Downside House Limited

Downside House

Inspection report

3-4 St Boniface Terrace
St Boniface Road
Ventnor
Isle of Wight
PO38 1PJ

Tel: 01983854525

Date of inspection visit:
21 July 2016
25 July 2016

Date of publication:
08 September 2016

Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

The inspection took place on 21 and 25 July 2016 and was unannounced. The home provides accommodation for up to 21 people, including people living with dementia care needs. There were 18 people living at the home when we visited. Accommodation is spread over three floors, connected by a passenger lift and stairwells. All rooms had en-suite toilet and washing facilities. There is a lounge/dining room on the ground floor and bathrooms on each of the floors.

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

Most risks to people's safety had been assessed and were being managed appropriately. However, we found risk assessment had not been conducted for people at risk of pressure injuries and there was no process in place to make sure that special pressure-reducing mattresses were kept at the correct setting.

People and their relatives praised the quality of care delivered with end of life care, in particular, being highlighted. Feedback from a family member described this as "tender, tactile, sensitive and sincere". They said their relative had received a "calm, dignified and comfortable" death. One doctor told us "Downside has the best end-of-life care that anyone could wish for." Another doctor described it as "exemplary". Staff also supported relatives of the person dying with empathy and understanding.

Staff showed commitment to people's well-being by going 'the extra mile', for example by taking them to events in their off-duty time. These included shopping, visits to coffee shops and trips to local attractions. Without exception, all the interactions we observed between people and staff were positive. Staff knew people very well and built positive relationships with them.

People felt safe living at Downside House. Staff knew how to identify, prevent and report incidents of abuse. An innovative solution, using a bead curtain, had been found to prevent a person from entering another's room and putting themselves at risk.

Medicines were managed safely by staff who were suitably trained. The home was clean and there were appropriate arrangements in place for preventing and managing the risk and spread of infection. Plans were in place to deal with foreseeable emergencies.

Recruitment practices were safe. There were enough staff deployed to meet people's needs. Staff had received relevant training and were supported in their work through one-to-one sessions of supervision and appraisal.

Staff sought consent from people before providing care and support. The ability of people to make decisions

was assessed in line with legal requirements to ensure their rights were protected and their liberty was not restricted unlawfully. Decisions were taken in the best interests of people.

People enjoyed the meals and were supported appropriately to eat and drink enough. The home was taking part in a pilot project to prevent unnecessary admissions to hospital. This had help ensure people received prompt medical attention when needed.

Care and support were delivered in a personalised and flexible way. People were supported to make choices. Their privacy and dignity were respected at all times. The provider sought and acted on feedback from people and there was an appropriate complaints policy in place.

People and their relatives told us the home was run well. There was an open and transparent culture. Visitors were welcomed, staff enjoyed good working relationships with external professionals and there were strong links with the local community.

There was a clear management structure in place. Staff understood their roles and worked well as a team. Staff described managers was "approachable" and "supportive". This had contributed to a low level of staff turnover which meant people were cared for by a consistent team of staff who knew them well.

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.

Pressure injury risks were not always managed effectively. However, other risks to people had been assessed and were being managed appropriately.

People felt safe and staff knew how to identify, prevent and report abuse.

Medicines were administered safely by staff who were suitably trained. The home was clean and infection control risks were managed appropriately.

There were enough staff to meet people's needs at all times. Safe recruitment procedures were followed before staff started working at the home.

Is the service effective?

Good

The service was effective.

People praised the quality of the food and received appropriate support to eat and drink enough. Staff followed legislation designed to protect people's rights.

Staff were suitably trained and supported appropriately in their work. The environment was supportive of people living with dementia.

Is the service caring?

Good

The service was caring.

People received high quality care at the end of their lives, which a doctor described as exemplary. They also provided support, empathy and understanding to relatives.

People were treated with kindness and compassion.

Staff build positive relationships with people. They knew people well and took them to events in their own time.

