Beamish Residential Care Home Limited

Beamish Residential Care Home

Inspection report

Old Vicarage
West Pelton
Stanley
County Durham
DH9 6RT
Tel: 0191 3701763

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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

Overall summary

The inspection took place on 3, 4 and 5 August 2015 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Beamish Residential Care Home on 12 December 2013, at which time the service was compliant with all regulatory standards.

Beamish Residential Care Home is a small residential home in West Pelton providing accommodation for up to 21 older people who require personal care. 21 people were living in the home at the time of our inspection.

The service has a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have

Summary of findings

legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was on annual leave at the time of our inspection. The operations manager and assistant manager were on site during our inspection. A recent management restructure meant they had more responsibility for the day-to-day running of the home than previously.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service. All staff were trained in core areas such as safeguarding, as well as training specific to the individual needs of people who used the service. The means by which the service ensured training for staff was current and refreshed when needed was not efficient and the operations manager was in the process of reviewing the training matrix system. We found that staff had a comprehensive knowledge of people's preferences, needs, likes and dislikes.

Dignity and privacy were at the forefront of the staff code of conduct and the policies and procedures of the service. We observed discreet and thoughtful interactions during our inspection and saw evidence in recorded documentation of the promotion of people's right to dignified care. Relatives and external stakeholders told us that people were treated well and unanimously agreed that the service was welcoming and effective.

There were effective pre-employment checks of staff in place and effective staff supervision and appraisal processes. The service was clean throughout.

Person-centred care plans were in place for all people using the service and the provider sought consent from people for the care provided. Regular reviews ensured relatives and healthcare professionals were involved in ensuring people's medical, personal, social and nutritional needs were met.

The service had individualised risk assessments in place and a robust range of policies and procedures to deal with a range of eventualities. We saw these processes were reviewed regularly and were supported by an effective quality assurance regime. All people using the service we spoke with, relatives, staff and external professionals were complimentary about the management and ethos of the service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The operations manager was knowledgeable on the subject of DoLS and had provided appropriate paperwork to the local authority to deprive people of their liberty, where it was in their best interests.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People using the service, relatives and healthcare professionals told us people were safe living at the home.

Medicines were administered, stored and disposed of safely and securely and in line with the National Institute for Health and Social Care Excellence (NICE) guidance.

Safeguarding training had recently been completed and staff displayed a good understanding of risk and the types of abuse people could be at risk of, as well as their prospective actions should concerns arise.

The service took a proactive stance with regard to infection control, with clear signage and comprehensive audits contributing to a clean environment which minimised the risk of infection.

Is the service effective?

Good

The service was effective.

People's medical needs were met through ongoing involvement of a range of healthcare professionals.

People's nutritional and hydration needs were met through the effective monitoring of potential malnutrition, dietician involvement and a flexible approach to catering.

The need for consent was embedded throughout care planning practices.

Is the service caring?

Good

The service was caring.

Interactions between staff and people were dignified and discreet but also characterised by warmth and fun where appropriate; staff had built good levels of rapport and meaningful relationships with people using the service.

People's dignity was maintained and promoted through inclusive policies and supporting documentation. People and their families were regularly involved in decision-making.

The management team and all staff had a good understanding of people's needs, preferences, likes and dislikes.

Is the service responsive?

Good

The service was responsive.

When people's needs changed, the service promptly ensured that relevant healthcare expertise was sought and people's needs met.

Regular meetings with people and staff ensured the service took into account and acted upon preferences regarding group and individual activities for people using the service.

Summary of findings

The operations manager proactively sought and acted upon advice from relevant experts regarding best practice across adult social care to ensure people's changing needs were supported.

Is the service well-led?

Good

The service was well-led.

All people using the service, staff, relatives and healthcare professionals agreed the atmosphere of the service was welcoming and homely and that privacy and dignity were paramount.

The operations manager had in place a strong quality assurance and spot check regime, which helped identify and potential risks and protect against poor practice.

The culture at the home was one of openness, where challenge was welcomed from people using the service or staff, alongside regular review meetings.

