The Wilverley Association

Little Haven

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 3 and 4 February 2016 and was unannounced.

At the last inspection on 2 May 2013 we found the service complied with all of the regulations we inspected.

Little Haven provides accommodation, personal care and nursing treatment for up to 43 older people. There were 37 people using the service at the time of this inspection.

The service did not have a registered manager. 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. The registered manager had resigned a short time before this inspection and an interim manager was overseeing the day to day management of the service.

The provider had made significant improvements to the governance arrangements in place. A range of audits were undertaken to assess and monitor the quality and safety of the service. These needed to be embedded and sustained to ensure that they continued to drive improvements.

Summary of findings

There were systems and processes in place to protect people from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns.

Medicines were managed safely as the staff responsible for administering people's medicines were suitably trained and competent.

There were sufficient numbers of staff to meet people's needs. Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home.

Staff were supported to carry out their roles and received an induction and ongoing training and supervision. Staff were kind and caring and worked in a manner that respected people's privacy and protected their dignity.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People received on-going health checks and support to access healthcare services. They were supported to eat and drink enough to meet their needs.

People were confident they could raise concerns or complaints and that these would be dealt with.

There was a positive and open culture within the service, which encouraged people's involvement and their feedback was used to drive improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff had a clear understanding of what constituted potential abuse and of their responsibilities for reporting suspected abuse.

Identified risks to people were managed effectively to help to keep people safe.

Staffing levels were sufficient and recruitment processes were robust.

People's medicines were managed appropriately so they received them safely.

Good

Is the service effective?
The service was effective.

Consent to care and treatment was sought in line with current legislation and guidance.

There was a programme of staff training and development to support staff to gain relevant knowledge and skills.

People were supported to eat and drink enough to meet their needs.

People had access to healthcare services when they needed them.

Good

Is the service caring?
The service was caring.

Staff had developed positive caring relationships with people using the service.

Staff communicated effectively and encouraged people's involvement in their care.

People's privacy and dignity was respected.

Good

Is the service responsive?
The service was responsive.

People received personalised care and support in line with their needs and wishes.

There were a range of activities available.

Complaints were listened and responded to.

Good

Summary of findings

Is the service well-led?

Systems to assess and monitor the quality and safety of the service were being further developed and needed to be embedded and sustained to ensure that they continued to drive improvements.

There was a positive and open culture within the service and leadership was good.

Requires improvement

Little Haven

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 3 and 4 February 2016 and was unannounced.

The inspection was carried out by an inspector accompanied by specialist advisor. The specialist advisor had experience and knowledge of best practice relating to the care of older people, particularly end of life care needs.

Little Haven provides accommodation, personal care and nursing treatment for up to 43 older people. There were 37 people using the service at the time of this inspection.

Before we visited the home we checked the information that we held about the service and the service provider, including previous inspection reports and notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we received feedback about the service from an external healthcare professional.

During the inspection we spoke with six people who used the service and seven of their visitors to seek their views about the care and support being provided. We also spent time observing interactions between staff and people who used the service. We spoke with the nominated individual, the interim manager, the quality manager, and eight of the nursing and care staff. We looked at care and treatment records for eight people, including four people who were receiving end of life care. We also reviewed records about how the service was managed, including risk assessments and quality audits, staff recruitment records, rotas and training records.

Good

Is the service safe?

Our findings

People felt safe and well treated living at the home. One person told us they felt "very safe" when staff assisted them to mobilise.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, risks associated with falls. Before people came into the home their mobility and risk of falling was assessed and guidance provided for staff to follow. Staff were aware of the risk assessment and management plans in place for people and care records showed that these were followed. A system of handover meetings and recorded communications took place between staff on each shift to help ensure that changes to people's health and welfare were discussed and any new risks were identified and acted upon.

