people were safe and cared for. People's individual needs were assessed and this was used to inform the staffing levels. For example, more staff were available at busier times of the day and less staff when people required less support and assistance. People, a relative, visiting healthcare professionals and staff told us that there was sufficient staff on duty to meet people's needs and that when people required assistance, staff responded in a timely manner and our observations confirmed this. Observations also showed that staff took time to interact and spend time with people in addition to assisting them with their care needs.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern within their workplace. One member of staff told us, "I'd speak to my manager or CQC". When asked about how they diffused situations which people might find challenging, a member of staff told us, "I would try to identify the problem then try to eliminate the source by changing staff, or giving people more time to calm down. If I noticed a change in behaviour I would look for the reason behind it, abuse for example".

Risk assessments for the environment, as well as for people's individual needs were in place and regularly reviewed. Each person's care plan had a number of risk assessments which were specific to their needs, such as choking and displaying behaviours that challenged. The risk assessments identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. One risk assessment identified that a person had an increased risk of choking. The registered manager had taken appropriate action by making a referral to a speech and language therapist (SALT) who had assessed the person and recommended a treatment plan. Observations and records confirmed that this had been implemented in practice as the person had their food cut into small pieces and they were supervised by staff when eating and drinking. Measures, to ensure the person had been involved in the risk assessment and recommend actions resulting from it, had been taken. For example, an eating and drinking care plan stated, 'I am at risk of choking and I refuse a meal that is liquidised as I am saying that I am not a baby'.

Further observations showed people were encouraged and enabled to take appropriate risks. Care records for one person stated that the person was at high risk of falls. A referral had been made to the falls prevention team to provide additional advice and guidance to minimise the risk of falls. People's wishes were taken into account when risk assessments and care plans were devised. Records of a monthly meeting between the person and their keyworker showed that the person had stated, 'I like walking a lot so please don't stop me doing that'. A keyworker is a member of staff who is allocated to each person, so that they can be a point of contact for the person if they wish to discuss their care needs or have any concerns.

Observations confirmed that staff took appropriate action when dealing with emergencies. One person experienced a fall, staff immediately went to the person's assistance and ensured that they were unharmed. They completed the relevant checks to ensure the person's well-being and assisted the person, using appropriate mobility equipment, to sit in a chair. Staff took time to reassure the person and the relevant records were completed. Accidents and incidents were recorded and monitored to identify patterns and trends and relevant action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements and appropriate referrals to external healthcare professionals had been made. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety were undertaken and people had personal emergency evacuation plans which informed staff of how to support people, in accordance with their individual needs, to evacuate the building in the event of a fire.

People were assisted to take their medicines by trained staff that had their competence assessed. People told us that they were happy with the support they received. Safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. Observations showed staff demonstrating patience when assisting people, ensuring that people were given explanations about their medicines and that they were not rushed. People confirmed that if they were experiencing pain, staff offered them pain relief and observations and records confirmed that this had been provided. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

Good

Is the service effective?

Our findings

People were cared for by staff with the relevant skills and experience to meet their needs. People, a relative and visiting healthcare professionals confirmed that they felt staff were competent, well trained and efficient. A comment within a healthcare professionals' survey stated, 'Your staff are very knowledgeable and caring about your residents'.

The registered manager had a commitment to staff learning and development from the outset of their employment. New staff were supported to learn about the providers' policies and procedures as well as people's needs. An induction was completed to ensure that all new staff received a consistent and thorough induction. Staff had undertaken induction workbooks and new staff had completed the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. In addition to this, staff that were new to working in the health and social care sector were able to shadow existing staff to enable them to become familiar with the home and people's needs as well as to have an awareness of the expectations of their role.

Staff had completed training which the registered manager considered essential and this was updated regularly. In addition, the registered manager had accessed training that was specific to the needs of people. For example, they had accessed a course that was specific to caring for people with a learning disability at the end of their lives. A majority of staff held diplomas in health and social care. There were links with external organisations to provide additional learning and development for staff, such as the local authority, external training providers and the dementia in-reach team. The dementia in-reach team provides advice, training and information for care home staff teams that provide care to people living with dementia. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. One member of staff told us, "They help us a lot here, if you have something you are not sure of, they will explain". People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive, however, they could go to the management team at any time as they found them approachable. One member of staff told us, "I am happy to put forward ideas, the managers are always open to new ideas".

People's communication needs were assessed and met. Observations of staff interactions with people showed them adapting their communication style to meet people's needs. People had access to relevant healthcare professionals such as opticians and audiologists, to maintain or improve their communication. The registered manager and staff had implemented additional measures to ensure communication was effective, particularly for people who had limited or no verbal communication. Records for one person stated, 'I am hard of hearing but I benefit from lip reading and hand signals'. Observations showed staff implementing this in practice. Staff told us how they communicated with a person who had a visual impairment and who was also unable to verbally communicate their needs to staff. They explained that sometimes the person did not want to participate in activities. In order to establish if the person wanted to

participate they had developed a way of communicating with them. Staff would gently throw a sensory ball to the person and if the person held onto the ball this would indicate to staff that the person wanted to engage with staff and undertake an activity, however, if the person threw the ball back to staff this would indicate that they did not want to participate.

