Tamehaven Limited

Poplars Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 23 and 24 January 2019. The inspection was unannounced.

Poplars Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Poplars Care Centre is registered to provide accommodation and personal care for a maximum of 71 frail and elderly people, some of which were living with dementia. At the time of our inspection there were 61 people living at the service. The service is a large extended property and people's accommodation is provided over two floors with a lift available to support people to the upper floor.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive their medicines safely. Medicines were not always being stored in line with manufacturers guidelines. People were not always receiving their medicine as prescribed. The registered manager did not always have the necessary oversight of the service to identify some of the concerns we found during our inspection.

People were protected from the risk of abuse. Staff were trained in how to identify abuse and knew how to report it. Risks to people and the environment were assessed, recorded and staff took steps to reduce them.

People had their care and support delivered in line with current legislation and best practice guidance. Staff had the skills and experience to provide effective care and support. Newly recruited staff received an induction which included training courses and gaining experience by shadowing more other staff. Established staff received refresher training that was built around those using the service.

There were enough staff to meet people's needs. New staff were recruited safely. People were protected by the prevention and control of infection. The registered manager took steps to learn from incidents, accidents and when things went wrong. They used information to help prevent future accidents.

People's nutrition and hydration needs were being met. People were involved in developing menus. Staff sought and followed guidance from health professionals if people had health conditions. People had access to health care and treatment. People's needs were met by the design and adaptation of the premises. People could decorate and furnish their rooms as they wished. Staff were knowledgeable about the Mental Capacity Act (MCA) 2005, and worked in line with its principles.

People felt cared for by staff. They were treated with kindness and compassion by staff who knew them well.

Staff used different ways to communicate with people. People were supported to express their views and be actively involved in making decisions about their care. People were treated with dignity and had their privacy respected.

Support was provided to people in a personalised way. Each person had their own care plan which had been reviewed taking into account their preferences and views. People were supported to take part in activities of their choosing. People said they knew how to make a complaint, and would do so if the need arose. Complaints and concerns were managed in accordance with the registered provider's policy. People were supported at the end of their lives to have a dignified death. Their preferences and wishes were gathered and staff worked closely with health professionals.

The culture at the service was honest and transparent. Staff said they felt proud to work at the organisation. The staff had oversight of the daily culture in the service, which included the attitudes and behaviour of staff. People, their families and staff were encouraged to be engaged and involved in the service. There were links with the local community.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the first time the service has been rated Requires Improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive their medicines in a safe way.

People were protected from the risk of abuse.

Risks to people and the environment were assessed, and staff took steps to reduce those risks identified.

There were enough staff available to meet the needs of people.

People were protected by the prevention and control of infection.

The registered manager took steps to ensure lessons were learned when things went wrong.

Is the service effective?

Good

The service was not always effective.

Staff had the skills and experience to meet the needs of people.

People had their care delivered in line with current legislation and best practice guidance.

People's nutrition and hydration needs were met.

Staff followed the guidance from healthcare professionals and ensured people had access to health care and treatment.

Staff knew how to seek consent from people and were knowledgeable about the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect.

People were supported to express their views about the support

they received.

People had their privacy and dignity respected and promoted.

Is the service responsive?

Good

The service was responsive.

People were in control of how their support was provided, and support was provided in a personalised way.

People said they knew how to raise a complaint and would do so if they needed to.

Staff were supporting people at the end of their lives to have a dignified death.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager did not have complete oversight of the service.

The culture was transparent and honest, and staff told us they felt valued by their managers.

People, their families and staff were encouraged to be engaged and involved in the service.

The service had developed links with the local community.

Poplars Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 24 January 2019 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor who looked at how staff managed people's medicines. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

We used information we held about the service and the provider to assist us to plan the inspection. This included notifications the provider had sent to us about significant events at the service. We also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We observed the care provided for people. 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.