Incidents and accidents were monitored by the provider and a record was maintained of the actions taken to mitigate any risks and prevent reoccurrences. An ongoing audit was used to check whether any trends or themes could be identified, allowing further preventative actions to be planned. Staff had been informed about how and when to record incidents and accidents. For example, following a person having a fall staff carried out a series of checks and observations to help ensure the person was safe and well.

A health care professional told us there had never been any issues, with patients they were involved with, regarding risk management. They said after one person had a fall staff did all they could to make sure it did not happen again, for example rearranging furniture and talking to the person about the risk.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe . Staff were aware that policies were in place in relation to safeguarding and whistleblowing procedures. They knew how to report any suspicion of abuse to the management team and agencies so that people in their care were protected and their rights upheld. Staff were confident any concerns they raised to the management would be appropriately addressed. Records showed and staff confirmed they had received training in safeguarding adults as part of their training and this was regularly updated. The interim manager told us staff knowledge of safeguarding procedures had improved and the service had developed a good relationship with the local authority safeguarding team.

There had been significant changes within the staff team, with eight new staff including seven nurses having commenced employment at the home in January 2016. The interim manager told us there was one nurse vacancy for 24 hours a week on the day shift, which was being covered by existing staff. The service used very few agency staff. Rotas showed shifts were covered in line with target staffing levels and to what level staff were trained. A new 4pm to 8pm shift had been added to help during this busy period.

The service followed safe recruitment practices. We looked at the recruitment records for two nurses and two care staff. Each file included application forms, health checks and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC).

The interim manager explained that changes had recently been made to improve the medicines administration systems. There was a nominated nurse to do monthly audits, which had recently commenced and the service was in the process of changing the pharmacy supplier. Each person had a medicine cabinet in their room, which was locked and used to store their 'as required' (PRN) medicines, which staff administered. Other general medicines came in blister packs for each person and were stored in purpose built locked trolleys. Medicines that were not in blister packs were stored in a locked cabinet in the treatment room. We randomly checked the packets for expiry dates and all were in date. Where required, medicines were stored in a locked fridge and the temperature was checked daily. We saw there were signing in and out procedures for controlled drugs (CD). A nurse received the CD, which were then opened and counted prior to signing the delivery record. The CD were then recorded in the CD book and placed in locked cabinets. The drugs were checked every week by two nurses. Procedures were in place and followed for the destruction of CD when no longer required.

Good

Is the service effective?

Our findings

We received mixed feedback from people and their relatives about the meals that were provided, however it was generally acknowledged that this was an area that was being improved upon. The catering provider had recently been changed as a result of the service provider's improvement plan. One person told us "It's getting better now for size. Sometimes it's so much dolloped on the plate". They added "Afternoon tea, with a piece of cake, is quite nice now". Another person told us "Personally I have no complaints about the food. On the whole it's pretty good".

The provider employed a quality manager who told us how the service sought people's views about the food provided. There was currently a weekly menu that included descriptions of the food and how it was cooked that staff could read to people. The quality manager carried out spot checks, including at weekends, to monitor the quality and presentation of food and support people received. They told us the service was looking into producing pictorial menus to assist people who were living with conditions such as dementia or hearing impairments.

A member of staff said "A lot has improved regarding the food since (the quality manager) got here". Each person had a dietary assessment recorded when they came into the home and this was shared with the kitchen staff. The assessment included people's preferences about what and when they ate, however people could change their choices and "Nothing is set in stone".

We observed the lunch time meal on the first day of the inspection. The dining room was clean and warm and tables were neatly and brightly laid. Staff asked people what drink they would like. Staff sat at tables and talked with people and offered support and encouragement when needed. People were also supported to eat in their own rooms if they chose or required it.

Records showed that people's nutritional needs and preferences had been assessed. Food and fluid charts were in place and up to date for people with specific needs that required monitoring. Kitchen staff had a list of people's likes and dislikes and details of people requiring special diets. One person received their nutrition by means of a percutaneous gastrostomy (PEG) which meant all of their food and fluid was administered in a liquid form through a tube directly into the their stomach. This is usually provided because of swallowing difficulties. There were nursing plans in place to support this and guidance was received from a speech and language therapist (SALT).