Beamish Residential Care Home

Detailed findings

Background to this inspection

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

We visited the service on 3, 4 and 5 August 2015 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spoke with five people who used the service. We spoke with eight members of staff: the operations manager, the assistant manager, three care staff, the cook, the cleaner and the handyman. We spoke with a visiting district nurse. We spoke with one relative who was visiting their family member and spoke with a further four relatives on the telephone after the inspection. We spoke to the Independent Mental Capacity Advocate (IMCA) of one person who used the service. We also spoke to the community matron and the GP.

During the inspection visit we looked at four people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

We spent time observing people in the living rooms and dining area of the home.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

Good

Is the service safe?

Our findings

One person who used the service told us "I'm very safe and settled here. Never any complaints." All five relatives of people we spoke with told us they had confidence in the service's ability to ensure their loved ones were safe. One said "Safety is a priority for us and we have no concerns here." Another said "It's a safe environment."

People's experience of feeling safe was supported by the management of risk within the home, which took the form of individualised risk assessments for each person. These covered all aspects of day-to-day risks and actions to mitigate against those risks. For example, one person chose to spend the majority of their time in their room, so they had in place a social isolation risk assessment and action plan. In addition to an easily accessible call bell, this plan ensured the person was checked twice as often to mitigate against unnoticed falls and potential social isolation. The plan also described the person's communication preferences and what behaviours might indicate discomfort. We observed these regular observations and interactions during our inspection. This meant people were protected from a range of avoidable harms, including neglect, without a negative impact on their freedom to choose to live how they wanted.

The management of the service anticipated risks to ensure they did not become incidents or accidents. For example, one person with diet controlled diabetes was identified as at high risk of malnutrition. Advice was sought from a dietician and diabetes expert prior to implementing a fortified diet to ensure that the risk of malnutrition wasn't inadvertently replaced by the risk of a diabetic episode being brought about by a high calorie diet. This meant the service anticipated the changing nature of risks and understood prospective risks to health and wellbeing if changes to people's care were made.

One healthcare professional told us "They respect the knowledge of nurses and always ask about what they can do to prevent problems." Another healthcare professional told us "They always know when to call for help."

People understood what it meant to be safe and were able to raise any concerns with any member of staff or directly to the operations manager, as set out in the Service User Guide in each room. Each room also had clear signage with a reminder of who the person's allocated keyworker was and that people could go to them with any concerns. We asked one person if they had ever had to raise concerns and they said "No, we're very well looked after here." They went on to state that they trusted staff to take any concerns seriously.

We reviewed a range of staff records and saw all staff underwent pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks. The operations manager also showed us that regular staff supervisions contained a question about whether the member of staff had been convicted for an offence since the last supervision. We also saw that the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees' prior to employment. This meant they were able to assure themselves of the ongoing suitability of staff to work with vulnerable people

All people using the service, their relatives, staff and healthcare professionals we spoke with felt staffing levels were appropriate. During our observations we saw that people were supported promptly and call bells were answered almost immediately. This meant people using the service were not put at risk due to understaffing.

We spoke to three members of staff about their recent experience of safeguarding training and all were able to articulate a range of abuses and potential risks to people using the service, as well as their prospective actions should they have such concerns. This demonstrated that the operations manager had ensured that appropriate safeguarding training had been delivered and that staff were able to identify situations where it would be applicable.

The operations manager confirmed there had been no recent disciplinary actions or investigations. We saw that the disciplinary policy in place was current, clear and robust.

The operations manager was the designated Infection Control Champion for the service and we saw they had attended relevant forums and implemented best practice. For example, they had ensured all bathrooms and toilets had large, clearly displayed signs explaining the need for hand washing, along with pictorial prompts.

Good

Is the service safe?

The Food Standard Agency (FSA) had given the home a 5 out of 5 hygiene rating, meaning food hygiene standards were very good, and the home clearly displayed allergen information regarding every foodstuff served alongside the menu rotas.

All bedrooms, communal areas, kitchen, bathrooms, toilets, laundry and sluice room were clean. One healthcare professional who visited the home wrote in the visitor's book "Home is always immaculate". One person using the service told us "It's clean and tidy every day" whilst a relative who visited regularly told us "It's always immaculate." A recent Infection Control Team inspection had noted some minor concerns, notably a mattress that was not clean. The report acknowledged that the mattress had been cleaned immediately and we saw that since the report the operations manager implemented additional mattress checks to protect against similar incidents. This meant that, through proactive application of best current practice as well as responding positively to any concerns, people were protected from the risk of acquired infections.

