Sovereign (George Potter) Limited

George Potter House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 4, 5 and 7 September 2018. At the last inspection in June 2017 we looked at the five key questions and identified six breaches of the regulations. The overall rating was "Requires improvement". The rating for safe, effective, caring, responsive and well-led was "Requires improvement".

The breaches of the regulations were regarding, the care and treatment of people, staffing, nutrition and hydration, person centred care, dignity and respect and systems and processes. We also recommended that the home sought guidance in respect of The Mental Capacity Act 2005 (MCA). This recommendation was followed.

For four of the breaches, we issued 'Warning Notices' against the service and required the provider to ensure the breaches were met by 27 August 2017. These breaches were regarding the care and treatment of people, staffing, nutrition and hydration and person-centred care. The provider sent us a report to say how they had met these breaches and we checked that they had followed their action plan. At this inspection we found that the terms of the 'Warning Notices' and the breaches of regulations identified in June 2017 were met.

George Potter House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is located in Battersea, south London and registered to provide care and support for 69 people who require nursing or personal care support.

The home had 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 and associated Regulations about how the service is run.

People said they experienced a pleasant, friendly and relaxed atmosphere at the home. This was created by the staff and people and their relatives were also satisfied with the care and support provided. They thought there were enough staff who met people's needs in a thoughtful, kind way.

The home's recording, auditing and quality assurance systems were kept up to date and now monitored and assessed the quality of the service provided. The information was clearly recorded, easy to understand and reviewed regularly.

People had access to community based health care professionals as required. Staff also discussed health needs with people and provided them with balanced diets and protected them from risks regarding nutrition and hydration. The meals served addressed people's likes, dislikes and preferences.

Most people said they enjoyed the meals, which were of good quality and there was a variety of choices provided. People were supported, by staff to eat their meals and drink at their own pace and enjoy the experience.

The home provided a safe environment for people to live and staff to work in. It was clean and well-maintained.

Staff knew the people they supported well and were appropriately skilled and trained to meet people's needs. They also understood their responsibility to treat people equally, respect their diversity and human rights and recognise and respect people's differences. People said they were fairly treated.

The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Appropriate applications had been submitted by the provider and applications under DoLS been authorised, and the provider was complying with the conditions applied to the authorisation.

Staff said the registered manager and organisation provided good support and they had opportunities for career advancement.

People said the registered manager and staff were approachable, responded to them and asked their opinions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe. There were appropriate numbers of skilled staff that followed effective safeguarding, infection control and risk assessment procedures.

Lessons were learnt when things went wrong.

People's medicine was administered safely and records were up to date. Medicine was audited, safely stored and disposed of if no longer required.

Is the service effective?

Good

The service was effective.

People received care and support from well-trained and qualified staff. Their care plans monitored food and fluid intake and balanced diets were provided. The home was decorated and laid out to meet people's needs and preferences.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures and staff were provided with training. People underwent mental capacity and DoLS assessments and 'Best interests' meetings were arranged as required.

Staff teams worked well together internally and across organisations.

Is the service caring?

Good

The service was caring.

People felt valued, respected and were involved in planning and decision making about their care. The care was centred on people's individual needs.

Staff knew people's backgrounds, interests and personal preferences well and understood their cultural needs. They provided support in a kind, professional, caring and attentive

way that went beyond their job descriptions. They were patient and gave continuous encouragement when supporting people.

Is the service responsive?

Good

The service was responsive.

People had their support needs assessed and agreed with them and their families. They chose and joined in with a range of recreational activities, if they wished. Their care plans identified the support they needed and it was provided.

People told us that any concerns raised with the home or organisation were discussed and addressed as a matter of urgency.

Staff were trained to meet people's end of life needs.

Is the service well-led?

Good

The service was well led

There were robust systems to assess, monitor and improve the quality of the service people received. People and their relatives were involved in these processes and in the development of the service.

There was a clear vision and positive culture within the home that was focussed on people as individuals. They were enabled to make decisions in an encouraging and inclusive atmosphere. People were familiar with who the registered manager and staff were and encouraged to put their views forward.

Staff were well supported by the registered manager and management team and advancement opportunities were available to them.

George Potter House

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 checked 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 was an unannounced inspection and took place on 4, 5 and 7 September 2018.

This inspection was carried out by one inspector over three days.