New staff completed an induction during which they learnt about their role and responsibilities, read policies and procedures and became acquainted with the environment and people using the service. The provider had introduced the Care Certificate induction for recently employed staff. The care certificate sets out the learning outcomes, competences and standards of care that care workers are expected to demonstrate and should ideally be completed within the first 12 weeks of employment.

Staff told us their induction training was thorough. They worked in a supernumerary capacity for a number of weeks until they had been assessed as competent in areas such as moving and handling and were suitably trained. This period also included working alongside experienced staff delivering care, with the permission of the individuals receiving care. A member of care staff told us there was "Loads of training at the moment". They had just completed catheter training. They had also received dementia awareness training, which had informed them about "different kinds of dementia and which parts of the brain are effected". This helped them to better understand the needs of people using the service. They said the previous training "had not been focused on us" and so had been too general to apply effectively. They were aware that the training provider had been changed. They said the managers asked them if there was any training they needed or wanted to do: "They ask us how they can help us".

The managers and staff told us a good working relationship had been established between the home and a local hospice, with palliative and end of life education for all levels of staff. An external healthcare professional commented that staff took part enthusiastically in the training sessions. The service also supported staff, where appropriate, to enrol on nationally recognised health and social care qualifications . All of the staff we spoke with said that the training provided supported them to perform their role effectively. Staff told us they received supervision that included direct observation of their working practices, for example to ensure correct infection prevention and control procedures were adhered to. Staff also received annual appraisals of their work.

Good

Is the service effective?

Staff had received training in the Mental Capacity Act, 2005 (MCA). The 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. The interim manager told us MCA was "Still an area for development", in terms of staff working knowledge and the completion of relevant documentation. The service was now in contact with one person's relatives, who had previously not been available, in order to agree a best interest plan.

The care records we saw contained information about people's capacity to make decisions and guidance for staff on how to support people in this respect, as well as the involvement of relatives and other representatives. Some sections relating to consent in the new care plans were not yet filled in and staff told us this was "Work in progress". Staff showed an understanding of the legislation in relation to people they were supporting. Before providing care, they sought consent from people and gave them time to respond. Records also showed that when a person had been confused at a time when staff asked them about a decision, the staff had left and come back at a later time to ask again. Staff told us that most people using the service had capacity to make decisions with support. A member of staff told us they had undertaken a mental capacity assessment with the interim manager in relation to one person who was living with dementia. "At this moment in time he still has capacity, so there is no need to go any further".

The member of staff told us about another person who had a room on the top floor, whose mobility now presented a measure of risk but they did not wish to move downstairs. They said staff had informed the person about the risks and the person "Is happy with that. It's not our right to take that away from him; that's his room. Everyone has a right to be treated as an individual". They added "It's my privilege to work in their home". An external healthcare professional told us that in their experience the service took into account people's mental capacity and consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The interim manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, occupational therapists, opticians and dentistry. An external healthcare professional commented that staff "Always listen to advice and guidance and are not afraid to ask for it". A senior member of the care staff demonstrated a good knowledge of when and how to use pressure relieving equipment, such as air flow mattresses that self- adjusted according to weight change. We observed effective communication between staff, for example care staff discussing a person's wound dressings with a nurse. On our arrival at the start of the inspection we observed staff had promptly called for an ambulance for a person who had a fall.

Good

Is the service caring?

Our findings

There was a welcoming atmosphere in the home and we observed positive, caring interactions initiated by staff. A person told us staff understood their support needs and said "All of them are caring without exception. They're really good". They told us staff always knocked on the door before entering, spoke in a respectful manner and "have a laugh and a joke". Another person said staff provided "A good service, I'm very happy here". Another person and their relative said they were both very pleased with the care and support and felt Little Haven was the best nursing home in the area.

