Herefordshire Care Homes Limited

Hazelhurst Nursing Home

Inspection report

Bishopswood
Ross On Wye
Herefordshire
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Tel: 01600890600

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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

Hazelhurst Nursing Home is located in Bishopswood, Ross-on-Wye.. The service provides accommodation and nursing care for people living with conditions such as dementia, Parkinson's disease and physical disabilities. On the day of our inspection, there were 35 people living at the home.

The inspection took place on 25 May 2017 and was unannounced.

There was no registered manager in post at the time of our inspection. However, this managerial change was a recent development and the provider was in the process of recruiting a new registered manager. Registered providers and registered managers 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 provider's model of care focused on people's quality of life, with a particular emphasis on 'living well.' New ways were continually found to enable people to lead the best possible life for them, and to ensure their enjoyment of life did not have to be curtailed just because they lived in a care home.

People were encouraged to maintain their hobbies and interests, as well as experience new social and leisure opportunities.

Links had been established with the local community to benefit the people living at Hazelhurst and prevent the risk of social isolation.

The provider believed that people's physical environment should be reflective of a dignified and respectful approach. People benefited from specialist equipment, such as blue lighting in their bathroom rather than the startling bright light omitted by regular lighting, and beds which were designed to purposely not resemble a medical product.

People and their relatives were consistently positive about the care provided, particularly in relation to end-of-life care.

People enjoyed a variety of different food and drinks, with mealtimes being a pleasurable and social experience. People were supported to maintain good health, with input sought from a range of health professionals, as required

There were enough staff to meet people's needs safely. Consideration had gone into balancing people's freedom, with ensuring their safety. Where possible, the least restrictive option was always taken to enable people to have greater freedom.

People received their medicines safely, and as prescribed.

The provider, clinical lead and quality assurance manager carried out regular audits of the care provided to people to ensure this remained at a consistently high standard,

The provider sought to continually develop the service, such as by partnership working with the local university in order to develop innovative ways of improving falls prevention for people, as well as appointing specialist Admiral Nurses to enhance the dementia care provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service is safe.

There were enough staff to meet people's needs. People's freedom was promoted, whilst ensuring their safety.

The provider had invested in initiatives to minimise the risk of falls. People received their medicines safely, and as prescribed.

Is the service effective?

Good

The service is effective.

The provider placed a strong emphasis on staff development and training to ensure people were cared for effectively. People enjoyed the mealtime experience and the variety of food and drinks on offer.

People were supported to maintain their health.

Is the service caring?

Good

The service is caring.

People's dignity was maintained both by the caring approach of staff, and the consideration the provider had put into people's living environment.

People and their relatives were consistently positive about the care provided, including end of life care.

Is the service responsive?

Good

The service is responsive.

The ethos of the service was for people to 'live well' and for every day to have value for them, with staff continually finding ways to make this possible.

Links with the local community had been established to benefit people living at the home and to prevent social isolation. The

provider had appointed specialist nurses in dementia care to ensure that people's needs were responded to.

Is the service well-led?

Good

The service is well-led.

The provider had a clear vision for the service, and values which were shared by the staff team. People, staff and relatives were positive about the improvements already made since the provider had taken over,

The provider worked in partnership with other organisations to ensure the most up-to-date and pioneering healthcare models were adopted in the home.

Hazelhurst 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.

We made an unannounced inspection on 25 May 2017. The inspection team consisted of two Inspectors 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 care service. They had knowledge and experience of care provided for older people.

We contacted the local authority before our inspection and asked them if they had any information to share with us about the care provided to people.We looked at the information we held about the service and the provider.

We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service.

We observed how staff supported people throughout the day. We spoke with 13 people who lived at the home and five relatives. We also spoke with the quality manager, the clinical lead, the provider and four care staff, one of whom was an agency staff member. We looked at three records about people's care, which included risk assessments, capacity assessments and healthcare information. We also looked at the medication administration records, quality assurance audits, and the complaints and comments the service had received.

Good

Is the service safe?

Our findings

People and relatives told us they had no concerns about people's safety, and that people were safe and secure. A relative we spoke with told us, "There has never been an issue with safety. The staff are very careful when it comes to moving [relative]." The provider told us the first thing they had addressed when they bought the home was fire safety. This had included upgrading the fire system previously in place, as well as ensuring fire drills took place so that staff understood what action to take in the event of an emergency.