The home was registered to provide care and support for 69 people. There were 29 people living at the home. We spoke with eight people, five relatives, six staff and the registered manager and their area manager within the organisation. We also contacted five healthcare professionals who had contact with the home to get their views.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and the home's maintenance and quality assurance systems.

We looked at the personal care and support plans for 7 people and six staff files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People said the home was a safe place to live and they were comfortable living there. One person told us, "A safe environment to live in." A relative said, "A very safe place."

At the last inspection we identified a breach of regulation and issued a warning notice regarding inadequate care and support in respect of pressure related wounds, specifically turning people at required intervals, inappropriate use of pressure relieving mattresses and inaccurate record keeping. There was also inappropriate infection control regarding food and general hygiene. At this inspection we found that people were turned at appropriate intervals and this was recorded, pressure relieving mattresses were correctly inflated and there was appropriate infection and food hygiene control taking place. Staff had received infection control and food hygiene training that was reflected in their working practices. The home conducted regular infection control and food hygiene checks. The home also minimised the risk of infection by holding a good stock of equipment that included gloves and aprons for giving people personal care.

At the last inspection we issued identified a breach of regulation and issued a warning notice for insufficient staffing levels. At this inspection we found that the home had sufficient numbers of staff to support people and meet their needs. Each month the home completed individual dependency audits for people that identified the required staffing hours, to meet their needs. We compared this with the staff rotas for June, July and August 2018 and found staff numbers exceeded the required numbers. There were enough staff to deliver care to people in a calm and relaxed atmosphere that made them feel safe, although some people and their relatives thought the home could do with a few more as staff worked so hard. One person said, "I think we have enough staff for the number of people here for the moment, anymore and they would be tripping over each other. We observed staff having the time to sit, on a one to one basis and chat with people who preferred or were unable to leave their own rooms. This was when staff were unaware that we were present.

At the last inspection there was an unsafe filing cabinet in the upstairs dining area that had a plate with mouldy food on it and there were food particles in chairs and a ground floor seating area that had a large stain on its cover. At this inspection, the filing cabinet had been removed, chairs were free of food particles and the ground floor seating area cover had been replaced. The home was clean, reasonably decorated, well-maintained and with no unpleasant odours. The layout provided people with a homely atmosphere and suitable communal and personal accommodation. This meant people had the space to socialize as much or as little as they wished.

Staff received training and were provided with policies and procedures regarding identifying and protecting people from abuse and harm, that was reflected in their care practices. Staff said that protecting people from harm and abuse was a very important part of their jobs.

Staff received safeguarding training, knew how to raise a safeguarding alert and when this was required. There was also information contained in the staff handbook. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. Staff said they would be comfortable using the whistle-

blowing procedure if it was necessary.

People's risk assessments enabled them to enjoy their lives safely. The risk assessments identified areas of risk pertinent to people, that included all relevant aspects of their lives, specifically health, welfare and social activities. The risk assessments were reviewed and updated as people's needs and interests changed. Relevant information was shared by staff, during shift handovers, staff meetings and when they occurred. The home also used risk assessments as an opportunity for discussion when things went wrong so that lessons could be learnt. The home kept accident and incident records and there was a whistle-blowing procedure that staff said they were aware of and understood.

The building risk assessments were regularly reviewed and updated. The home's equipment was checked and serviced as part of the audit system. There were individual fire evacuation plans for people.

Staff recruitment procedure was robust and thorough. It was centralised by the provider who advertised internally and externally within the organisation. A job description and person specification was supplied and an application form required to be filled in. Initial screening took place and prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's care philosophy, communication skills and knowledge of the type of care the home provided. If there were gaps in the knowledge of prospective staff, the organisation decided if they could provide this knowledge, within the induction training and the person was employed. References were taken up, work history checked for any gaps and Disclosure and Barring Services (DBS) security checks carried out prior to staff starting in post. There was a six-month probationary period. The home had disciplinary policies and procedures that staff confirmed they understood. The home was not currently recruiting to vacant posts.

Staff were booked to receive training in October 2018 in de-escalation techniques to appropriately deal with situations where people may display behaviour that others could interpret as challenging.

Medicine was safely administered to people. The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. All people's medicine records were checked and found to be complete and up to date. This included the controlled drugs register that had each entry counter signed by two staff members who were authorised and qualified to do so. A controlled drug register records the dispensing of specified controlled drugs. Medicine kept by the home was regularly monitored and the medicine administered recording records (MAR) were audited. The drugs were safely stored in a locked facility and appropriately disposed of if no longer required. There were medicine profiles for each person in place.