People's privacy was protected and they were treated with dignity and respect at all times.

Is the service responsive?

Good

The service was responsive.

People received personalised care and staff understood people's individual needs.

Staff were flexible in the way they delivered care and people were supported to make choices. An appropriate range of activities was provided.

The provider sought and acted on feedback. People knew how to complain and there was a suitable complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

People enjoyed living at the home. There was an open and transparent culture. Positive links had been made with the community.

There was a clear management structure in place. Staff were happy in their work, felt supported by management and worked well as a team.

Directors of the provider's company were actively involved in managing the home. They had a clear vision of the standard of care required. They sought and acted on feedback from staff.

Downside 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 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 21 and 25 July 2016 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home and seven visiting relatives. We spoke with the registered manager, the deputy manager, seven care staff and the cook. We also spoke with a nurse and reviewed written feedback from two doctors who had regular contact with the home.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and 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.

The service was last inspected on 16 December 2014 when we identified no concerns.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Downside House. A family member said their relative was "relaxed and [staff] are always available for a chat." The provider had appropriate policies in place to protect people from abuse. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. They said they would have no hesitation in reporting abuse and we saw examples where they had done this. One person raised a safeguarding concern during the inspection and the registered manager took prompt and effective action to protect the person.

Following an incident where a person living with dementia had entered another person's room and put themselves at risk, staff had installed a bead curtain in the person's doorway. This allowed the person to keep their door open, which they preferred, while also acting as a visual barrier to deter the other person from entering their room. This was an innovative solution that had proved to be highly effective.

Staff knew how to care for people's skin, to reduce the risk of skin breakdown and this was recorded in the personal care sections of people's care plans. However, risk assessments had not been completed to assist staff to identify people at risk of pressure injuries and measures needed to reduce the likelihood of them occurring. Following assessments by district nurses, some people were using special mattresses to reduce the risk of pressure injuries. However, two mattresses were not set correctly, according to the person's weight, and there was no system in place for staff to ensure they remained at the correct settings. The district nurses had recommended that another person needed a pressure relieving cushion when sat in a chair, but we saw one was not in place. We drew these concerns to the attention of the registered manager who agreed it was an area for improvement and took immediate action to address the issues.

Other risks to people's safety had been assessed and were being managed appropriately. For example, two people experienced seizures; there were clear plans in place to support them safely when they had a seizure, which staff understood and followed. Risks posed by the environment had been assessed and this had led to the use of restrictors on windows and external doors on the upper floors of the building to reduce the risk of falls. People who were at risk of falling out of bed had bed rails in place and staff had considered, and were aware of, the dangers associated with these. A family member told us, "I asked for [bed rails] and we talked about [the risks]. I feel [my relative] is safer now they are in place."

People were supported to receive their medicines safely. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Medication administration records (MAR) confirmed people had received their medicines as prescribed.

Training records confirmed that staff were suitably trained and had been assessed as competent to administer medicines. Staff were aware of how and when to administer medicines to be given on an 'as required' (PRN) basis, for example to relieve anxiety or agitation. PRN guidance was in place to help ensure staff administered these medicines to people in a consistent way. The registered manager had introduced an 'antibiotics box' in the medicines store to keep short term antibiotics for people. This had made it easier

for staff to identify when antibiotics had been prescribed and had reduced the likelihood of them not being given.