During our inspection we spoke with ten people about what it was like to live at the service. We spoke with two relatives. We also spoke with three care staff members, three nurses, the chef and food and beverage assistant, the activities coordinator, the business manager, the clinical lead, the deputy manager, the registered manager and the operations manager. We inspected the environment, which included checking some of the bedrooms, the laundry area, kitchen and communal areas.

We looked at risk and quality audit records, policies and procedures, complaint and incident and accident monitoring systems. We looked at five people's care files, six staff recruitment files, the staff training programme and medicine records. We displayed a poster in the communal area of the service inviting feedback from people, relatives and staff.

Requires Improvement

Is the service safe?

Our findings

People told us the care and support at Poplars helped them feel safe. One person told us, "I definitely feel safe. There is care available 24 hours a day. I get my medication regularly and I have a good rapport with staff." Another told us, "This is my home now. I feel safe here. I am well looked after and the carers are very helpful." A relative said, "Mum has her own room, a buzzer to call assistance so she is not on her own at night. She is happy and content." However, we did not always find the service to be safe.

Medicine records were not always completed accurately. Each person had their own medicine record (MAR) which indicated how much medicine they needed and at what time. The nurse on duty signed to show the medicine was given, and the clinical lead carried out a regular audit of the MAR to make sure people were receiving their medicines as prescribed. However, these audits showed a number of occasions where a nurse had not signed to indicate they had given a person their medicine. The clinical lead confirmed that rather than checking if the medicine had been given or not, they only asked the nurse to go back and sign the record later. This meant there was no way of knowing if the person had received all the medicine they needed, at the time they needed.

Some people were at risk of not receiving their medicine as prescribed. We carried out an audit of people's MARs and compared them to the amount of medicine people had left. The clinical lead told us the number left should match the records. Despite these assurances, we found one person had 8 more tablets than expected for one type medicine, 4 for another and 12 for a third. Following our inspection we received further information from the operations manager which showed the additional medicines were found in the person's possession when they returned from hospital, but had not been recorded in the persons medicine records. Another person's MAR indicated they should have had two tablets left of one type of medicine, but in fact had 13. The clinical lead confirmed there had been no stock count to provide information if these were record keeping errors or omissions of treatment. However, upon further investigation during our inspection both we and the clinical lead concluded that these were recording errors.

Other records were completed without due regard to the registered provider's policy and nationally recognised best practice. For example, some people had received new medicines which needed to be added to their MAR. The registered provider's policy stated that the medicine, dosage and time can be added by hand but should be recorded by one nurse and checked by another to make sure it was accurate to the prescription. However, we found records for two people where this procedure had not been followed, and the medicine was not being checked by a second member of staff. This mean there was an increased risk of error, and an increased risk of people not receiving their medicine as prescribed.

Medicines were not always stored in line with manufacturers recommendations. Some people used medicines which needed to be stored in a fridge at a temperature of between 2 and 8 degrees Celsius. Each day, staff recorded the temperature of the fridge, and the records were checked each month to ensure the fridge was operating effectively. However, records for September 2018 showed the fridge recorded a temperature outside these levels for ten consecutive days. This discrepancy had not been identified in audits, and the concerns had not been reported to the registered manager in line with the provider's policies

and procedures. This mean the registered manager was unable to act to make sure medicines were being stored safely. Additionally, one person needed medicine for their diabetes. The manufacturer recommended it be stored in a fridge until opened, and once opened should be discarded within 28 days. However, we found one person's medicine had been out of the fridge since 21 September 2018, meaning it had been out of the fridge for over four times the recommended amount of time.

Some people who were at risk of choking when drinking fluids needed a thickener to be added to their drinks to keep them safe. Thickener can be harmful to a person if they were to ingest it accidentally, and nationally recognised guidance states it should be stored in a safe place to help prevent this from happening. However, we found one person's thickener had been stored in the communal lounge next to cups and glasses used for drinking. This put people at risk of harm if they were to mistake the thickener for, for example, sugar or milk. We spoke to the registered manager about our concerns. They stated that the risk was low as residents were not independently mobile, however they took immediate action and removed the thickener.

