Cedars Castle Hill

The Cedars Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 June 2017 and was unannounced. The inspection continued on 14 and 15 June 2017 and was announced. It was carried out by a single inspector.

The Cedars Nursing Home provides accommodation for up to 31 people. It delivers palliative and end of life care to older people, including people with dementia type illnesses. There were 31 people living in the home at the time of the inspection. The home was split across two floors. On the ground floor there were 15 bedrooms three of which were en-suite and on the first floor there were 16 bedrooms two of which were en-suite

The service had a registered manager in place. 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.

Quality monitoring systems used at The Cedars Nursing Home were not effective and did not give the auditor space to write comments or record actions to be taken. We found gaps in recording which had not been picked up during quality checks.

The service did not display their rating from the previous inspection on their website. On day two of the inspection this had been rectified.

Medicines were not always managed safely. We found one person who had recently been admitted had gone nine days without one of their medicines. A GP was called and recorded that the person had not suffered any adverse effects as a result of this. Medicine Administration Charts (MAR) were not always accurately completed.

People's capacity was assessed and best interest decisions were recorded however, records only evidenced that the acting manager had been involved in the decision making which meant that decisions made might not always be the least restrictive or in the person's best interest. We were told that these would all be re-reviewed and that families and professionals would be involved.

People, relatives, health professionals and staff told us that the service was safe. Staff were able to tell us how they would report and recognise signs of abuse and told us they had received safeguarding training. We reviewed the training records which confirmed this.

Care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about how they lived their lives. Each person had a care file which also included guidelines to make sure staff supported people in a way they preferred. Risk assessments were completed, regularly reviewed and up to date.

Staff had a good knowledge of people's support needs and received regular mandatory training as well as training specific to their roles.

Staff told us they received regular supervisions which were carried out by management. We reviewed records which confirmed this. Staff told us they found these useful.

People were supported to maintain healthy balanced diets. Food was home cooked using fresh ingredients and people said that they enjoyed it. Food options reflected people's likes, dislikes and dietary requirements.

People were supported to access healthcare appointments as and when required and staff followed GP and District Nurses advice when supporting people with on-going care needs.

People told us that staff were caring. We observed positive interactions between staff and people throughout the inspection. This showed us that people felt comfortable with staff supporting them.

Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes, interests and communication needs. Information was available to people. This meant that people were supported by staff who knew them well.

People were supported with end of life care. The registered manager told us that the home had been awarded a beacon status for the Gold Standards Framework (GSF) for past five years. The Gold Standards Framework is a programme care homes use to improve end-of-life care by offering staff training and a framework to help identify, assess and deliver good care.

People had their care and support needs assessed before using the service and care packages reflected needs identified. We saw that these were regularly reviewed by the service with families and health professionals when available.

There was system in place for recording complaints which captured the detail and evidenced steps taken to address them. People and relatives told us that that they felt able to raise concerns or complaints and felt that these would be acted upon. This demonstrated that the service was open to people's comments and acted promptly when concerns were raised.

People and staff felt that the service was well led by the registered manager. The registered manager and others in the management team all encouraged an open working environment. All the management had good relationships with people and all worked shifts with staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely or recorded accurately.

People were at a reduced risk of harm because staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

People were at a reduced risk of harm because risk assessments and personal emergency evacuation plans were in place and up to date.

People were at a reduced risk of harm because there were sufficient staff in place to support people with their care and support needs.

Is the service effective?

Good

The service was effective. Capacity assessments were completed and best interest decisions were recorded. However best interest decisions only evidenced the acting manager's involvement.

People's choices were respected. Staff had a good understanding of the requirements of the Mental Capacity Act 2005.

Staff received training, appraisals and supervision to give them the skills and support to carry out their roles.

There was an effective menu planning system in place which captured people's feedback, likes and dislikes.

People were supported to access health care services and attend hospital as and when necessary.

Is the service caring?

Good

The service was caring. People were supported by staff that spent time with them and knew them well.