Effective communication was also seen to be used amongst the staff team. Regular handover and team meetings as well as written communication books ensured that staff were provided with up to date information to enable them to carry out their roles. Observations of a handover meeting showed that staff were provided with information about each person from staff that had worked during the previous shift.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered manager 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 registered manager and staff had a good understanding of MCA and DoLS and had made the necessary applications and sought advice from the DoLS team to ensure people were not being deprived of their liberty unlawfully. Records showed that best interest decision meetings had taken place with external professionals to ensure that decisions being made for people were done so in their best interests.

People's health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, falls prevention teams, district nurses, dementia support workers, dentists, chiropodists, opticians, audiologists, consultants and speech and language therapists (SALT). A visiting healthcare professional told us that staff responded promptly to people's health needs and had a good awareness of them, they told us, "Some people here struggle to communicate their needs but I don't have any concerns, I feel comfortable that they are okay. We've made a plan today for a couple of people and I'm confident they'll carry it out". Another visiting healthcare professional told us, "I enjoy coming here, people are really well looked after. When I ask them to do something for someone, for example, obtain a urine sample, it is done". A comment within a healthcare professionals' survey stated, 'One of the best organised visits I have been to. The care your residents get with their oral hygiene is exceptional'.

It was apparent that staff knew people well and staff told us that they were able to recognise any changes in people's behaviour or condition if they were unwell to ensure they received appropriate support. Care records informed staff of the behaviours that people, who had limited or no verbal communication, might display if they were experiencing pain. Records provided clear guidance to staff with regard to what they should do to ensure the person was provided with the appropriate support and pain relief.

People had a positive dining experience. There were two main dining areas, one for people who were less dependent and who were able to communicate more freely with one another, and another for people who were more dependent and who required assistance when eating and drinking. People chose to eat their meals in the main dining areas. Staff were aware of people's preferences with regard to eating and drinking. For example, one person preferred not to eat in the dining room when it was being used by a lot of people, instead they waited until the dining room was quieter and then had their meal. People told us they were happy with the food available. One person told us, "I really enjoyed it today". The dining rooms created a

pleasant environment for people to have their meals, tables were laid with tablecloths, napkins, jugs of drink and glasses and people were offered condiments such as sauces to flavour and season their food. People were able to sit with their friends and we observed staff enjoying conversations with people to promote a sociable atmosphere.

The registered manager was responsive to people's changing needs in relation to their nutrition. One person had lost some weight and a referral to a speech and language therapist (SALT) and a dietician had been made. Further measures, to encourage the person to eat and drink had been taken. For example, care plans records stated that the person often refused food. Staff had been advised to offer nutritional supplements and to ensure that they avoided offering food, cups and cutlery of a certain colour as the person disliked this and would refuse the food and drink provided. Observations showed that this had been implemented in practice. A comment within a recent healthcare professionals' survey stated, 'From a nutritional point of view residents are provided with everything they need'.

Good

Is the service caring?

Our findings

People were cared for by staff that were kind, caring and compassionate. It was apparent that positive and warm relationships had developed between people and staff. People, a relative and visiting healthcare professionals confirmed that staff were kind and caring. A visiting healthcare professional told us, "They go for a family feel, they are extremely caring". Records of a recent residents' meeting showed that one person had stated, 'I am pleased with the staff that are working here, especially my key-worker'.

People were cared for by staff that knew their needs well. It was apparent that positive relationships had been developed. There were warm and friendly interactions between people and staff and people told us that staff were liked and that they were happy living at the home. A comment within a recent visitors' survey stated, 'I have seen so much care and love towards residents'. People were encouraged to maintain relationships with their family and friends and observations showed people receiving visitors.

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regard to people's religion and there were regular religious services provided if people wished to participate.

People were involved in decisions that affected their lives. Records showed that people and their relatives had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and a relative confirmed that they felt involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. Regular key-worker and residents' meetings were held enabling people to be kept informed of information relating to the running of the home, as well as being able to share their feelings and opinions. Records showed that people had been able to discuss topics such as their rooms, the staff, the food and things that they would like to do. Records of a meeting between a person and their key-worker contained a comment that stated, "I love my bedroom and bathroom".

People were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and treated people with respect. The registered manager had recognised that some people might need additional support to be meaningfully involved in their care. In these cases they had involved people's relatives or Independent Mental Capacity Advocates (IMCAs) when appropriate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People's privacy was respected and maintained. Information held about people was kept confidential, records were stored in locked cupboards and offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People confirmed that they felt that staff respected their privacy and dignity. When asked how they maintain

people's privacy and dignity, one member of staff told us, "By drawing curtains and closing doors for personal care. I would always get a screen for hoisting people. I put blankets over people's skirts to preserve their modesty. I always knock on bedroom doors". This was implemented in practice, staff were observed knocking on people's doors before entering and using privacy screens when assisting people to move and position using hoists, to ensure people's privacy and dignity were maintained.