The failure to ensure people received their medicines safely was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed our concerns with how medicines were being managed with the registered manager. The registered provider employed nurses who were registered with the Nursing and Midwifery Council (NMC). The NMC is a regulatory body which sets the standards for nurse's education, to make sure they have the right skills and qualities to nurse. The registered manager further supported nurses with additional training and supervision where staff could discuss areas for further development. However, the registered manager confirmed nurses did not have their competency regularly and systematically checked by senior staff. This meant the registered manager was unaware that some nurses were not always following nationally recognised best practice guidelines as we had identified during our inspection.

We recommend the provider seek guidance on how to effectively ensure all nursing staff have their knowledge updated in line with best practice.

People were protected from the risk of harm. Staff received training on how to identify and report safeguarding concerns as part of their induction. Records showed more established members of staff had regular refresher training to make sure they were up-to-date with best practice. Staff were knowledgeable about different types of abuse, and were confident that any concerns they had would be treated seriously by their managers and investigated appropriately. The registered manager demonstrated a good understanding of safeguarding procedures, and records showed they had reported concerns to CQC and the safeguarding team at the local authority when required.

Risks to people were assessed and steps were taken to reduce risks to keep people safe. Senior staff had carried out risk assessments for each person when required, and information was kept in their care records so staff knew what action to take to reduce the risks. For example, where one person was identified as being as risk of pressure sores, staff were provided with guidance on how to reduce the risk by applying creams and regularly turning the person in their bed.

Checks were made to the environment to make sure it was safe for people to live in. Senior staff carried out a daily 'walk around' to check the environment was organised and tidy, making sure outstanding repairs were being followed up by the handyperson. Monthly health and safety checks were in place and any areas of concern identified were followed up. Steps were taken to make sure people were safe in an emergency. Staff received fire safety training and there were regular fire drills which helped staff know what to do in an

emergency. Fire safety equipment such as fire extinguishers were serviced yearly. Each person had a readily available personal evacuation plan which was used by staff to help them leave the building safely if there was an emergency.

Staff were recruited safely. Recruitment files were stored securely and only accessible to authorised staff. Records included information on the applicant's full employment history and references. A Disclosure and Barring Service (DBS) checks had been carried out, these helped inform the registered manager's decision about the suitability of the candidates. A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with people.

There were enough staff to meet people's needs. The registered manager used a tool to calculate the support people needed and how many staff were required to meet their needs. Rotas were drawn up in advance and the registered manager had access to agency staff if needed, although these were used infrequently. Staff told us they were not rushed, and felt they had enough time to support people in the way they needed. We observed that people had the call buttons beside their hand whether they were in bed or sitting out in their chair. On the day of inspection, the call button were responded promptly by staff. People and their relatives told us they thought there were enough staff with one person saying, "There are enough staff, I can always see them wandering about. They are always busy helping people."

People were protected by the prevention and control of infection. Staff were following best practice guidelines which helped reduce the risk of infection. We saw staff wearing personal protective equipment like gloves, hats and aprons when supporting people with personal care or cooking. Hand sanitisers were positioned on walls throughout the home and we observed staff regularly using them before entering people's rooms. The deputy manager carried out monthly infection control audits and areas of concerns were passed to the infection control lead, who ensured appropriate action was taken. Infection risks to people, such as urine or chest infections were recorded and tracked. Action was taken when patterns were identified.

Accidents, incidents and near misses were recorded by staff, and reported to the registered manager in line with the provider's policy. The registered manager kept a log of safeguarding concerns and other incidents and reviewed this information to look for patterns and trends and acted when needed. The registered manager said, "I look at the time of day an accident happened, to see if we can change the person's routine to help prevent it happening again." Senior staff looked to embed improvements in the service when things went wrong. For example, a visiting health professional raised some concerns about how one person had been transferred using a hoist. The registered manager arranged for refresher manual handling training to be provided to all staff, and one senior member of staff was trained to be able to support care staff when using hoists. Manual handling techniques were also discussed in subsequent team meetings and supervision sessions where staff could identify if they needed more support.