Medicines were administered, stored and disposed of safely and securely and in line with the National Institute for Health and Social Care Excellence (NICE) guidance. Temperatures of the medicines fridge and the room where medicines were kept were regularly monitored and within guidelines. We saw that annual supervision of staff was in place to assure their competency with medicines administration, whilst weekly and monthly double-signed audits, as well as documented spot-checks by the operations manager, further assured safe management of medicines. The Medication Administration Records (MARs) had been double-checked daily and contained photographs of each person as well as allergy information. We conducted our own sample of entries and found no errors. Topical medicines were also noted in the MAR charts, with senior carers applying creams as per body map instructions. This meant people were protected against the risk of maladministration of medicines.

With regard to potential emergencies, there was an accessible fire file in the main office, with floor plans, locations of services and individualised needs of people in the event of an evacuation. Fire extinguishers had been recently serviced, whilst there were also internal weekly checks of the home's fire equipment and monthly emergency lighting tests. Call bells, all accessible, were also tested monthly, whilst the service had clear policy stances on issues such as whistleblowing, hazardous substances, personal protective equipment and Legionnaires. We saw that all water temperatures were tested daily. All staff were either trained in First Aid or had their training course date confirmed and we saw that First Aid equipment was clean and complete. This meant the service was helping to protect people using the service from risks brought about through fire or accident.

We saw documentation confirming up to date maintenance of the stair lift, hoist, gas boiler, electrics and catering equipment. Upkeep of the premises contributed to the safety and wellbeing of people using the service. For example, we saw that in the week preceding our visit the handyman had removed and repainted radiator covers, done the same with drawers, replaced light bulbs and ensured driveways and walkways were clear of debris. This meant people were not at risk of injury through faults or flaws of the premises.

Good

Is the service effective?

Our findings

People who used the service told us the care they received was effective and that staff knew them well. One person told us "They can't do enough" and another "They're very nice" and "They look after you." One relative told us "They are very good with bed sores" and referenced the knowledge and skills used by staff to ensure their family member had seen a marked improvement in skin condition. This was corroborated by a healthcare professional, who said "They are very proactive in pressure sore care." A comment by a visiting healthcare professional in the visitor book read "The staff appear to know the medical needs of the residents", whilst one member of staff said "You get to know everyone's needs as it's a small service."

Staff told us they felt sufficiently trained to carry out their roles. Staff training was relevant to people's needs, with all members of staff undergoing safeguarding, first aid, manual handling, fire safety and infection control training. There was a commitment to continuous professional development of staff and we saw signs on the noticeboards encouraging staff to request further training. One member of staff had requested to go on a diabetes training course and we saw this had been facilitated. We also saw that the most recent members of staff were being supported to complete the Care Certificate. This meant people could be assured that staff providing care had good basic training and had the opportunity to develop their skills further.

The training matrix used to record training completed and plan refresher training was not practical, contained some duplication and there was a risk that, whilst staff were currently sufficiently trained, they could miss future refresher training. Not all members of staff had completed Mental Capacity Act training or Care Planning training. The operations manager acknowledged the shortfalls in the training matrix. They confirmed it was already under review and that staff training would be kept up to date. They were able to show us that training regarding the Mental Capacity Act and Care Planning was planned for the remainder of staff.

Despite the above, care planning and application of Mental Capacity Act principles across the home were in line with best practice and in the best interests of people using the service. For example, care plans were person-centred and detailed with regard to people's preferences, whilst capacity assessments on file were comprehensive and assumed capacity from the outset, until established otherwise, at which point professional and family opinions were sought.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where that freedom is restricted a good understanding of DoLS ensures that any restrictions are in the best interests of people who do not have the capacity to make such a decision at that time. We saw that the operational manager had a clear understanding of Mental Capacity issues, including DoLS and had submitted appropriate applications to the local authority.