We found information was provided to people and their families, both at the point of admission and during reviews, regarding what to do if they felt unsafe at any point, or felt their relatives were unsafe. Posters were displayed for people and visitors containing the contact details of the local safeguarding team. In addition, safety observations were routinely carried out and action taken, where necessary.

We saw that people's freedom was promoted as much as possible, whilst ensuring their safety. Throughout the course of our inspection, we saw people moved freely around the house and the garden. Consideration had been given as to removing any unnecessary restrictions for people. For example, one person had been using a tilt-in-space (Kirton) chair. Several months' ago, the person used a Kirton chair during the day. Following an assessment of this person's sitting balance, a standard armchair was now used, with a wheelchair being used for transfers. This change meant the person could sit close together with their husband, particularly at mealtimes, as they both indicated this was their wish. This person was also now able to sit at the table at lunchtime and enjoy the social aspect of the meal.

Risks associated with people's individual care and support needs had been assessed, reviewed and managed. The provider had recently invested in specialist BaKare beds, which had been designed to benefit people at risk of falls, without the need for restrictive bed rails. The beds were adjustable and could be lowered to the ground. Similarly, reverse pressure mats had been introduced, which notified staff of when a person had lifted themselves up from a chair and would be at risk of a fall. Both of these initiatives had resulted in a reduction of falls for people.

We considered whether there were enough staff to meet people's needs safely. People and relatives told us they thought the staffing levels were sufficient. One person we spoke with told us they felt safe because they were never "kept waiting" when they needed staff assistance. They told us, "It is wonderful. Everyone is so attentive." Our observations throughout the course of the inspection reflected this. We saw staff responded to people quickly when they needed assistance, such as with mobilising. We saw this approach to safety extended beyond the care staff. For example, some people were enjoying being in the garden in the sun. The gardener made sure people were not too hot or uncomfortable, and that they had the option of being in the shade.

Staff told us that whilst they felt there were enough staff on duty at any one time, there was currently regular usage of agency staff due to vacancies at the home. Staff told us that there had been times where there were as many members of agency staff on duty as regular staff, which some people living at the home did not like. Whilst people's safety was not compromised by the use of agency staff, staff told us it did mean there was

not always consistency in people's care. The provider and manager acknowledged the use of agency, but this was unavoidable at present due to unfilled vacancies. Where possible, regular agency staff were used so that people were supported by familiar staff. We spoke with an agency member of staff, who told us staff always ensured important information was relayed to agency staff. They told us, "There are no secrets." We asked the agency staff member about a recent safeguarding incident, and they were knowledgeable about this and what measures were in place as a result. This demonstrated to us that information was shared about how to keep people safe.

Staff we spoke with knew the different types of harm and abuse and the possible indicators of these. Staff told us if they had any concerns about a person's wellbeing, they would raise it with management. If they felt no action had been taken, they told us they would raise it with the local authority and the CQC. However, staff we spoke with told us management always took swift action when concerns were raised.

Before staff members were allowed to start work, the provider carried out checks to ensure any prospective staff members were safe to work with people. These checks included references and checks with the Disclosure and Barring Service (DBS). Once the provider was satisfied with the responses, they could start work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care.

People told us they received their medicines when they should, including any 'as required' medicines. One person told us, "They bring me my tablets in the morning before breakfast." One relative we spoke with told us, "Medicines are managed very well. [Person] always gets them on time." We spoke with the clinical lead, who was responsible for the administration of medicines. They carried out routine competency checks on nursing staff to ensure that medicines were administered safely and as prescribed. Medicines were stored appropriately, with no overstock.

Good

Is the service effective?

Our findings

Relatives we spoke with told us they felt staff were skilled and knowledgeable in their roles. One relative we spoke with told us, "When [person] first arrived, the nurses talked to me and the carers fed back about how [person] had been. They chat to me, and there is a book they record the chats in. They give me relevant and considered information. I feel there is an umbrella of people supporting us- staff, the GP and the palliative care nurse. We couldn't have come to a better place." Another relative we spoke with told us about the clinical lead, "Their clinical skills are outstanding."