People were supported by staff who used person centred approaches to deliver the care and support they provided.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected each person's privacy and dignity.

People were supported appropriately with end of life care.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs because staff had a good knowledge and up to date information about the people they provided care and support for.

People were supported by staff that recognised and responded to their changing needs.

People were supported to take part in activities which were linked with their own interests and hobbies.

A complaints procedure was in place which was up-to-date. However not everyone was aware of the complaints procedure.

Is the service well-led?

Requires Improvement

The service was not always well led. Quality monitoring systems were in place but were not effective nor were they always completed accurately.

The service did not display their previous rating on their website until day two of the inspection.

The registered manager promoted and encouraged an open working environment.

Staff, health professionals and relative spoke highly of the registered manager.

The Cedars Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 June 2017 and was unannounced. The inspection continued on 14 and 15 June and was announced. The inspection was carried out by a single inspector.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

The provider had returned a Provider Information Return (PIR) from us. 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.

We spoke with four people who used the service, a health care professional and one relative. We also spoke with the registered manager, systems manager, staff services manager and the home's acting manager. We met with five staff. We reviewed three people's care files, policies, risk assessments and quality audits. We observed staff interactions with people and observed a meal time in the dining room. We looked at five staff files, the recruitment process, staff meeting notes, incident reporting, training, supervision and appraisal records.

Requires Improvement

Is the service safe?

Our findings

The Cedars Nursing Home did not always manage medicines safely. On the 15 June 2017 we found that one person who had been admitted to the service on 5 June 2017 had not received one of their medicines for high blood pressure since 6 June 2017. This meant that they had gone without this medicine for a total of nine days. We discussed this with the acting manager who told us that the person had only come to the home with one of these medicines and that they had contacted the hospital asking for more when they arrived. The acting manager told us they called the hospital again on the 7 June who said more wwould arrive and we were shown that a fax that was sent to the local pharmacy requesting more on 11 June. We observed the acting manager following this up with the GP surgery and pharmacy and noted that a GP visit was arranged. The GP visited the person during our inspection and recorded that following observations they felt the person was fine and had not suffered from any adverse effects. The acting manager told us this had been an oversight. The registered manager told us that they had requested for itto be recorded as a near miss and would use it as a learning opportunity and ensure it did not happen again.

Whilst reviewing people's Medicine Administration Record (MAR) sheet we found that there were some recording errors. One person's eye drops had not been signed for on the morning of 15 June, another person's eye drops had been signed for the morning of the 16 June instead of the 15 June and another person's had been signed to say both morning and evening eye drops had been administered on 15 June 2017. The acting manager said, "These were done. I was put off by you (the inspector) being there". We observed the errors being amended by the acting manager. We also noted that one person had not been administered one of their medicines and a code "O" for other had been used on 30 and 31 May and 12, 13 and 14 June 2017. It is a requirement that when codes are used on people's MAR charts comments are recorded on the back of the sheet however no notes or comments had been recorded on any of these dates. The registered manager told us this would be looked into.

People, relatives and professionals told us that they felt the service was safe. A person said, "It's alright here, I'm happy". Another person told us, "I feel safe here staff speak nicely to me". A relative said, "Cedars is very good. I'm happy. I feel my loved one is safe because I've got to know the staff and it's homely". A health professional told us, "The Cedars is brilliant, all the staff seem to work from their heart. I have never had any concerns about people's welfare here".

Staff we spoke to told us that they felt the service was safe. They were able to tell us what systems and processes were in place to reduce and manage risks to people. For example, appropriate equipment, 24 hour staffing and risk assessments.

People were protected from avoidable harm. Staff were able to tell us how they would recognise signs of potential abuse and who they would report it to. Staff told us they had received safeguarding training and training records we looked at confirmed this.

We reviewed three people's care files which identified people's individual risks and detailed control measures staff needed to follow to ensure risks were managed and people were kept safe. Staff we spoke to

were aware of these. A staff member explained to us how the service had supported people who were assessed as high risk of falls. We found that the home provided appropriate equipment such sensor mats and wheeled mobility frames. This demonstrated that the service ensured safe systems and practice were in place to minimise and manage risks to people.