Good

Is the service effective?

Our findings

People and their relatives told us they were supported by staff who were skilled to provide them with effective care and support. One person said, "All the staff have been well trained, they help me in the way I want them to." A relative added, "I feel confident that staff know what they are doing. They're very helpful to mum and reassuring to me." However, we did not always find the service to be effective.

People's care and support was delivered in line with current legislation and best practice. People received an assessment before they moved into the service so the registered manager could be sure staff were able to meet their needs. The assessment included contributions from the persons relatives and health professionals if appropriate. One relative told us, "The deputy manager came to do an assessment. They were very thorough, asked lots of questions about mum and her health and what help she needed."

Assessments also considered any additional support that might be required to ensure people did not suffer from discrimination, such as needs around cultural or religious beliefs, and other protected characteristics under the Equality Act 2010. The Act makes it against the law to discriminate against a person because of a protected characteristic, which includes their age, disability, sexual orientation or religion. The assessment was used to devise a person-centred care plan, and each person had their own care plan which showed the support they wanted and needed. This included information about their physical, mental and emotional needs.

Staff had the skills and experience to deliver effective care and treatment. Recently recruited staff had completed the Care Certificate, which is a nationally recognised set of standards that health and social care workers should adhere to deliver caring, compassionate and quality care. They also received support by having a full induction into the service and the opportunity of shadowing more experienced staff when they were learning the role. Established staff received regular updates in their training on subjects such as basic life support, first aid, moving and handling and dementia awareness. All staff received regular supervision from their managers. Staff found the supervision to be valuable, as they could discuss learning and development needs. Managers used the sessions to discuss topics with each staff member, such as health and safety at work, which helped make sure all staff were aware of changes to practice. Staff also received an annual appraisal of their work.

People were supported to eat and drink enough to maintain a balanced diet. People were involved in devising the menus, which were well balanced and nutritious. People could choose meals off the menu, and we saw people choosing what they preferred, such as corned beef or poached salmon. Kitchen staff were also able to cater for specialist diets such as vegetarian or vegan food. Kitchen staff were aware of people with dietary needs, such as those at risk of choking, and made sure these people received their food safely. People could choose to eat in the communal dining room or in their bedrooms, and there were enough staff to support those who chose to take their meals in their rooms. If people needed support to eat, this was carried out in a dignified way with staff taking their time, offering encouragement and getting down to people's eye level.

Staff worked together both with each other and across other organisations to help deliver effective, joined-up care and support. We saw positive and discrete communication between staff members when discussing people's needs. At the end of each shift staff took part in a handover where any changes to people's needs was discussed. People's health needs were monitored, and referrals were made to health professionals when needed. We saw recent referrals had been made to physiotherapists, occupational therapists and the GP visited weekly to review people's health needs. People said they felt well supported. One person told us, "Recently I had a chesty cold I asked the nurse to ask the doctor to visit, and there was no delay. I always see the optician, chiropodist and dentist when I need them to visit."

People's needs were met by the design and adaptation of the premises. People live in spacious rooms, which along with the communal areas were brightly lit. The doors to bedrooms were painted different colours to help people with dementia recognise where they lived. The service was set over two floors with access via a lift. There was a large communal dining room and a separate lounge and people had access to communal gardens if they wished to. Some people lived in shared rooms but their consent was sought as people could choose their room when they moved in. One person, who lived at the service with their spouse, told us, "We had the manager and nurse visit, they took full details of both of our health issues and what care we needed help with. It was difficult to find a home where we could be together." People were free to bring their own personal possessions to decorate their rooms, and rooms were freshly decorated when people moved into the service.