A person and their relative told us "Most of the staff are kind and caring. They are good". The relative added "I'm happy with mum being here". The person told us one of the domestic staff "Looks after my flowers" when cleaning their room. One person told us that, while they would prefer to be at home, they were happy at Little Haven because it was the best place for them. Both the person and their relative said everyone was very helpful and caring and would do anything for them.

Staff promoted positive caring relationships, being respectful and courteous towards each other and people who used the service. There was a calm, quiet approach together with smiles and laughter. We met a person in the corridor who told us they were on the way to get a haircut. They were still relatively new to the home and told us "I love it here". A member of staff came by and asked the person if they were okay, then gently took them in the direction of the hairdresser. A nurse commented that the care staff were very good and reliable and gave excellent care.

The care notes in people's records were systematic and demonstrated a personalised approach. For example, staff talking to a person while they were in their room and letting them know when their relatives were visiting. The records showed that the person was offered personal care every three hours as planned.

We received feedback from an external healthcare professional, who said they had only heard positive comments about the care from people and their relatives. They said their patients always seemed happy and well cared for. They told us they felt staff had good relations with people and their families. On occasions when a person's health deteriorated, staff communicated well with the person's relatives. The healthcare professional said they had seen lots of examples where people and their relatives had been involved in the care planning process, including during admission when staff asked for background information, such as the person's likes and dislikes and about any communication difficulties. This was also reflected in feedback we received from people and their relatives during the inspection. For example, a relative told us they were kept informed and invited to part take in decision making with their family member.

Staff gave examples of respecting people's privacy and protecting their dignity, for example closing doors and curtains and keeping a person covered as much as possible while assisting them to wash. They said they would ask the person's permission before providing care and encourage people to be as independent as they wished. They would not talk about one person in earshot of another. We heard staff discussing people during handover and talking with people in their rooms and this was done with care and warmth.

People who were receiving end of life care and support had specific care plans that were clear and regularly reviewed and reflected their wishes. For example, people were supported to continue receiving care in the home as their needs changed and not be admitted to hospital. People had prescribed anticipatory medicines that they received to help ensure they remained comfortable. An external healthcare professional told us the service managed pain control and anticipatory medicines well. One of the nurses we spoke with had a lead role in end of life care, which they had a special interest in. They told us they had attended educational / training days provided by the local hospice and now had close links with the hospice team. They and two other staff had been nominated as bereavement leads, a role that involved supporting staff, residents and relatives. They helped to ensure the relatives or representatives of people who were dying were aware of the accommodation available for them and that all staff were aware of their situation.

Good

Is the service responsive?

Our findings

The majority of comments we received from people and their relatives indicated that the service responded well overall to individual needs and concerns. A person told us "They look after me very well. The staff are all very nice. They're very prompt and they check on me". Another person said "In the main they're very helpful". One person told us staff responded when they used their call bell and added "You always have the emergency one if you need it". We saw call bells were within people's reach and were responded to promptly.

People's needs were reviewed regularly and as required. Where necessary external health and social care professionals were involved. Before people moved into the home they and their families participated in an assessment of their needs to ensure the service was suitable for them. Involving people and their relatives in the assessment helped to make sure that care was planned around people's individual care preferences. The service was currently introducing more personalised care plans that provided guidance in greater detail about how each person would like to receive their care and support, including how they communicated their needs and preferences. The new plans reflected the importance of meeting people's needs in ways that gave them as much choice and control as possible. A nurse said they felt the service was improving and getting systems in place to support this. The current care plans were a start although it was taking time to change them over.

The service had also recently introduced a key working system, where named staff take special responsibility for supporting and enabling a person. The aim of this system is to maximise the involvement and help to build relationships between people using the service and staff. A member of the care staff said communication was good within the staff team and they would report any changes in a person's care needs to a nurse, so a review could take place.