People had Personal Emergency Evacuation Plans (PEEPs) which were up to date and formed part of their care plan. These plans detailed how people should be supported in the event of a fire. The service had a business contingency plan in place which was used in situations such as; bomb threats, catering disruptions, loss of electricity or gas and flooding. Local internal and external contacts were listed and there were incident checks and log sheets to complete in any event necessary.

We discussed staffing with the registered and systems managers and were told that staffing numbers had been increased over the past year which had had a positive impact on people and the team. The systems manager showed us the dependency tool which the home used to determine staffing numbers. On each day of the inspection the home reflected the numbers we were given. People, staff, family members and professionals told us there were enough staff. One person told us, "There are enough staff for me, they are always available". A health professional said, "There seems to be enough staff. They seem to back each other up. I have observed some very good morale here". A relative told us, "There are times when staff may seem a little stretched like meal times but I have never thought there weren't enough staff which may result in my loved one being put at risk". A staff member told us, "There is normally enough staff we can always get cover when there is sickness". Another staff member said, "I feel there are enough staff here. We have reasonable time with people and activity co-ordinators are in each day to offer additional quality time with people".

The staff services manager took us through the recruitment process which were safe. We reviewed five staff files, all of which had identification photos in them either from passports or driving licences. Details about recruitment which included application forms, employment history, job offers and contracts were on file. There was a system in place which included evaluation of potential staff through interviews, references from previous employment and checks from the Disclosure and Barring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Good

Is the service effective?

Our findings

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.

Staff were aware of the Mental Capacity Act and told us they had received MCA training. The training record we reviewed confirmed this. There was a system in place to assess and record people's understanding and decisions made. Capacity assessments had been completed for some people and best interest decisions recorded. These were in relation to areas such as medicines, personal care and bedrails. However it was hard to establish whether all decisions made were in fact in people's best interest as we found that only the acting manager had signed to say they were involved in the decision making process. This was not in line with best practice guidelines. We discussed this with the acting manager who told us that they involve families in care reviews but does not record their involvement on the best interest decision paperwork. We were told that all best interest decisions would be reviewed and that family, professionals and carers would be involved where appropriate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). At the time of inspection. applications had been made and were in process with the local authority.

Staff were knowledgeable about people's needs and received regular training which related to their roles and responsibilities. We reviewed the training records which confirmed that staff had received training in topics such as infection control, health and safety, moving and assisting and first aid. We noted that staff were offered training specific to the people they supported for example; dementia and end of life care. Registered nursing staff completed specialist training which included syringe driver training, verification of death and other palliative care training. In addition to this some staff had completed or were working towards diplomas in Health and Social Care. A staff member told us, "There are good training opportunities. We have a mix of on-line training and in house like manual handling and fire". Another staff member said, "Very good training. I'm doing my diploma level 4 now. I have completed levels 2 and 3". A relative told us, "Staff come across competent and seem well trained".

Induction records included the new Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff told us that new staff received thorough inductions which included shadow shifts with experienced staff before working on their own. We spoke to one staff member who had been in post for five days.
The staff member told us that they had covered areas such as introductions to people and staff, personal care delivery, feeding, transfers, repositioning and manual handling. They said, "The induction so far has been good. My confidence is growing". A relative told us, "New staff are supervised well and get to know

people and the job first". This demonstrated that people were supported by staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

We reviewed staff files which evidenced that regular supervisions and appraisals took place and were carried out by the management team. A staff member told us, "We have supervision monthly (ish). I find these helpful. Managers can feedback to us and I can share any concerns I may have".

We were told that the acting home manager had implemented a daily communications file. This file captured important information about people, tasks and appointments and was used during handovers to aid effective communication. The registered manager told us there were three handovers a day where information is shared using this file.