The clinical lead and quality manager told us one area they felt the home was particularly effective in was wound care. We saw evidence of where people had moved into the home with existing wounds. People's leg ulcers had improved significantly in a short space of time of moving into the home, with one person experiencing marked improvement after a period of 10 days. The clinical lead and manager told us this was down to good nutrition and hydration, as well as the clinical care provided, particularly in respect of wound and dressing care.

We spoke with staff about the ongoing training, development and support they received in their roles. Staff told us the managerial changes had not impacted upon the support they received, with staff supervisions and staff meetings continuing to be regular. Staff commented that they would benefit from additional training, including bespoke training in areas such as Parkinson's disease, dementia and epilepsy. We discussed this with the provider, who had already identified where training would be beneficial. For example, bespoke training on diabetes had already been arranged. They told us they were committed to staff development, which included lead roles, such as a nutrition lead, an infection control lead and an end of life lead. Additionally, a team leader model had been introduced as part of the management structure. As part of this model, specialist team leader training for staff had been arranged. The provider had also introduced the Advance Practitioner training, which enabled the nurses to delegate some of their duties to care staff who were looking to develop their practice and study to become a nurse.

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 provider was working within the principles of the MCA.

We looked at how the MCA was being implemented. Relatives we spoke with commented on how skilled staff were at offering choices, respecting people's choice and obtaining people's consent before assisting them. One relative we spoke with told us. "[Person] often refuses personal care. Staff are very good at

offering the choice, as well as keep trying. They understand the importance of different ways of asking and leaving [person] for a bit and trying again later." Where people lacked the capacity to make certain decisions, any decision made on their behalf was in the person's best interest, with relatives and other health professionals involved in this process.

Although staff we spoke with had an understanding of the Act and how this underpinned their daily practice, they were not familiar with the DoLS process, including how many people living at Hazelhurst had a DoLS in place, and what these restrictions meant for people. We discussed this with the provider, who demonstrated that staff had previously received training on this. However, they acknowledged the need for additional training and support and told us this would be provided to staff to bring their knowledge to the necessary level.

We asked people about the meals provided and whether these were enjoyable. One person told us, "It's always very good. I like the braised beef and stout." Another person we spoke with told us, "It's wonderful; we eat too much! We're always being offered drinks-coffee, tea and cakes. I have a cooked breakfast every morning." We spent time with people during the course of their lunch. People were offered choices in respect of the main meals, desserts and drinks; the drink option included alcohol. Vegetarians were catered for, as were people with allergies and intolerances. The main meals contained fresh vegetables, with fresh fruit an option for dessert. Additionally, there was the option of 'seconds' for people, which several people opted for, with one person telling us, "You can have as much as you want." Where people needed support with eating their meals, this was provided in a discreet manner. Consideration had gone into making the dining experience a pleasant one for people. Music played in the background; there were fresh flowers on the table and people chatted and laughed with staff, and each other. Some people chose to eat their lunch in the garden, whereas other people chose to eat their meal in their bedroom.

The quality manager told us improving the mealtime experience for people had been one of the priorities when the new provider took over. This had included offering more choice and variety, as well as improving the dining area. Additional snacks had also been introduced. We saw that where there had been concerns about people's weight, their weights had increased after the additional snacks had been introduced. We saw people enjoying snacks and drinks throughout the course of our inspection, with particular focus on offering people sitting in the sunny garden additional drinks to ensure they were kept hydrated.

We looked at how people's health was maintained. People and relatives told us people saw medical professionals, as and when required. One relative we spoke with told us their relative saw a chiropodist regularly. We saw health information recorded in people's care plans, which demonstrated people had access to a range of health professionals including social workers, GPs, occupational therapists and community psychiatric nurses.

Good

Is the service caring?

Our findings

We spoke with a relative about their recent experience of the end-of-life care provided at Hazelhurst. They told us, "I have 20 years' experience in healthcare, and never before have I seen such gentle, respectful and amazing care. The cook spent time with [relative] to find out what their favourite foods were. These were then served to [relative] every day. The gardener asked [relative] what their favourite flower was and every morning, these flowers would be on the patio for [relative] to see." The relative told us that as a result, the person had been able to spend their last days not just in comfort and peace, but in luxury. The person's relative told us they had been impressed by the respect shown to the person, and one thing which stood out for them was the way staff had bowed their heads as a mark of respect as the person left the home with the undertaker. The relative told us how much that gesture had meant to them and their siblings.