All areas of the home were clean and hygienic, and staff followed appropriate infection control procedures. The registered manager had assessed infection control risks and taken action to reduce the risks; they had also completed an annual statement of infection control detailing events that had occurred over the past year. Regular audits were conducted to check that best practice guidance was being followed. These had led to the installation of washable pull cords in bathrooms and dispensers for liquid soap and disposable aprons in all bedrooms. Some toilet frames and side tables had also been replaced in the interests of hygiene. Cleaning schedules were in place for each area of the home, together with a colour coded system to help reduce the likelihood of cross contamination between areas being cleaned. Staff completed check sheets to show they had undertaken cleaning in accordance with the schedules, which we saw were up to date. A process was also in place to deep clean the home on a regular basis and care staff had worked extra hours to do this.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Staffing levels were determined by the registered manager on the basis of people's needs and by taking account feedback from people, relatives and staff. They had recognised that some people living with dementia needed more support in the evenings, when they could become agitated and had introduced a 'twilight shift' to cover this. Staff told us they worked flexibly; for example, when people were receiving end of life care they worked additional hours to provide support to the person and their family.

The provider had an effective recruitment procedure in place, which included seeking references and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found all checks had been completed before new staff started work at the home.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm sounded; they completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. People had personal emergency evacuation plans in place detailing the support they would need in an emergency. Staff were trained in administering first aid and first aid equipment was readily available. A hospital transfer form was also in place to help make sure medical staff would have up to date information about people if they were admitted to hospital in an emergency.

Good

Is the service effective?

Our findings

People and their relatives praised the quality of the food, describing it as "fantastic", "nice" and "brilliant". One person told us, "You can't fault it, it's wonderful." A choice of meals was offered each day, including produce grown in the home's greenhouse and picked freshly for salads in season. Staff were aware of people's dietary needs and people who needed special diets. For example, one person needed a low fat diet and we saw this was provided. However, two people needed their meals pureed and this was not always done in a consistent way. Some staff said they presented individual food items separately on the plate, to allow the person to distinguish the different tastes; but other staff said they blended all the food items together. We discussed this with the registered manager who took action to help ensure that pureed meals were prepared appropriately and consistently for people.

People could choose where they took their meals. Some people stayed in their bedrooms and needed support with their meals; this was provided on a one-to-one basis. Other people needed to be encouraged to eat and this was done in a supportive way. Staff ate with people in the lounge/dining room and this helped make it a social occasion. People had drinks within reach at all times and were encouraged to drink often. Staff monitored the intake of people who were at risk of not eating or drinking enough. They also monitored people's weight or body mass index. When people started to lose weight, staff took appropriate action, for example by referring them to a doctor or fortifying their meals.

People and their relatives spoke highly about the standard of care delivered. They told us staff understood, and were skilled at meeting people's needs. A family member told us, "The care is excellent." Another said, "I can't fault anything they do; [the care] is super." Written comments from a doctor who had regular contact with the home, in a response to a survey conducted by the provider, included: "Overall high standards, resulting in well cared for and happy residents."

People's needs were met by staff who were skilled and suitably trained. In addition to the provider's mandatory training, the registered manager ran a series of training workshops based on specific topics. These included medicines administration, the Mental Capacity Act (MCA) and safeguarding. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. For example, some staff had attended four day dementia awareness courses. A staff member told us, "The dementia training was really good. It helped understand the different forms of dementia and how to communicate with people. You have to be patient, sit at their level and make eye contact. It also helps to know their interests and their backgrounds."

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of experienced staff had completed, or were undertaking, vocational qualifications in health and social care.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one

sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal, with the registered manager, to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from management on a day to day basis. One staff member said, "Supervisions are good; they give you the chance to off-load."

Staff followed the MCA and its code of practice. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Where assessments indicated that people lacked capacity to consent to the care and support they received, families were consulted and decisions made in the best interests of the person. For example, one person was declining to take their medicines. An assessment of their ability to make an informed decision about this had been completed and the person's family and their GP had been consulted. This identified the person lacked capacity and a decision was then made in their best interests to administer the medicine covertly. The process protected their rights and ensured they received essential medicines to keep them well.

Staff sought verbal consent from people before providing care and support by checking they were ready and willing to receive it. One person often declined personal care and staff described how they respected the person's decision. They said they would return to try again later or ask another staff member to offer support to the person.