People, relatives and staff told us that the food was good. Meals were home cooked using fresh ingredients and people's likes and dislikes were recorded. We found that people were able to choose from two choices for lunch and dinner. Alternative options were available should someone change their mind on the day a certain meal was served. A person told us, "I don't like fish. Fish is on a Wednesday. I can request an omelette. These are nice". A relative said, "My loved one enjoys the food here". We found that food and fluid charts were completed where appropriate, and were up to date. On day three of our inspection we noted that a person had been assessed by the Speech and Language Team (SALT) in relation to a safe swallow plan. This demonstrated that the service was supporting people to eat and drink enough whilst maintaining healthy balanced diets.

We observed a meal time. There was a relaxed atmosphere in the room and staff were present to support people who required it. We observed one person coughing regularly between mouthfuls and saw that although the staff member stopped at the time of coughing more food was given to the person as soon as they had stopped which caused them to cough again. We discussed this with the registered manager who told us that staff received training during induction around how to assist people with meals/to eat. It was identified that the staff member supporting the person was an activities coordinator. The registered manager told us that they would see that this was addressed.

People were supported to maintain good health and had access to healthcare services. We noted that appointments were recorded in people's care files and communicated between the team. We saw that community professionals like GP's, foot health practitionors and community nurses visited the home and that people were supported to appointments. A health professional told us, "Staff listen and follow advice. For example, drying in-between toes to reduce the risk of toe infections. I record my visits in the care files and inform the nurses of any actions or concerns".

Good

Is the service caring?

Our findings

We observed staff being caring and respectful with people. Throughout the inspection the atmosphere in The Cedars Nursing Home was relaxed and homely. A person told us, "Staff are caring and speak nicely to me". A relative said, "Staff here are extremely caring and hard working. I always feel welcome here". A health professional told us, "Staff definitely come across caring. There is a homely and cosy feel. The interior and staff help this". A staff member said, "I see everyone as an individual person. I am caring; I love to talk to people. I see them as people and respect them". Another staff member told us, "I'm caring. I like to make people feel happy and treat them as I would want to be treated. My colleagues are caring too".

We observed positive interactions between people and staff throughout our inspection. Staff were seen to get down to people's level when communicating with them and made time to listen. We observed staff supporting people who required support when walking with mobility aids. Staff made sure that they walked at the person's pace and talked to the person to offer reassurance and guidance when sitting into chairs, passing furniture and going through door ways. This demonstrated that a positive caring relationships had been developed between people and the staff supporting them.

People were regularly given opportunities to be involved in making decisions about their care. Staff told us that they provided people with information which supported them to make choices and decisions in relation to their care, support and treatment. For example, clothing, nutrition, activities and personal care. A staff member said, "We ask people everything from times they wish to get up/go to bed, where they want to eat, what they would like to do, what they want to wear and the support they wish to receive. We respect them as people. This is their home". A health professional told us, "People appear to have choice with their routines".

We noted that people had a personal history profile in place which was introduced as a way of gathering important day to day information about people. They were intended to help staff get to know the people they were supporting well and as quickly as possible. We saw that there were clear personal care guidelines in place for staff to follow which ensured that care delivered was consistent and respected people's preferences. Care files held person centred care plans with pen profiles of people, recorded important people involved in their care, how to support them, people's likes and dislikes and medical conditions. This information was used by staff to ensure a consistent approach to the delivery of care was given.

People's privacy and dignity was respected by staff. Staff we observed were polite and treated people in a dignified manner. We asked staff how they respected people's privacy and dignity. One staff member said, "I cover people's private areas when delivering personal care, knock on doors, close curtains and doors and would take someone into a private area if I needed to talk to them privately or deliver some personal care". A relative told us, "(Name) is always kept nice and clean. They are respected and always presentable".

People were supported with end of life care. The registered manager told us that the home had been awarded a beacon status for the Gold Standards Framework (GSF) for past five years. The Gold Standards Framework is a programme care homes use to improve end-of-life care by offering staff training and a

framework to help identify, assess and deliver good care. In addition to this the registered manager told us that the service had been awarded a national award for quality in this area of care for the past five years running and had made links with the local hospice.