Handover between staff at the start of each shift helped to ensure that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. We observed the handover between the morning and afternoon staff, which was led by the nurses form both floors. Their presentation was professional, clear and relevant and discussed events from the past 12 hours. They highlighted people whose condition had deteriorated and how to manage the changing situation, including support for a person's family. It was evident from the way the discussions took place that the staff team knew the people well.

People had a range of activities they could be involved in and were able to choose what activities they took part in. There was an activities list on a notice board. During the morning there was a movement to music activity followed by sherry in the lounge. Later in the day a reminiscence activity took place. We heard people and staff talking about meals and types of food they had enjoyed, or not, in previous times. People were clearly engaged in the discussion and enjoying it. A person told us there was "Always something to do". They said they had missed the Christmas carole concert put on by staff but "The pantomime was very good". Another person said "They put on a lot of activities. Have you seen the notice board? We do have fun here". They also told us about boat trips from a local marina.

We spoke with a member of staff who had a lead role in activities for people using the service, supported by a part-time assistant and care staff. We asked them how they ensured people who were cared for in their rooms did not become isolated. They told us they always asked entertainers to visit people in their own rooms also. They told us about the system they had to monitor who received one to one activity sessions and "What works and what doesn't work". The activities coordinator showed us a new format that was being introduced for recording activities. They demonstrated knowledge of individuals who did not take part in group activities and their preferences and interests. For example, one person became more engaged if staff talked to them about different foods, and "will let you know when they have had enough". Another person was interested in farm machinery and birds and staff had put up pictures of animals for them in their room.

There was a complaints procedure and records were kept of the actions taken in response to complaints received. The complaint procedure had not been working effectively as staff had not always taken concerns forward appropriately for investigation. The recently in post nominated individual and the interim manager subsequently revised the process and staff awareness of the procedure to follow. The provider had received two complaints relating to nursing and end of life care and,

Good

Is the service responsive?

following investigation, had taken steps to reduce or minimise the risk of the incidents reoccurring, through increased monitoring of care plans, call bell responses and staff competencies.

A complaints and compliments book was available in the reception area. A person and their relative told us they had complained about the food quality and this was an issue that "Is being worked on". Another person told us they had never made a complaint and staff "Are all very approachable". One person said "I have never complained at all. I find they are very friendly and I am very comfortable here".

Requires improvement

Is the service well-led?

Our findings

A safeguarding investigation had taken place following concerns raised about non-reporting of incidents to CQC and other concerns including people's end of life care, the attitudes and competencies of nursing staff, and care planning. The previous registered manager had since resigned and the home now had an interim manager and a new nominated individual had taken up post in 2015. There were plans in place to recruit and register a manager for the service.

The interim manager provided us with some background information relating to recent changes within the service. There had been issues with the culture among nursing staff and a number of nurses had recently left. This meant the interim manager's first focus had been on recruitment, which had been successful and a new nursing team was in place. Another area of focus was on the paperwork, which the manager said had not been fit for purpose and still presented some challenges, however, the service was introducing new paperwork and nurses were currently working supernumerary hours to enable them to complete the task. We saw there were processes in place to enable the management to account for the actions, behaviours and performance of staff, and the interim manager told us how she had implemented the procedures when necessary.

There was an improvement plan for the service that had been in place since August 2015. The plan included the development and implementation of key performance indicators for staff, training for staff in safeguarding and incident reporting, and medicines audits. The majority of actions were reported to be complete and we saw evidence of this. The interim manager told us audit tools were being established and would then be reviewed, along with staff learning.

We saw new systems of audits were being implemented, such as for care plans and medicines. The records did not always show what actions had been completed. The audits would need to be embedded and sustained to help ensure that they continued to drive improvements.