People were encouraged to be independent. Observations showed people independently walking around the home, choosing how they spent their time and using aids to promote their independence, such as the use of plate guards to enable them to eat independently. Staff encouraged independence, they told us about one person who had, until recently, not been able to independently eat or drink. Observations showed the person eating their meal independently whilst being encouraged by staff. The person was clearly happy with their achievement and staff took time to acknowledge and praise this.

Good

Is the service responsive?

Our findings

People were central to the care provided. People and a relative told us that they were fully involved in decisions that affected people's care. A visiting healthcare professional told us that the registered manager and staff were responsive to the needs of people and would contact them without delay if there were ever concerns in relation to people's health. A comment within a recent healthcare professionals' survey stated, 'A willingness to adapt the environment and aids to meet changing needs is impressive'.

People's social, physical, emotional, and health needs were met. People's needs had been assessed when they first moved into the home and care plans had been devised, that were person-centred, comprehensive and clearly documented the person's specific preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed that people had been involved in the development and review of the care plans through the feedback they had provided within key-worker meetings. These reviews took into consideration changes in people's needs and care was adapted accordingly.

Care plans contained information about people's interests and hobbies. Staff told us that this was helpful and provided them with useful information that helped them to care for people in a way that was specific to them. Observations showed that this information had been used to enhance people's lives. For example, care plan records for one person stated that the person liked to look at books of cats. Observations showed staff had ensured that the person was given their book about cats and made comments about this with the person, it was apparent that the person took great joy from this. People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes with regard to what clothes they wanted to wear, what activities they wanted to do, what they had to eat and drink and what they needed support with.

The home had its own activities building and allocated two staff to work there to ensure people had access to dedicated support during activities. Observations showed everyone using the building throughout the day and enjoying activities such as exercises, craft work, listening to music and doing jigsaw puzzles. People told us they were happy and our observations showed that people enjoyed taking part in the activities and stimulation provided. One person told us, "I like the music on the radio and I like colouring and watching the television at weekends". Observations showed the person making a rug, the person told us, "Tying the rug helps with my arthritis". A relative told us about their loved one, who had recently moved to the home, they told us, "They have started making things again. There is lots of encouragement". Records showed and staff confirmed that people were supported to access events within the local community and enjoy trips to the shops. External entertainers regularly visited the home to provide entertainment and stimulation for people and the frequency of their visits had been increased in response to the reaction and enjoyment of people. Despite people's rooms being easily accessible they chose not to spend time in their room, instead they preferred to spend their time in the communal lounges or in the activities building and therefore people were not at risk of social isolation. A relative told us, "My relative has an en-suite room that they have been able to personalise with pictures. But they spend little time in their room because they like the day centre".

There was a complaints policy in place. There had been no complaints about the care provided since the previous inspection. The registered manager encouraged feedback from people, relatives, healthcare professionals and staff, there were regular questionnaires sent to obtain feedback as well as meetings to enable people to voice their concerns and share their ideas. A relative told us, "I have never had to make a complaint. They are upfront and honest".

Good

Is the service well-led?

Our findings

People, a relative, staff and visiting healthcare professionals were complimentary about the leadership and management of the home. One member of staff told us, "They have helped me to undertake courses but have also helped me with my childcare and they make sure I work when I can, this is so important". A comment within a healthcare professionals' survey stated, 'The home has a lovely atmosphere, the staff are very helpful and they seem particularly happy. I think it is a lovely home'.

The home was a family run home and was the only home owned by the two providers. The management team consisted of one of the providers, a registered manager and a team leader. The providers' aims stated that they aimed, 'To provide a homely atmosphere with professional care giving every service user security, choice and independence within a framework of support and stimuli that maintains and enhances their quality of life. We take pride in being a family run home and this ethos is extended to our service users'. It was evident that this caring and homely approach was embedded in the culture and implemented in practice. Observations showed that people looked content, comfortable and at home. There was a friendly, warm and homely atmosphere. The registered manager echoed this within their comments, they told us, "We try to work to it being 'our residents' home' rather than just a home. They can say whatever they want, when they want. We try our best to ensure that they have the same life here as they would choose to have in their own homes". A relative told us, "After only four weeks here my relative called The Manor, home. I can't praise them enough. I always feel welcome when I come".

There were good systems in place to ensure that the home was able to operate effectively and to ensure that the practices of staff were meeting people's needs. There were quality assurance processes such as surveys that were sent to gain feedback as well as regular audits conducted, providing the registered manager and providers with an oversight and awareness of the home and to ensure that people were receiving the quality of service they had a right to expect. Records showed that action had been taken as a result of the audits that were completed. For example, the registered manager monitored and analysed the amount of accidents that occurred each month and had ensured that actions were taken to minimise the risk of these occurring again by making referrals to external professionals such as the falls prevention team.

There were further links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. The registered manager attended regular meetings with other registered managers within the area to share best practice and also worked closely with external health care professionals' such as the GP, district nurses, dementia in-reach team, community learning disability team and speech and language therapists (SALT) to ensure that people's needs were met and that the staff team were following best practice guidance.

The manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.