Good

Is the service responsive?

Our findings

People, staff and relatives all told us that they felt the service was responsive to people and their changing needs. A relative told us, The Cedars Nursing Home adapt and respond well to my loved one. (name) recently started bleeding. The nurse was called in quickly and it was sorted". People told us that if they needed support whilst in their room all they had to do was call their bell. During a discussion with one person we tested their bell and saw that staff responded within just less than a minute by knocking on the door and seeing if the person was ok. A professional said, "Staff seem to work in a way that meets people's needs. For example, if people get distressed staff have good approaches to calm them down". The acting manager told us that they had recently worked with an occupational therapist and physiotherapist to get a person re-assessed for a new wheelchair. We were told that the person sat forward in their current one which posed a risk of them potentially falling out. The new chair would be set to slant back slightly which would meet their needs and reduce this risk. This showed us that staff responded efficiently to people's care and support needs.

We found that activities regularly took place. We met with the activities team lead and were told that there were two activity supervisors and nine coordinators. The home displayed a visual weekly activities timetable which included things like; card games, gardening, communion, quizzes, music and one to one room visits for those who were supported in bed or who chose to stay in their room. On day two of our inspection we noted that a local ukulele band attended the home which people appeared to enjoy. The activities lead told, "Last week I took three people out into the community one at a time. People seemed to really enjoy this". They went on to say, "For Father's day this Sunday we have arranged ale tasting and a cheese board". We were told that a daily report was completed by the activity coordinators. This was a summary of what activities the person had been involved in or interactions coordinators may have had with people. We reviewed the records with the activities lead and found that there were a number of gaps and some non-meaningful information for example one read, "(name) room visit. Sleepy in lounge". We discussed these findings with the activities lead who was sure that interactions had taken place between people and coordinators but they had not been recorded. The lead told us they would monitor the recording more and add prompts onto the record sheets to aid the coordinators when recording activities.

The Cedars Nursing Home provided personalised care and responded effectively to people's changing needs likes and interests. We saw that people received monthly reviews which were logged in their files. These captured information linked to people's needs. A relative told us, "I have been involved in my loved one's care reviews. I am promptly informed of any changes to their wellbeing which is important to me".

Pre-admission assessments were completed prior to people's admission and covered areas such as mobility, personal care, independence and medicines. These then formed the foundation of people's care plans and risk assessments. A staff member told us, "Needs assessments are completed on referral. Before admission peoples care plans and guidelines are in place".

People and relatives told us they felt able to raise concerns and said that they would discuss them with staff or management. However one person did inform us that they weren't aware of the complaints procedure.

The registered manager told us that it was part of people and family welcome packs but that they would look into re-issuing these to people. There was a complaints record book in place which recorded complaints and actions taken to resolve them. We noted that there were no open complaints at the time of our inspection. A relative said, "I have raised one concern before which was dealt with promptly". We discussed how feedback from people was captured and evidenced with the acting manager and registered manager. We were told that currently there was not a process in place to do this on a day to day or monthly basis but that they would look into implementing this. The registered manager said that they will involve key workers in this piece of work to get them thinking what questions people could be asked and how it would be best captured.

Compliments and thank yous were also logged by the home. We noted that one read, "You all do wonderful work and are very much appreciated". Another read; "Thank you for the compassionate care you gave our loved one during the last weeks of their life".