There was an emphasis in the home on dignity and respect. When people were receiving personal care in their bedrooms, discreet lights above the door flashed so that staff and visitors knew not to disturb. This was to uphold people's privacy. Consideration had been given to ensuring people's environment reflected the fact they were valued as people and deserved respect. For example, the provider had bedroom standards in place for each bedroom. These included blue lighting in the bathrooms, which provided all the light people needed to see at night, without being startled by the bright light omitted by regular lighting. Additionally, the standards included ensuring people's bedding was Egyptian cotton of at least 200 thread; wi-fi telephone points; and coordinated soft furnishings. The manager told us the ethos behind this was that no-one living in care should expect to live in conditions in which others would not want to live. Renovation work was taking place at the time of our inspection to ensure every room was of the same standard. We looked at one of the recently refurbished bedrooms and saw it met the standards specified. The provider had recently bought specialist BaKare beds, which had the benefits of standard profiling beds, with the added benefit of the fact they did not resemble these. These had been bought with people's dignity in mind.

People's continence aids were kept in 'dignity boxes' in their bedrooms, so these were out of sight for any guests or visitors. The manager told us, and we saw that, other recent changes by the provider included replacing plastic clothes protectors previously used at lunchtime with napkins to maintain people's dignity, as well as replacing the cups and beakers previously used with more appealing items. Additionally, specialist silicone food moulds had been bought for textured diets. The moulds meant that pureed food could be made to look more appetising and appealing by shaping it into recognisable meals. This also upheld people's dignity as their meals did not look different to other peoples. One member of staff we spoke with told us, "Dignity is definitely higher on the agenda now." A relative we spoke with told us about the respectful approach displayed by staff. They told us, "They are very respectful, even when they don't know I am about."

People and their relatives were consistently positive about the care people received. One person we spoke with told us, "My real name is [name], but I like to be called [name], and that is what they (staff) call me. They have all been very good." One relative we spoke with told us, "The care here, and the carers, are absolutely wonderful." Another relative we spoke with told us staff understood their relative's communication needs and style and were good at ensuring they spoke to the person in a way which would not make it difficult for

them to understand. Throughout the course of our inspection, we saw that people were relaxed and comfortable with staff, and that staff knew people well as individuals.

We spoke with the quality manager and the provider about the importance of independent advocacy for people. An independent advocate is someone who helps people make sure their views and opinions are heard. The provider had recognised a couple living at the home may benefit from the assistance of an advocate. The advocate was able to help the couple to successfully challenge a decision which had been made by the local authority regarding their care.

The provider demonstrated a commitment to equality, diversity and human rights. The provider told us their ethos was to make all of their homes an inclusive and safe environment for people. This was reflected in the provider's "Safe to be Me" statement in their brochures and service user guides.

Good

Is the service responsive?

Our findings

The provider told us their passionate belief was that people's quality of life should not be compromised once they move into a residential home. They told us, "The only thing which should change is the person's address; every day should be a good day for people, and every day should have value." We looked at how the provider created this ethos in the home, and the subsequent effect it had on people's care. The provider had adapted the NHS hospital tool of "Red and Green Days" for use in residential care. This model considers red days as bad days for people, and green days are good days, with the emphasis being on staff ensuring that every day becomes a 'green' day for people. Underpinning this framework is the principle of enhancing people's quality of life, as well as understanding what would increase the opportunity for each individual to have a 'green' day.

We saw examples of this ethos in practice. One person living at the home had previously spent the majority of their day, each day, sitting in a specialist chair, which was to prevent the risk of falls and injury. Their needs had not been re-assessed to see whether this chair was the least restrictive option for the person. The provider had arranged for the person's sitting needs to be re-assessed by an Occupational Therapist and, as a result, the person was now in an electric wheelchair. This person told us they enjoyed the greater independence this gave them and that they felt like a "new woman."