We saw that staff supervisions were undertaken four times during the year along with an annual appraisal. Staff we spoke with were positive about the opportunities they had to contribute to the improvement of the service, their own development and, ultimately, outcomes for people using the service. This meant people could be assured they were cared for by staff who regularly had the opportunity to challenge practices as well as access resources to improve their skills.

Consent was integral to care, with clearly documented consent from people regarding all aspects of care in their files, alongside clear reasoning why that consent was needed. For example, consent to weigh people regularly had been sought and documented, clearly explaining how this information could be shared with other healthcare professionals should the need arise. This meant people's right to a private life, as set out in the Human Rights Act 1998, was being respected through the proper handling of sensitive personal information.

We saw that people who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place had been fully involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. Anyone with a DNACPR in place had this reviewed monthly and we saw the service had an effective reminder system in place. This meant people were involved in regularly monitoring their needs and making prompt changes where required.

Good

Is the service effective?

We found there was comprehensive evidence that people were supported to maintain health through accessing healthcare such as opticians, podiatrists, occupational therapy, speech and language therapy, GP appointments and District Nurse visits.

With regard to nutrition, one person told us “The food is very good” and another person using the service commented on the high standard of cooking. We saw that people were given a choice of food each day and that, where they preferred something else to that served, alternatives were quickly prepared. The dining experiences we observed during our inspection visit were calm and unrushed. One person chose to eat in their room and we observed them being given a choice of main course shortly before lunch was served.

We saw food being prepared freshly on each day of our inspection with specialised dietary requirements clearly on display in the kitchen, as well as anyone noted as at high risk of malnutrition via the Malnutrition Universal Screening Tool (MUST), which had been successfully implemented. MUST is a screening tool using people’s weight to identify those at risk of malnutrition. These people received supplements to their diet but not without due individual consideration by the caring and cooking staff. One healthcare professional who had worked with the cook pointed out “They are very willing to be flexible to meet people’s preferences – it’s not just about giving people lots of bland fortified drinks.” This meant the service ensured that risks to people through malnourishment were managed successfully alongside respecting and enabling their preferences.

Good

Is the service caring?

Our findings

All staff we spoke to, including those not in a caring role, were passionate about the importance of caring and conveyed a team spirit centred on achieving the best outcomes for people using the service. One staff member told us "You've got to love it; the people make it." Another said "We all work together to make sure the residents are looked after". One relative told us "The care is exceptional; you wouldn't get this level of care at the bigger homes." Another said "They're a team. Old people can have accidents but if that happens, it doesn't matter who is around, whether it's the cleaner or the manager, they sort it out quickly and discreetly." A healthcare professional told us "The staff are very caring."

In line with what people told us, we observed a range of patient, dignified and warm interactions between staff and people who used the service during our inspection. We saw that one person who chose to stay in their room and was therefore at a higher risk of social isolation, was spoken to jovially by other care staff and the cleaner when they were near that person's room. This was in addition to the allotted additional checks the care file had in place. This meant staff embodied the code of conduct principles of treating people with dignity, respect and courtesy.

The caring atmosphere at the home was commented on by a range of visitors, professionals and family alike. One relative said "The home is clean and staff friendly; nothing is too much bother" and another "It's like coming into someone's home." One visiting healthcare professional said there was a "Calm and friendly atmosphere". One relative said "There's free access so we can go whenever we like and visit." This meant people using the service and their families felt more able to consider the service a home and were not restricted in their visiting hours.

People were involved in their care and all rooms were personalised with photographs on each person's door and furniture they had brought with them to the home. When asked about their involvement in their care one person told us "People ask me about my preferences," whilst the 2015 resident survey indicated that all respondents confirmed they were consulted before treatment.

Staff had a good understanding of people's interests and were able to articulate individual likes and dislikes, as well as act on these preferences during the inspection. For example, during our inspection we saw that one person expressed they were cold. Whilst there were ample blankets in the vicinity, a member of staff went to the laundry to find the persons' favourite blanket, which had been washed. We also saw one member of staff holding lively games of dominoes and cards with people who had this interest noted in their care plan. This meant staff adhered to potentially small individualities to ensure people received aspects of care tailored to their interests.