We discussed quality assurance questionnaires with the staff services and systems managers. We were told that these took place six monthly. We were shown the results from September 2016 which were mostly positive. The home had created a you said, we're doing poster which detailed actions from feedback and how the home was going to address them. For example, families had fed back saying, what and who is a key worker? The service had requested each key worker to contact the family to introduce themselves and explain their roles. People had feedback saying; the steps to the front door can be restrictive. In response the home was looking into building a new ramp to ease the access into the home. This told us that The Cedars Nursing Home had some systems in place which were effective in listening to people's experiences and concerns.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems were not always robust or recorded accurately. For example following the review of medicines we asked to look at the medicine audits. We found that the last weekly audit in the file was completed on 5 June 2017. We approached the acting manager and asked if one had been completed week commencing 12 June 2017. We were told that one was completed but that they couldn't find it. The acting manager said that they would complete another audit and bring it back to us. There were 31 people living at the Cedars Nursing Home at the time of our inspection most of whom received medicines. There were two wall mounted medicine cabinets, two trollies and two MAR chart files so we were concerned when the audit was returned to us nine minutes later completed. This audit showed that no concerns or errors had been found despite our findings during the medicines review earlier that morning. Medicine audits did not cover stock levels or new admissions which could have been a contributing factor as to why a person went nine days without medicines. This did not demonstrate robust quality monitoring or effective management.

Audit recording systems used were not effective as the paperwork used did not have anywhere to record comments, log actions or add timeframes. We saw that currently audits were very tick box orientated and gave total numbers and percentages which the registered manager then used to populate headline reports and graphs to share with the board. This meant the findings were not detailed nor could evidence be gathered to ensure service delivery, operations and quality care was being received by people.

A resident of the day process was established at the Cedars Nursing Home where people's records were quality checked, reviewed and updated. This system used a tick box process and didn't include other areas where gaps in record keeping were found. These records included activity logs and checks to ensure people were repositioned where necessary, beds, air mattresses and pads were checked and nutritional needs were met.

We discussed auditing with the registered and systems managers who told us that quality monitoring had been an area they had been meaning to develop and that this is an area that would now be prioritised and led by them. The registered manager told us that they would ensure that staff were involved and consulted in the review and development of these to ensure an inclusive approach. The registered manager also discussed looking for an independent person/company to come into the home and complete an audit to quality check the work and practice.

Staff meetings took place regularly. However from the notes we reviewed they did not appear well structured and actions from the meetings were not clearly identified. The registered manager told us that due to previous issues of staff not attending staff meetings and to encourage team building the acting home manager had changed the style of the staff meetings to be less formal and more staff led. Other meeting notes for senior managers and board meetings appeared well structured with actions clearly logged and discussed at the start of each meeting.

We identified during the planning of the inspection that the service did not display their last rating from CQC

or have a link to their report via their website. It is a requirement under regulation 20A that all care homes must display their rating following inspection on both their website and within the home. We discussed this with the systems and staff services managers who told us that a digital meeting had been arranged for the 13 June 2017 and that they would ensure it was discussed there. We were shown on day two of the inspection that the rating was clearly displayed on the website and within the home.

Throughout the inspection the registered manager demonstrated a positive and inclusive culture and staff told us that they found the registered manager empowering. The registered manager worked at least one care shift a week which they told us was important to them. Staff told us that they appreciated this and felt that it ensured people and staff were able to build relationships, trust and respect with them. One staff member said, "The registered manager will help care staff like with personal care and medicines. It's nice that managers help us. We work as a team. It's what it's all about". The registered manager told us that there was a staff committee which had representatives from staff in different roles. We were told that this supported the registered manager to drive change and development from the floor up.

Staff, professionals and relatives all told us that they felt the registered manager managed the home well and led by example. A relative told us, "The home seems well managed and organised". A health professional said, "The registered manager seems open and approachable. They come across competent and very capable of management". A staff member said, "The registered manager is outstanding from a personal and management point of view. They are honest, fair and professional. Very supportive and always talks about people's best interests". Another staff member told us, "The registered manager is lovely. They are reassuring and always acknowledge a good job. They are supportive and open to both questions and new ideas".

We found that both the registered manager, staff services manager, systems manager and acting manager all had very good knowledge and were open to learning and further developing the home. They were all responsive throughout the inspection and supported us with questions we had and gathering the evidence we required.

As far as we are aware the service had made statutory notifications to CQC as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

We were told that information from incident reports was recorded. This data was then analysed to look for trends and learning which could then be shared with the board.