Meetings of the Trustees took place, which showed the provider monitored what was happening in the service. There were records of Trustee's visits to the home, during which they carried out observations and spoke with people using the service. On one occasion a person had spoken with a Trustee regarding concerns about access to their finances, however there was nothing in the report to indicate that any action was taken. The report also stated 'we witnessed an incident where a relative pressed the call button. The response time was 10 minutes'. There was no further entry to show what the outcome was of this observation. The visit record template included a section titled 'actions required', which was not being completed following each visit. We spoke with the nominated individual who informed us she had taken action regarding the person's concerns about their finances and for the past month had been monitoring and analysing call bell data. The nominated individual acknowledged that the Trustee's visit reporting would be improved by recording any follow up actions.

A person and their relative said they had seen the Trustees on three occasions in the past 18 months: "They come and walk around and don't tell anyone they're coming". They told us when they had complained about something it was sorted out. One of the Trustees had given the relative their phone number. They told us meetings had been held to discuss issues such as the food. Another person told us residents meetings were held, where "People can speak freely". We saw minutes of the meetings were on file and future meetings were scheduled to take place.

Quality assurance questionnaires had been sent out in December 2015 to people who used the service and their relatives. The managers had not yet collated the responses but told us they would monitor these in order to see if any action needed to be taken to improve the service. We saw 20 responses had been returned to date, with eight people rating the overall quality of the service as good, another eight rating it very good and four people rating it excellent.

Clinical governance meetings were held, which enabled learning to take place between the two services operated by the provider. Following a number of medicines errors, the provider had changed the pharmacy supplier and medicines blister pack system. Clinical leads had been assigned to areas of the service, including medicines. An incident form had been completed in relation to a person being given their medicines late. Records showed that the management had investigated and followed the incident up with the agency responsible for supplying the member of staff. An audit of the facilities had resulted in a number of

Requires improvement

Is the service well-led?

items of equipment being replaced, including commodes, wheelchairs, slip mats and hoists. Records showed that equipment was serviced regularly by appropriately qualified engineers.

The provider demonstrated a commitment to investing in and developing their staff. An associate practitioner role had been introduced that enabled senior care staff to develop their skills further. A member of staff spoke enthusiastically about the new role, saying "Now it's exciting again". They said they felt their experience was valued, as they were given more responsibility, for example recruiting, interviewing and planning work schedules. They told us about the work staff were doing on changing over to a new model of care records, which was "More personalised".

Care staff we spoke with were aware of the changes taking place, such as the new care plans and records being introduced. They said staff were being informed about the changes and asked to bring forward any questions or issues to meetings. They said there were regular meetings and individual supervisions and that the managers and senior staff were approachable and listened to what staff said. Records of staff meetings showed managers and staff jointly discussed matters, including the changes in the service, safeguarding reporting, new handover procedures and care documentation, dependency assessments and staffing levels. The minutes of a meeting with senior staff on 1 October 2015 reflected that the provider had taken the decision not to admit new people until the correct staffing numbers and competencies had been established.

A member of the care staff said "The last nine months has been a rocky road". They told us "The new management are a breath of fresh air, what Little Haven's needed for a long time, they listen". They said if staff had raised an issue "previously you wouldn't see an outcome. Now, we have more staff on duty at 4pm". They told us the management had listened to what staff were saying and "Looked at people's dependency and acted. They're looking at dependency now for the whole building". As another example, staff had asked for more training on dementia and the provider had asked staff to put their names forward if they were interested in this. They told us "Nothing is a secret" as the management were open with staff about the challenges of improving the service; and said "As a team we can make this happen".

An external healthcare professional confirmed that a good working relationship existed between their service and Little Haven. They told us "The staff are always very helpful with answering my questions regarding (patients) symptoms/problems. I have great confidence in their abilities to give me a good handover, which obviously I need to rely on in my role. I am also confident that they would call me if I am needed to visit the home, sooner than planned, due to a change in one of my patient's condition". They added "From my experience of nursing homes, I feel that they have a very strong, capable, compassionate, and experienced group of healthcare assistants".