Each person using the service had a specific communication plan in place, meaning any new caring staff would benefit from information about whether the person had any specific communicative needs. This meant people could be assured involvement in day-to-day aspects of their care, as well as more formal care planning reviews. All relatives we spoke with also confirmed that they were invited to care review meetings. One relative said "If there are any issues we are approached."

We saw that information regarding advocacy services was available in every room in the Service User Guide, as well as on the communal noticeboard. One person using the service had an advocate, who had been fully involved in all aspects of decision-making with that person. The advocate told us that they never had any concerns about the care provided at the home.

We also saw that one person's relative had made themselves available to represent people using the service at the Service User meetings. The operations manager had welcomed and supported this idea. This meant the operations manager was open to innovative forms of advocacy that further supported the rights of people using the service.

The Service User Guide stated that all denominations welcome and we saw that two people using the service were regularly visited by the local priest. This meant people's religious beliefs were respected.

The service supported end of life care where it was the individual's choice to remain at the home. We saw that the person's preference drove these decisions, which were also made through consultation with family members and healthcare professionals, one of whom told us "They can support end of life care through their use of district nurses and always in consultation with families." This meant the service provided dignified and compassionate end of life care within a familiar and caring environment.

Good

Is the service responsive?

Our findings

One person who used the service told us "You can do anything you want." One relative said of their loved one, "They can choose their clothes and what they want to do."

People were able to engage in the day-to-day activities they preferred. For example, we saw that two people with documented preferences for country and western music spent some of their time listening to such CDs in a dedicated area of the hall, whilst one person who preferred to spend time alone did so in the second smaller lounge. The home routinely involved people in activity planning by holding activities audits. These showed that the most popular activities, as rated by people using the service, had already been re-booked, to ensure people's preferences were met. For example, due to the popularity of a visiting dog service, this now happened twice a week, whilst a popular visit by the Salvation Army had also been rebooked. This meant people were involved in planning events across the coming year, as well as having their day-to-day choices and preferences supported by staff.

Care was personalised through involvement with people receiving care and those who know them best. A pre-admission assessment was completed in every care file we looked at, as well as a 'Promoting Independence' and 'Life History' document, which set out people's likes, dislikes, personal history and preferences. We saw recent minutes from a staff meeting where the operations manager reiterated the need for an ongoing detailed knowledge of individual care plans, as well as the need to ensure care plans centred on a person's preferences. We saw evidence of this guidance being applied. For example, one person who chose to eat meat when visiting their family opted for a vegetarian diet whilst in the home. Staff respected this wish and we saw that the person had a choice of vegetarian options at meal times.

We saw that all care files were reviewed monthly and included photographs, personal histories of people, likes and dislikes. There was a range of personalised and comprehensive care plans and risk assessments, going into a level of detail that ensured effective care was supported through clear documentation. For example, one person's communication care plan was exact in its instructions to care workers to introduce themselves at every interaction, introduce only one idea/question at a time and to speak slowly whilst ensuring eye contact was kept. This detailed focus on the person's communication needs meant that any member of care staff, including a new member of staff, could provide effective personal care and also that the person could be fully engaged in their own care. Resident Surveys sought feedback regarding any dissatisfaction or complaint and there were also clearly accessible copies of the complaints procedure in everyone's room and copies of blank complaints forms in the main hallway. We also saw that, in each room there was a clear sign with key worker and manager information to remind the person who and where to go to if they had any concerns. This meant people using the service were more able to engage with staff and raise concerns if they had any. No complaints had been made but we saw the service had a robust complaints procedure in place and encouraged challenge from people using the service through surveys and regular review meetings.

Other useful signage in the home included large signs at the end of a long corridor pointing to the lounge and dining areas. This meant that people's visual and cognitive needs had been taken into account. Whilst there was some useful contrasting of hand rails in both communal areas and bathrooms/toilets, the home was not generally dementia friendly. The operations manager was looking into ways to redecorate the home with a view to making it more dementia friendly and was able to cite sources of information they had consulted.