Another person living at the home had a particular interest in Tai Chi. Tai Chi sessions were already available for people living at the home, but this person had now become an assistant to the instructor for these sessions, which the person was proud of and had been given an assistant's certificate. We also spoke with a person about their interest in a particular art form, which had been a big part of the person's life and their identity. Staff understood this, and had supported the person to enter a national competition. We spoke with the person, who told us, "I tackle my painting and glasswork with gusto!"

The provider spoke with us about the importance of reducing social isolation for people living in care. They were aware that living in care can be a lonely and isolating place unless efforts were made to provide stimulation. As Hazelhurst is situated in a remote area, plans were underway to create an in-house shop for people. This was so they could re-create the experience of going to the local shop, as well as retaining some of their independence. On the day of our inspection, a clothes sale took place for people in a communal area. One relative we spoke with told us what a good idea it was and how much their relative had enjoyed it. People had the opportunity to enjoy a variety of social and leisure opportunities. One person we spoke with told us how much they enjoyed the gardening club at the home. They told us they had always enjoyed gardening and being outdoors and were pleased they were able to continue to pursue this particular passion. We spoke with the gardener who ran the group. They told us about the garden club, "It's an important space for people and they enjoy it a lot." Forthcoming events included a cup cake tea dance, with previous events including a smoothie making morning, where people had been able to try a range of tropical fruits, as well as a bread-making session.

Where people chose to spend time by themselves, this was respected. For example, we noticed that one person was sitting by themselves during the lunchtime meal. Staff, the manager and the person themselves

told us this was the person's choice and their preference was respected. People had the choice of two communal areas, the 'activity lounge' and the 'quiet lounge.' We saw that people made use of both these areas, according to their personal preferences.

Links had been established with the local community for the benefit of people living at Hazelhurst. For example, there were established links with a local school and the church. A "teddies bear picnic" had recently taken place at the home, with the local school invited. People had enjoyed this experience. One person in particular had valued this as their own teddy bear was of significant importance to them and during the picnic, the vicar had blessed the bear, which had given the person a lot of happiness ; they told us their bear had been "anointed." The person's relative told us, about the event "[person] never goes anywhere without their bear. Two ladies came and sang; it was very good."

The provider told us there were plans to appoint a 'twilight' activities coordinator due to the fact there were some people living in the home who became restless during particular hours of the day. Staff we spoke with showed understanding and awareness of people's individual needs, specifically in relation to people who would benefit from extra stimulation during this time of day. Staff shared ideas with us about what they thought would be of an interest to people during the evenings, such as craft-based tools and products. Staff told us they felt comfortable making these suggestions to the manager and clinical lead, and were confident action would be taken as a result.

We looked at how the provider responded to people's needs in respect of both their health and wellbeing. The provider had established links with Admiral Nurses, and would soon have two designated Admiral Nurses working in the home. Admiral Nurses are a specialist nursing group working within dementia care, who focus on improving people's physical, psychological and emotional wellbeing. Most Admiral Nurses work in the community for the NHS, with others working in hospitals, hospices and care homes. The provider told us the purpose of the appointment of an Admiral Nurse was to support people, their families and GPs to provide innovative dementia care. The provider told us it was about going beyond dementia-specific training for staff and about ensuring the home was equipped to respond fully to people's diverse needs, and that this specialist approach would be integrated across the staff team. The provider told us, "With dementia training, the advice typically given is things like use red toilet seats for people (to help them see it better). Who really wants a red toilet seat, and how is that person-centred?"

The provider and the manager told us a priority was to revisit people's care plans due to the fact these had been inherited when the new provider took over. The provider employed a Person-Centred Occupation Lead, who worked across the provider's other services to ensure all care plans were reflective of individuals' preferences, life histories, aspirations and needs, and that these were created in collaboration with people and their relatives. The provider recognised the inherited care plans were not in keeping with the model of care in which the home now operates, with there being an overemphasis on the medial aspect. Notwithstanding this, staff we spoke with had an understanding of people as individuals, and we saw how they tailored their approach and communication style to the needs and preferences of people living at Hazelhurst. A relative we spoke with told us, "They (staff) know the residents. They know how many sugars [person] takes. They have a very good and in-depth understanding, and it's not just for show."

We looked at whether there was a system in place for capturing and acting on feedback and complaints. There was a complaints procedure in place, which was visible for people, relatives and health professionals. At the time of our inspection, one formal complaint had been received and this had been investigated, responded to and resolved. People and relatives we spoke with told us they would be happy to raise concerns or give feedback, and were confident this would be acted on.