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 are called the Deprivation of Liberty Safeguards (DoLS). 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. We found the provider was following the necessary requirements. DoLS authorisation had been approved for two people and applications had been made for a further four people. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. Written feedback from a family member included: "Decisions of if and when to call the doctor were always the right ones. Nothing was ever left to chance. You saw to it that [my relative's] comfort was paramount."

The home was taking part in a pilot project to test the use of 'telemedicine' in conjunction with one of the local surgeries. This involved sending data about people's health, such as their blood pressure, temperature and oxygen levels, electronically to the surgery for a doctor to review. The intention was to reduce unnecessary admissions to hospital by diagnosing illnesses quickly. Staff told us this was working well. For example, when a person became unwell after an epileptic seizure, the doctor asked them to conduct a series of observations over a period of days which the doctor was able to review online. This had allowed the person to remain at the home rather than be transferred to hospital.

The provider had undertaken refurbishment and redecoration of some areas of the home. The colour schemes supported people living with dementia or visual disorders. Large signs helped people to find their way around the home. Handrails along the main corridors were in a contrasting colour to the walls, making

them easy for people with poor eye sight to spot and use. The door surrounds to en-suite bathrooms had been painted bright yellow to make them stand out. Two areas had been created for people along routes they liked to walk which contained items of interest they could interact with. People had been involved in choosing the colour schemes for their bedrooms and their doors contained easily identifiable pictures or signs to help people find their rooms. A staff member told us, "The pictures on doors definitely help. [One person] gets a bit lost, but as we take her towards her room she sees her name and says 'oh there's my room'."

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "They're nice. I like talking to them." A family member told us, "There are good interactions; [staff] enjoy a laugh and a joke with [my relative] as she gets a bit cheeky. They are really lovely with her." Another family member said staff were "always kind and attentive". A further family member said they were impressed by "the continuity of the staff and also by the fact that two of the staff had a relative at the home themselves".

People were given support to receive high quality end of life care, leading to a comfortable, dignified death. Staff achieved this while also caring for, and supporting, the people that mattered to the person who was dying with empathy and understanding. Written feedback from a family member whose relative died at the home included: "She received from you the very best care that one human being can give to another. You were tender, tactile, sensitive and sincere." They added, "[My relative's] final weeks were calm, dignified and comfortable. The affection and care that [my relative] received from you was continuous and unfailing right to the end. You shared your support of her by supporting us and kept us going with tea, toast and even a wonderful meal, so we did not have to leave her and go out to find food. Thank you so much."

Written feedback to us from a doctor who had regular contact with the home stated: "Downside has the best end-of-life care that anyone could wish for. They are proactive in identifying [end of life] residents and engaging with us on care planning. They liaise well with all community services and families of residents." The doctor had arranged for a person to be transferred to the home from hospital and told us, "Within hours of arriving I made an unannounced visit to find her washed, mouth care given, comfortable in a clean bed with a carer holding her hand and reading poetry to her. This is an example of their care to every resident." Comments from another doctor who had regular contact with the home, in response to a survey conducted by the provider included: "Personal care and end of life care can only be described as exemplary." A district nurse confirmed that staff contacted them at an early stage for support with end of life care and always followed their advice.

Staff told us they took pride in providing end of life care. One staff member said, "We try to prepare families for the event; we have conversations and give them time on their own [with the person]." Another staff member told us, "It's nice to give people a nice death. We don't leave them on their own; we sit with them, make the environment calm and have the lights down low. And afterwards, we clean them and make them look lovely for their families."

Staff built positive relationships with people. They spoke about their work with passion and spoke about people warmly. They demonstrated a detailed knowledge of people as individuals and knew their personal likes and dislikes, showing they had taken the time to get to know the people in their care. They also showed commitment to people's well-being by going 'the extra mile', for example by taking them to events in their off-duty time. These included shopping trips, visits to coffee shops and, in one case, a trip to visit the historic dockyards in Portsmouth. The person was not funded to receive support when attending events on the mainland, so this trip would not have been possible without the goodwill of staff. Photographs of the event showed the person had clearly enjoyed the day.