The health care professionals we contacted raised no concerns regarding the care home providing a safe service for people.

Good

Is the service effective?

Our findings

At the last inspection we identified a breach of regulation and issued a warning notice regarding people's nutrition, hydration and record keeping in this respect. At this inspection we found that people's care plans contained information regarding health, that included nutrition, hydration and diet. Full nutritional assessments were carried out, updated as required and audited monthly. This was using the Malnutrition Universal Screening Tool (MUST) to assess a person's nutritional status. People were weighed, as required and their weight recorded on charts, as well as nutrition and hydration intake records that staff and the management team monitored. There was also person specific information regarding any support required at meal times. People were registered with a GP practice and weekly GP visits took place. A GP was present on the first day of our visit. The GP practice and staff worked together to reduce the number of unnecessary visits to hospital. Staff said that if they had any concerns, they would raise and discuss them with the person's GP and relatives as appropriate. Staff, including the catering team provided nutritional advice. People had annual health checks. People's consent to treatment was regularly monitored by the home and recorded in their care plans.

People enjoyed their lunch, with a lot of good humoured banter shared with staff, including people with dementia. There was much laughter, joking and smiling. Staff spoke with people in an unrushed way that they could understand and using a re-assuring manner. People responded positively to this and it enhanced the ability of staff to meet people's needs in a way that they wanted and were comfortable with. Staff explained meal choices to people as many times as people required to help them understand what they were. They also spent time explaining to people what they were eating during the meal and checked that they had enough to eat. Staff were supportive, encouraged people to eat meals at their own pace and made sure people, who needed support and encouragement to eat, received it. Staff met people's needs in a re-assuring and unrushed way. Staff either sat with people to assist them and engage them in conversation or made eye level contact with them by kneeling. This elicited positive responses and body language from people.

The meals were of good quality and special diets on health, religious, cultural or other grounds were provided. They were well presented, nutritious, hot and monitored to ensure they were provided at the correct temperature. Staff supported people in a timely way and no one had to wait for their lunch, although the upstairs unit where lunch was served was a little cramped for space. People had weekly meetings with the chef to discuss the quality of the meals and the type of choices people would like. Most people said they enjoyed the meals, whilst others were less enthusiastic. During lunch, one person was enjoying their fish and chips so much, they had a second helping. One person said, "The meals are excellent." Another person told us, "The food is not to my taste." A visitor said, "I've seen the meals and wouldn't mind eating one. I have been offered." The home was awarded a five-star rating for food hygiene.

People and their relatives said they were involved in the decision-making process regarding how and when they received care and support. They said staff gave care and support in the way that was needed and it was provided in a friendly, patient and professional way. One person told us, "I'm on the residents' committee and represent people. I like things done properly, if not don't do it at all" Another person said, "In a much

better place now, than it was12 months ago. Not perfect, but improving." This was referring to the home. A visitor commented, "Very nicely run, efficient and friendly."

Staff received three-day induction and annual mandatory training. The induction comprised of what staff roles entailed, their responsibilities, the organisation's expectations of them and the support that staff could expect to receive from the organisation. Each aspect of the service and people who use it was covered and new staff shadowed more experienced staff, during the induction period. Each new staff member had an experienced mentor who supported them to complete their induction booklets. This increased their knowledge of the home, people and enabled better quality of care. The training matrix and annual training and development plans identified when mandatory training was due. They also received a staff handbook. A staff member told us, "The training is good and helps me do my job. I much prefer the group rather than e-learning training as it is more meaningful to me."

Training encompassed the 'Care Certificate Common Standards' and included dementia awareness and dignity in a care home, communication, fire safety and evacuation, moving and handling, first aid, recording and health and safety. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. Staff meetings included an opportunity to identify further training needs. Supervision sessions and annual appraisals were partly used to identify any gaps in training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 people lack mental capacity to take 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 that 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. Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications had been submitted by the provider and applications under DoLS had been authorised. The provider was complying with the conditions applied to the authorisation. Best interest's meetings were arranged as required. Best interest's meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in people's care plans. Staff received mandatory training in The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. During our visit staff frequently checked that people were happy with what they were doing and the activities they had chosen.

The home had a policy and procedure for informing other services within the community or elsewhere of relevant information regarding changes in people's needs and support. Records also demonstrated that staff liaised and worked with relevant community health services especially district nurses, GPs and physiotherapists, making referrals when required and sharing information. This meant there was on-going communication with health care professionals.