Care reviews were centred on people's changing needs and not an exercise in administration. For example, we saw that one person's mobility had decreased significantly, to the point whereby they were spending much of their time in bed. A review of needs was held promptly, with involvement of family and healthcare specialists, ensuring that a profiling bed and crash mat were in place. This meant the person received individualised care and equipment to support their changing needs.

We saw other evidence that staff at the home identified changing needs quickly then liaised promptly and proactively with healthcare professionals to ensure people using the service received the best outcomes from treatment. For example, one person had been losing weight and, through additional monitoring, staff discovered the person had been removing food from the plate rather than eating it. Staff immediately involved healthcare professionals and family members and ensured that the root cause was investigated but also that the

Good

Is the service responsive?

person was supported to regain an appetite and counter weight loss. A family member confirmed they were now "Putting weight back on" and were "Much better." This meant, through knowing a person's preferences and behaviours, and responding thoughtfully and rigorously when changes occur, the service was able to identify a potential risk at the earliest stage and ensure a positive outcome for the person.

With regard to potential transition between services we saw that everyone who used the service had a document similar to a hospital passport in place. This documented essential information to be used if a person was admitted to hospital.

Good

Is the service well-led?

Our findings

The service had undergone changes regarding the management structure at the location, with the registered manager taking a more strategic role recently, whilst the operations manager and the assistant manager were on site, overseeing day-to-day running of the service. All staff we spoke with were positive about the "Hands-on" approach of the management team in place, saying of the operations manager "She's proactive; she listens" and "I'm well supported by my manager." Another member of staff said of the operations manager "If you have any problems you can just ask." Staff turnover was extremely low and this stability and associated continuity of care was commented on as a positive for people using the service by a number of relatives.

During the inspection we asked for a variety of documents to be made accessible to us during our inspection. These were promptly provided and well maintained.

Both the operations manager and the assistant manager had a sound knowledge of the day-to-day workings of the service and we observed both assisting people using the service in a caring manner during our inspection. Their practical support was recognised by other members of staff and, likewise, management colleagues expressed pride in the staff: "The girls work hard to meet people's needs."

The operations manager held regular staff meetings and we saw evidence that they acted on the feedback received at these forums. For example, providing training days wherever possible rather than a large number of 'piecemeal' training sessions. The operations manager also held regular service user meetings and regular reviews of care plans with the input of people, relatives, social services and day care staff to identify areas where the service could improve. This meant that the operations manager actively sought the views of all relevant people and that people using the service, relatives and staff had the opportunity to challenge aspects of the service if they felt it necessary. People using the service, relatives and staff were encouraged to raise queries openly and we saw this management stance echoed in policies, procedures and accessible signage, meaning that people had the opportunity to make their concerns heard. This meant the management team had successfully fostered an approachable, open and transparent working environment.

The operations manager undertook a range of audits to ensure care practices were being delivered in line with care plans and policies. These audits were supported by regular analysis of information and subsequent actions. For example, analysis of falls and the provision of that information to the local Fall Prevention Team for advice. With regard to the "Hands-on" approach described above, the operations manager also undertook daily checks of the cleanliness of bathrooms, toilets, bedrooms and communal areas.

Strong links were in place with the local church and the Salvation Army. This meant the service, centrally located within a community, maintained links that people using the service continue to access as members of that community.

The operations manager undertook annual regular Service User and Staff surveys to gather further information about the service and how to improve it. For example, one survey response asked for safeguarding information to be made more prominent in the home and we saw this had been implemented.

The operations manager had recently agreed a Homely Remedies policy in agreement with local healthcare professionals and was able to show us the research and risk analysis they had invested in the process, which would mean people could receive preferred non-prescription medicines. The manager had arranged another meeting with healthcare professionals to ensure the policy did not present any associated risks to the administration of prescribed medicines already in place. This meant the operations manager was ensuring the service had a joined-up approach to implementing new policies to ensure that they were in the interests of improving care and did not carry associated risks.

The Statement of Purpose stated a main aim was to "help in intimate situations as discreetly as possible." We saw this embodied in care planning and staff behaviours, from cleaning staff through to management, throughout our inspection and in the conversations we had with people and their relatives. The management of the service had successfully maintained this focus on individual dignity through a period of change, meaning that people continued to receive high quality care.