Without exception, all the interactions we observed between people and staff were positive and staff clearly knew people very well. They used people's preferred names and approached people in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. At lunchtime, staff promoted conversation by including people in discussions and encouraging them to reminisce about their lives.

People's privacy was protected at all times. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Confidential care records were kept securely and only accessed by staff authorised to view them. All bedrooms were for single occupancy ensuring privacy whilst people received personal care. When a person showed signs of needing to use the bathroom, a staff member discreetly asked the person if that was what they wanted. They then led them quietly to the bathroom without fuss.

Staff treated people with dignity and respect. For example, they described practical steps they took to preserve people's dignity when providing personal care. People said they could choose the gender of the care staff member, or request particular staff members, to support them with personal care. This information was also included in care plans.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes to the health of their relatives. Most people had been assigned a key worker. A key worker is a named member of staff who took responsibility for supporting a person and liaising with family members. People who were able to had chosen their own key worker. Other people had been assigned key workers who they related to well. Key workers held monthly review meetings with people to discuss their care and any changes they requested.

Good

Is the service responsive?

Our findings

Most people received personalised care and support that met their needs. One person said of the staff, "They actually do things for you here. You can do anything you like." A family member praised the way staff cared for their relative and told us, "They'll ring me straight away if there's anything wrong."

One person living at the home had a learning disability. Whilst the person told us they were happy and felt safe at Downside House, staff told us they did not have experience of supporting people with learning disabilities. The person's care plan identified life skills that they wished to develop, such as improving their reading ability, but staff were not supporting the person to achieve this. We discussed this with the registered manager. Between the two inspection days, they met with the person's social worker and identified ways the person could be supported to achieve their goals using resources from within the community.

Staff demonstrated a good awareness of the individual support needs of all other people living at the home, including those with dementia care needs. They knew how each person preferred to receive care and support. For example, they knew which people needed to be encouraged to drink; the support each person needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. Care plans provided sufficient information to enable staff to provide appropriate care in a consistent way and were reviewed regularly.

Staff delivered care in a flexible way. For example, one person was reluctant to bathe. Their care plan encouraged staff to 'seize the moment' when the person was agreeable to receiving a bath, which staff told us they did. A family member told us their relative had started to find baths too tiring and had asked staff to start giving the person bed baths instead. Care records confirmed that staff were doing this.

Staff understood how to support people when they became anxious and put themselves or others at risk. They used distraction techniques and engaged the person in conversations about their interests, families and early life. This had reduced the need to administer sedatives, which we saw were rarely given to people. A staff member told us, "[One person] is easily placated if you take them to a quiet area and play their favourite music or sing with them. Then they don't needed [a sedative]."

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed; and how and where they spent their day. Most people were happy for staff to check them regularly throughout the night to make sure they were comfortable, but one person had asked for this not to be done. Staff had respected their decision. The person later changed their mind and asked staff to check them "occasionally" to provide reassurance and we saw this had been implemented. Another person liked to choose their clothes each day by taking most of them out of the wardrobe first. Staff understood the person's need to do this and supported them with it. A staff member told us, "We prompt [the person] to keep their room tidy and take responsibility for their possessions. We also gave [the person] a laundry bin, which they are getting good at using."

People had access to a range of activities. These were advertised on the home's notice board and people were encouraged to take part. They included movement to music, reminiscence, poetry, local news and quizzes. Feedback from a family member included: "We sometimes chanced upon activities and entertainment that you had arranged and saw how much [our relative] and the other residents lit up during those afternoons of music and singing." Staff also spent one-to-one time with people who chose to remain in their rooms, to reduce the risk of them becoming socially isolated. Two people accessed the community independently and staff provided emotional support, encouragement and reassurance for them to do this.