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 law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. In care homes, people can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In supported living services, applications for restrictions of liberty must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most people living at the service had dementia, and we found staff to be knowledgeable about the MCA, and were following its principles when helping people make decisions. For example, when one person with dementia was at risk of falling out of bed, staff made sure the MCA was followed before staff used bed rails to help keep the person safe at night. A staff member told us, "I always ask people if they want support. If they don't we respect that decision."

Good

Is the service caring?

Our findings

People and their relatives told us they felt cared for by staff. One person said," Staff know me pretty well. They always treat me with courtesy and dignity, and a certain amount of banter." A relative said, "Staff are very nice, friendly and helpful. I am satisfied with the way mum is being looked after."

People were treated with kindness and compassion. Staff were cheerful and polite and created a friendly atmosphere within the service. We heard staff saying please and thank you to people when they spoke to them. When we heard another person say they needed to use the bathroom, staff were readily available to respond quickly. We asked staff what skills they needed to support people in a compassionate manner. One staff member told us, "First of all you need to have an idea of the kind of person they are. If someone feels a bit sad, given them an extra five minutes to hold their hand and reassure them."

Staff used different ways to communicate with people. One relative told us, "Staff are very friendly. They know [relative] is deaf and when they speak to her, so they lean towards her and speak a bit louder. And they always give her time to respond." Most people using the service were living with dementia and we saw staff communicating with people compassionately when they showed signs of distress. One staff member said, "We've had training on how to support people with dementia. One person doesn't remember her husband has passed away, and if you were tell her it's like the first time she's ever heard it. She relives the grief each time. So, it's about diverting the question, whilst not treating her like a child."

People were supported to express their views and be actively involved in making decisions about their care. Care plans were reviewed each month, and staff sought the input from the person being reviewed as well as their relatives. If people did not have relatives to support them, the registered manager would refer to external lay advocates for support. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes. Health and social care professionals were invited to the reviews and encouraged to contribute to the planning of care and support.

People were treated with dignity and respect. We saw staff making sure doors and curtains were closed before they carried out intimate support. Senior staff made sure staff were treating people with dignity during random spot checks, which included making sure the person looked clean and was dressed appropriately.

People were supported to be as independent as possible. A staff member told us, "Even if people have dementia they might still be able to choose what they want to wear. If someone can no longer tell me their favourite colour I'll speak to family members to find out what it was." People could take part in their support as much as they could. One person said, "I can manage most things for myself, if I decide I want a rest I just go back to my room and undressed and get back into bed."

People's privacy was respected, and their private information was treated confidentially. One person who lived in a shared room told us, "When staff are washing and changing [person they shared a room with] staff make sure that the curtain is pulled around her and the door is closed." Computers and phones were

password protected so they could only be accessed by authorised staff, Care and medicine records were locked away when they were not being used by staff.

Good

Is the service responsive?

Our findings

People told us they received support which was responsive to their needs. One person told us, "I always join in with the activities. There is something on every afternoon, like bingo, music shows. I took part in a Robin Hood play and won a prize, it was great fun!" A relative told us, "I have no complaints about mum's care. If I had an issue I would speak with the manager."

People's care was delivered around their needs and choices. Each person had their own care plan which contained details about their needs and how they liked to be supported. The provider had introduced a new electronic care planning system in December 2018, and staff were positive about the new system. Care plans contained information on a wide range of people's needs including communication, support people needed with sleeping and support needed around their dementia. Care plans were reviewed each month or as and when people's needs changed. Where people were not able to be involved in these reviews records showed that support had been discussed with people's relatives and professionals, where appropriate, and decisions made were based on people's life history and previous preferences.

People were positive about the activities provided at the service. The provider employed an activities coordinator, who's role was to organise communal activities. Details of the activities were displayed in the notice board, and people were given a monthly newsletter with details of external activities. During our inspection we observed people and staff playing a game of bingo. Staff used enthusiastic behaviour to encourage people when they were looking for the numbers and celebrated with them when they were able to cover number. People told us the activities coordinator also visited people in their rooms to encourage them to join in. Another staff member told us, "People's interests are listed in their care plan, so we can go to sit with people in their rooms to keep them company."