The health care professionals we contacted raised no concerns regarding the care home providing an effective service for people.

Good

Is the service caring?

Our findings

At the last inspection we made a requirement regarding treating people with dignity and respect, specifically two people left for an unacceptable time in soiled clothing and others having a low level of hygiene. At this inspection we found that people had their personal care needs attended to appropriately and people were clean and well groomed.

The service that the home provided for people was based on treating them with dignity, respect and compassion. People were promptly responded to by staff, who were attentive and spoke to them by their preferred name, nickname or title. They knocked on people's bedroom doors and waited for a response before entering and were discreet if people needed to visit the toilet. People said that staff paid attention to them, acknowledged them and valued their opinions whilst delivering support in a friendly, patient and helpful way. One person said, "Everyone [staff] is really lovely." Another person told us, "This is a happy place, like a family." A visitor said, "This is a hard and emotionally stressful job that they [staff] do well, with empathy and sympathy."

There were a number of positive staff care practices and interactions with people. Staff were patient, stimulated people skilfully and encouraged them to have conversations with each other as well as staff. They managed to achieve this by applying their knowledge of people, their needs and preferences. This enabled people to lead happy and rewarding lives. Staff were interested in people and treated them with kindness and understanding. Their approach to care was enabled and underpinned by their knowledge of what people had done in their lives, their families and was built up as relationships between staff and people grew.

Staff received equality and diversity training that enabled them to treat people equally and fairly whilst recognizing and respecting their differences. This was reflected in staffs' positive care practices and confirmed by people and their relatives. Staff did not talk down to people and they were treated respectfully, equally and as equals.

There was an advocacy service available that people had access to if required.

There was a confidentiality policy and procedure that staff were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's right to privacy, dignity and respect, that staff followed throughout the home, in a courteous, discreet and respectful way, even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of people. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

The health care professionals we contacted raised no concerns regarding the care home providing a caring service for people.

Good

Is the service responsive?

Our findings

At the last inspection we issued a warning notice regarding care and treatment of people's hygiene and oral care and their lack of choice regarding the time they went to bed. At this inspection we found that people's hygiene and oral care was appropriate and choice of when they went to bed was decided by themselves.

People said that the registered manager and staff sought their opinions formally and informally. This enabled people to make decisions that staff could then act on. The registered manager and staff made themselves available to people and their visitors. This was when they wished to discuss any problems or just have a chat. The staff worked hard to speedily resolve any issues people might have. This gave people the opportunity to decide the support they wanted and when and how support was delivered. One person said, "People [staff] come straight away." Another person told us, "They [staff] are quick to respond." The call bell system was activated frequently, during our visit and responded to in a timely way by staff.

Staff worked as a team, irrespective of their roles and shared information with each other, as required, throughout the home. There were staff handovers, after each shift where relevant information about people was shared by staff going off shift with those coming on. People were referred to as people, not tasks or room numbers. This manner of working complemented the key worker system and extended to the sharing of people's issues and concerns within the teams.

There was easy to understand written information about the home, that was in sufficient detail to enable people to understand the type of care and support they could expect. It also laid out the home's expectations of them.

Having received a needs assessment from a commissioning local authority or the NHS, the home carried out its own needs assessment with the person and their relatives. If people's needs were identified as being able to be met, they and their relatives were invited to visit. A relative said, "We visited before she [person] moved in." People could visit as many times as they required to help decide if they wanted to move in and were consulted and involved in the decision-making process. Visits were also used to identify if people would fit in with others already living at the home. Some people had first experienced a respite stay at the home, before moving in permanently or had prior knowledge as relatives had used the service.

People's assessments provided the basis for their initial care plans. The care plans focussed on people as individuals and were live documents. They included people's interests and were added to as new information was forthcoming. The information gave people the opportunity to identify activities they may wish to do and the home to provide them. Staff said it was essential to capture people's views as well as those of relatives so that care could be focussed on the person. Care plans were reviewed monthly by keyworkers or more often, if required and monitored by the management team. There were daily notes that fed the monthly reviews and the care plans were underpinned by risk assessments. Care plans were then reviewed six- monthly. The quality of the daily notes varied with differing levels of legibility that meant some were easy to understand, whilst others were more difficult.