The provider sought feedback from people through the use of survey questionnaires. These showed people, their relatives and healthcare professionals were satisfied with the care provided. The registered manager also held 'residents meetings' to discuss menus, activities and to seek feedback about the care and support provided by staff. Where feedback indicated improvements could be made, these were acted on. For example, a relative had criticised the lack of space for visitors to talk with people in private, so a 'snug' area had been created on the ground floor for this purpose.

People knew how to complain and there was a suitable complaints procedure in place which was advertised on the home's notice board. Relatives told us they would approach one of the managers if they had any concerns. A family member said, "I've raised a few complaints and they've always been resolved."

Good

Is the service well-led?

Our findings

People told us they were happy living at Downside House and felt it was well run. One person said, "It's a lovely homely place." A family member told us, "[The managers] are lovely and they know what they're doing." Feedback from a doctor who had regular contact with the home included: "[Downside House] is a well managed home. All staff know their roles and responsibilities and there are good working relations with the practice." In response to a survey conducted by the provider, another doctor had stated: "Easy to talk to senior management who respond appropriately."

There was an open and transparent culture at the home. Visitors were welcomed at any time and could stay as long as they wished. There were good working relationships with external professionals. Most notifications about significant events had been reported to CQC as required. Although we identified a safeguarding incident that had not been notified, staff had taken all appropriate action to keep the person safe and had notified the local safeguarding authority.

The registered manager operated an open door policy and we saw staff and people regularly visited their office for a chat. They, and the deputy manager, were visible around the home, interacting with people and staff throughout the day. Strong links had been developed with community groups. For example, people and staff attended the local Alzheimer's café on a regular basis, for which one of the cooks had volunteered to do the catering. A mutually beneficial project was also being run with a local school; this involved children visiting the home to meet people as part of an 'enrichment class'. People told us they enjoyed the children visiting.

There was a clear management structure in place. This comprised the registered manager, the deputy and senior care staff. One senior care staff member stepped up to manage the home when neither of the regular managers was available; they also took part in an on-call scheme to be available to provide advice and support to staff out of hours. Each senior staff member had responsibility for taking the lead on an aspect of the home, such as fire safety, infection control and medicines. This spread responsibilities and allowed the registered manager more time to spend with people and visiting relatives. The registered manager was a member of the local care homes association and belonged to a 'managers' network'. This helped them keep up to date with best practice guidance.

Staff enjoyed working at the home and spoke positively about the management, who they described as "approachable" and "supportive". Comments from staff included, "It's brilliant, the way it's run. [The registered manager and the deputy manager] are the nicest managers I've ever worked for;" and "[The registered manager and the deputy manager] go beyond the call of duty for residents and staff. They are always there for you". The registered manager felt that staff satisfaction with their work had contributed to a low level of staff turnover. This helped ensure that people were cared for by a consistent team of staff who knew them well.

Staff understood their roles and worked well as a team. A staff member told us, "We all work together to support people. For example, if I offer to [support a person] and they say 'no' someone else will try and she

then says 'yes'; so she gets the help she needs."

Two of the directors of the provider's company visited the home weekly and were actively involved in its management. The registered manager completed monthly reports for them, from which any actions were identified and monitored through to completion. Senior staff conducted a range of audits to assess and monitor the quality of service. These included reviews of the arrangements for infection control, the management of medicines and care planning. Following the audits, improvement actions were identified and implemented.

The directors had a clear vision of the care they aimed to provide, which one of them summed up by saying, "The place has to be good enough to put our parents here." When we spoke with staff, they understood this vision and applied it consistently in the way they supported people.

The directors sought and acted on feedback from staff. For example, staff had made comments about the size of the laundry and plans were in place to construct a new one. Other staff had sought more opportunities to interact with the directors and the directors had made efforts to make themselves more available to staff. They were also considering further developments to the home, including better us of an upstairs lounge area.