The service was meeting the accessible information standard. This standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. People who had communication needs had them clearly recorded in their care plan so staff knew how to support them. People had access to large print information if they required it.

Staff understood the importance of promoting people's diversity and equality. Local churches visited each week to help people meet their spiritual needs. People were supported by staff to maintain their personal relationships. Relatives and friends were able to visit without any restrictions, and had access to private space within the service to hold private conversations.

People and their relatives said they knew how to make a complaint, and they thought any issues they had would be taken seriously by the registered manager. One person told us, "They started to build a shed outside and moved the recycling bins just outside my window. It's my only view so I spoke to nurse and it was dealt with straight away." The provider had a complaints procedure which was followed when dealing with complaints. Records showed that complaints were dealt with swiftly.

People were supported at the end of their lives to have a pain free and dignified death. When appropriate,

staff spoke to people and their relatives about their preferences and wishes such as how they would like their room to be set out. This information as recorded in the person's care plan. Staff worked closely with a nearby hospice to support people at the end of their life to make sure people receiving end of life care were supported with dignity. During our inspection we met a professional from the hospice, who told us who told us they and the service had a close working relationship, and referrals were always made in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

People and relatives all told us that they thought the home was well managed and that the managers were approachable. One person said, "I always see the manager when she walks through, she always says hello." Another told us, "It seems to be run very efficiently. When something happened to my bed, it just went down, it was reported and repaired with three quarters of an hour." A relative said, "The home seems quite efficient. It appears to run smoothly and I have found the deputy manager very helpful." However, we did not always find the service to be well led because quality audits did not identify concerns we found relating to people's medicines.

The registered manager told us systems were in place which continuously assessed risks and monitored the quality of the service. These included, for example, the managing accidents and incidents, risks to people's health and monitoring the quality of care and support provided by staff. Additionally, the registered manager reported information to the provider on a monthly basis, which meant the operations manager had oversight of issues and concerns within the service. However, these systems and processes did not identify all the areas of concern we identified at the inspection relating to how people were being supported with their medicines. We spoke to the registered manager and operations manager about our concerns. They agreed to take action to improve the audits of medicines, and following our inspection we were sent newly devised daily checks which they hoped would address the areas of concern. Additionally, the lack of competency checks on nursing staff meant the registered manager could not be sure if they were able to carry out their role effectively.

The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was aware of their responsibility to comply with our registration requirements. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating both on their website and within the service.

The registered manager was aware of the culture within the service, and said they operated an 'open door' policy where staff, people and their relatives were free to speak to them about any concerns they might have. Staff told us they felt supported by their managers, with one telling us, "We get on well with the

managers. They listen to us, and help us do our jobs better." People and their relatives told us they saw staff getting on well with their managers. One person said, "They're always very jolly." And a relative telling us, "Staff and managers seem to work well together, they're always helping each other out." The registered manager told us the service had a philosophy which was "to make people feel comfortable in their own homes, and to train staff to support them."

People, their relatives and staff were involved in shaping the service. The provider gathered their views by carrying out yearly surveys, and results of the most recent survey was overall positive. Staff took part in team meetings and told us their views were considered by managers. For example, one staff member said they wanted to make changes to how lunchtime was organised, and as a result a new system was implemented by managers. Staff and people commented on how the new system ran more smoothly. People attended team meetings and minutes of the meetings showed they could raise concerns and managers took steps to address them.

Staff worked in partnership with other organisations in the local community to ensure they provided joined up care. They worked openly and transparently with the local authority when discussing new referrals into the service or safeguarding concerns. Staff had established links with local schools which enhanced the lives of those living at the service. They worked in conjunction with health professionals such as district nurses, GPs and speech and language therapists.