The home provided a weekly timetable of varied activities, based on people's interests and staff knowledge of people's likes and dislikes. There was also a newsletter that kept people up to date. The activities were regularly reviewed to make sure they were focussed on what people wanted. People were encouraged to join in but not pressurised to do so. One person said, "There are enough activities, but I prefer my own company, in my room. I have lots of visitors." Staff reminded people of what was scheduled each day. The activities co-ordinators facilitated a programme of activities with people. These included 'Resident of the day', word search group, coffee mornings, musical entertainment, garden sessions and arts and crafts sessions. There were also church services and a hairdresser that visited with a hair salon that was arranged to mirror a hairdressers in the community. The home held a barbecue and had access to transport with a visit to the theatre and a picnic. One person said, "I think there are enough things going on. I like the garden, I go out in it every day."

The home provided end of life care with a philosophy that people could stay until or unless their needs could no longer be met. The home worked in tandem and liaised with the Trinity Hospice, who provided training and palliative care and with district nurse teams. There was specific reference to end of life wishes in people's care plans. The home supported relatives during a distressing and sensitive period for them. The home was awarded platinum status by the National Gold Standards Framework Centre for end of life care, in August 2018.

People told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. There had been two complaints since January 2018 that were responded to, addressed, acted upon and learnt from with care and support being adjusted accordingly. Staff said they had been made aware of the complaints procedure and there was also a whistle-blowing procedure. They also knew of their duty to enable people to make complaints or raise concerns.

People and their relatives were invited to quarterly home meetings as well as those specific to themselves. The meetings were minuted and people were supported to put their views forward including complaints or concerns. The information was monitored and compared with that previously available to identify that any required changes were made.

The health care professionals we contacted raised no concerns regarding the care home providing a responsive service for people.

Good

Is the service well-led?

Our findings

At the last inspection we made a requirement regarding systems and processes, specifically audits and record keeping. We followed up the requirement and found it to be met. The quality assurance system contained performance indicators that identified how the home was performing, any areas that required improvement and areas where the home was performing well. It contained a range of feedback methods and the records we saw were up to date. There were daily, weekly and monthly home audits carried out by the registered manager, deputy and staff, as appropriate. These included care plans, medicine, risks, health management, falls, nutrition, health and safety, people's involvement and activities. There was a very detailed improvement plan for 2018 that was reviewed and updated monthly. Annual policy and procedure reviews were carried out. Six monthly surveys were also sent out to people, their relatives and staff.

The registered manager pursued an open-door policy, that made people, their relatives and staff comfortable in approaching them. One person told us, "Both the [registered] manager and regional manager have the welfare of people and the staff at heart, although we seldom see the owners." Another person said, "Nice [registered] manager, treats me nicely and listens to my moans and groans." Another person told us, "People like the [registered] manager, there is no side to her. She works hard, has attention to detail, does the job and has the home at heart." People's conversation and body language showed that they were positive regarding the registered manager's management style.

There was a clear vision and set of values that staff were made aware of as part of their induction, on-going training, understood and embraced. The vision and values made clear what people could expect from the home, staff and organisation. The management and staff practices reflected the vision and values as they went about their duties. People said they were also kept up to date with what was going on in the home and organisation with three-monthly 'residents and relatives' meetings taking place.

The home worked in partnership with other agencies, particularly the tissue viability and palliative care nurses who it had a close working relationship with.

Staff had personal development plans and there were opportunities for personal advancement and to develop knowledge and skills. One person described how that had begun as a care worker and was now in a management role. A number of senior posts were filled by staff that had been promoted internally. One staff member told us, "I enjoy my job. It can be challenging, but very rewarding and gives you a smile." Another staff member said, "We work as a team and that makes staff more diligent."

Areas of responsibilities and communication were very clear throughout the home and staff were aware of their specific responsibilities.

Currently the home was looking to build and improve links to engage with the local community, although it did have two-monthly singing visits from a local school and the 'Mehandi' Muslim community organisation.

Staff said they were well supported by the registered manager and management team. They felt suggestions

they made to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. There were also quarterly staff get togethers to encourage team spirit. A staff member told us, "The [registered] manager is nice and fair. They really put their heart into it" Another member of staff said, "She [registered manager] is sympathetic and approachable if we need a day off for a good reason."

Our records demonstrated that appropriate notifications were made to the Care Quality Commission when needed.

The health care professionals we contacted raised no concerns regarding the care home providing a well-led service for people. One health care professional did mention that although there were no issues, the home could improve its engagement with other professionals by attending more meetings, such as care home forums and training sessions.