Good

Is the service well-led?

Our findings

At the time of our inspection, the provider had been running the home for a period of nine months. There was no registered manager in post, which was a recent development, but there was a temporary management structure in place whilst a new registered manager was appointed. The day-to-day running of the home was managed in the interim by the provider's quality assurance manager and the clinical lead. Some relatives we spoke with expressed concern over the change in management, which specifically related to a lack of communication. However, the circumstances involving the change had meant that it was not possible for the provider to discuss this until the matter had concluded. The provider and manager told us as they were now in a position to share the changes to the management team, they would cascade this information and discuss it with people and their relatives.

Aside from this particular concern, people and relatives we spoke with were positive about the running of the home. When we told one person why we were visiting the home that day, the person told the quality manager, "You have no worries, you are doing an excellent job." One relative told us of the home, "(the home is) Very efficient, caring, organised; I can't praise it highly enough." Both relatives and staff spoke of the positive improvements and changes the provider had already made. One relative told us, "I have certainly seen cosmetic changes already, such as new carpet. I know there are plans for further improvements." Staff told us the biggest improvements they had seen were in relation to communication. Staff told us that previously, they had not been involved in decisions about the running of the home, but now they felt more included. They told us the quality manager and the clinical lead both spent time with people and staff throughout the day, which staff felt was positive as it meant they had support and guidance. One member of staff summed up the changes by saying of the home, "It's definitely on the up."

We spoke with the quality manager and the clinical lead about the changes the provider had already made, and planned to make. They told us some of the immediate changes which had been made. This included new pressure cushions for people who needed them, as well as ensuring everyone had their own individual slings. They both told us how quick the provider was to take action where new equipment was needed for people and that there had been an investment in this area. The quality manager told us, "The provider is genuinely committed to high-quality care."

We spoke with the provider about their visions for the service. The provider had established links with Worcester University regarding falls prevention work. Specifically, the use of personal stability instructors and 'exercise prescribers' to create individual exercise plans for people to increase their core stability, therefore reducing the risk of falls and increasing people's confidence in their mobility. The provider told us this approach fitted theirs as it was an enhanced healthcare model, with the focus on 'living well.' The provider told us this approach was about prevention, rather than just solely management of risk of falls. The provider understood that a loss of confidence was an important factor in people's falls, which then led to reduced mobility, which affected muscle wastage and resulted in more falls. This approach aimed to break that cycle.

The provider had also launched a hospital avoidance scheme. The provider had looked at the main four

reasons for hospital admissions for older people in the county, and had 'RAG' rated each individual living at the home to assess their risk of hospital admission. When a person was rated as high risk, anticipatory medicines were used, as well as carrying out baseline observations for people as part of a 'virtual ward round.' Paramedics had been involved in delivering training for staff. This scheme had been a success for people living at Hazelhurst, with no hospital admissions. In order to increase more timely and effective communication between staff at the home and medical professionals, the provider had secured NHS.net email addresses for their staff.

We looked at how the provider monitored the quality of care provided to people. Monthly audits were undertaken in relation to areas such as falls, skin integrity and people's weights. We saw examples of where action had been taken as a result of these audits. For example, an increase in available snacks for people, which resulted in an increase in weight of people at risk of malnutrition, to the point where their dietary supplements were no longer prescribed. As part of the quality assurance measures, the provider's personal assistant routinely visited the provider's homes to experience a day in the life of a resident. This included areas such as eating a meal with people at the home, as well as experiencing how staff interacted with people. This experience was then relayed to the provider, who used it to look at any areas of improvement, as well as identifying what worked particularly well for people.

The provider's management team met monthly to discuss areas such as changes in legislation and to share best practice. The provider told us the importance of these meetings, "Goalposts will always move and we have to continually challenge the way we do things to ensure we are always providing the best possible care."

The provider had, when appropriate, submitted notifications to the Care Quality Commission (CQC). The provider is legally obliged to send the CQC notifications of incidents, events or changes that happen to the service within a required timescale. Statutory notifications ensure that the CQC is aware of important events and play a key role in our ongoing monitoring of services.