Western Health Care Limited

Downs House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 27 and 28 June 2018 and was unannounced.

Downs House 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.

Downs House accommodates up to 49 older people, some of whom may be living with dementia in one adapted building. At the time of this inspection there were 39 people living in the home.

A registered manager was 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.

Managers and staff understood and acted on their responsibility to protect people from abuse. Staff supported people to manage risks to promote their safety. There were sufficient staff available to meet people's needs.

The home provided a clean and comfortable environment for people. Procedures were in place and followed to manage the prevention and control of infections. People's medicines were managed safely.

The provider and registered manager had worked with others to ensure that lessons were learnt when things went wrong. Improvements had been made in response to safety incidents to prevent a reoccurrence.

People were supported to have choice and control and staff supported them in the least restrictive way possible; However not all of the processes in the service supported this practice. Improvement was required to ensure the use of equipment which can restrict people's freedom of movement and constitute a restraint, was assessed in line with the Mental Capacity Act (2005).

Not all of the protected characteristics of the Equality Act 2010 were considered as part of the needs assessment or person-centred care planning. We have made a recommendation about this.

People were supported by staff who were trained and supported to meet their needs effectively. People's nutrition and hydration needs were known and met.

People told us staff provided respectful, dignified and compassionate care. Personal care was delivered in private and people's decisions about their care were respected.

People's care plans were person centred and people received care in line with their assessed needs and preferences. People were supported to participate in a range of activities to meet their needs for social activity and stimulation.

People's complaints were investigated and responded to. People were aware of the complaints procedures and were confident the manager and staff would listen and act on complaints.

People were supported at the end of their life by staff who provided, sensitive, appropriate and compassionate care for people and their families. Plans were in place to improve end of life care planning and training for staff.

There were effective systems in place to monitor and improve the safety and quality of the service people received. Feedback from people, their families and staff was used to drive improvements to the service. The registered manager led by example and was committed to promoting a positive culture where the needs of people were prioritised and staff were valued.

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 were supported by managers and staff who understood and acted on their responsibility to protect people from abuse.

Risks to people had been assessed and plans were in place to mitigate risks and keep them safe.

There were sufficient staff to support people safely and meet their needs.

People's medicines were managed safely.

The home was clean and odour free. Infection prevention and control procedures were followed to provide a safe environment for people.

Lessons were learnt when things went wrong and improvements were made to prevent a reoccurrence of incidents.

Is the service effective?

Requires Improvement

The service was not always effective

An improvement was required to ensure the decisions to use equipment which can restrict people's freedom of movement and constitute a restraint, were assessed in line with the Mental Capacity Act (2005).

Nationally recognised tools and best practice guidance was used to inform aspects of people's care. Needs assessments did not include all the protected characteristics of the Equality Act 2010 to ensure person centred care in relation to people's diverse needs.

The home provided a comfortable and homely environment for people.

Staff completed an induction, training and on-going supervision to support them to provide an effective service for people.

People were supported to eat and drink sufficiently and their dietary and nutritional needs were met.

Is the service caring?

Good

The service was caring

People told us they were supported by kind and caring staff. Staff provided respectful and compassionate care.

People were involved in decisions about their care and treatment and their feedback about the service was acted on.

People's privacy, dignity and independence was promoted and their communication needs were met.

Is the service responsive?

Good

The service was responsive

People received care and support that was personalised to their individual needs and wishes in line with their care plan.

People participated in a range of group and individual activities to meet their need for social activity and stimulation.

There was a complaints procedure in place which was followed to ensure complaints were responded to appropriately.

People were supported at the end of their life by staff who provided, sensitive, appropriate and compassionate care for people and their families. Plans were in place to improve end of life care planning and training for staff.

Is the service well-led?

Good

The service was well led

People, their relatives and staff had confidence in the leadership of the registered manager. Staff were supported in their role and held accountable for their responsibilities.

Systems were in place to monitor and improve the quality and safety of the service people received. There was a culture of continuous improvement and people's feedback was acted on.

The service worked with other organisations to promote positive outcomes for people.

Downs 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.

CQC was aware of past injuries sustained at the location and we explored aspects of the current care and treatment during the inspection.

The inspection took place on 27 and 28 June 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had expertise in dementia care.

Before the inspection, we reviewed all the information we held about the service including notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. Prior to the inspection we reviewed information included on the Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection. We requested, but did not receive feedback from the local authority safeguarding team and Healthwatch.

During the inspection we spoke with 13 people and the relatives of six people. We interviewed or spoke with four care staff, two head of care staff, the activities coordinator, the head of housekeeping, the general manager and the registered manager. We observed interactions between staff and people in communal areas of the home, during lunch time and during activities. We observed a staff handover and looked at documentation related to staff recruitment, induction, training and supervision. The minutes of recent staff meetings, the staff duty rota for the previous three weeks and documentation related to the management of the home including incidents and accidents. We reviewed 14 people's care plans to see how different aspects of care were planned to meet people's needs, for example; risk assessments, medication, nutrition, personal care.

We previously inspected Downs House on 25 and 26 February 2016 when the home was rated 'Good' overall and in each key question.

Good

Is the service safe?

Our findings

People and their relatives we spoke with told us they were safely cared for at Downs House. Comments included "They (staff) know what I need, I'm unsteady on my feet and they are helpful & kind." A person's relative told us their father kept falling when he first came in the home at night and said "They (staff) called in an expert, not sure who they were, but the suggestion was to move the room around, so that his bed was opposite the bathroom. He stopped falling, because he wasn't turning to go to the toilet."

The staff members we spoke with had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member said, "I know the manager would deal with issues like abuse and there are phone hotlines we can use, to the council or the CQC". The registered manager said, "I consider safeguarding an important part of care I ask every staff member at supervision about their knowledge of safeguarding and whistle blowing and we talk about case scenarios and who to report things to." From our discussion with the registered manager and the notifications we had received it was evident they understood their responsibilities to safeguard people and acted to protect them from abuse.

Risks to people's personal safety had been assessed and plans were in place to minimise them. Staff were aware of people's risks and told us about the actions they took to promote people's safety and wellbeing. We saw people were supported safely in line with these assessments such as; walking with staff assistance to prevent falls, using equipment to minimise the risks to people from pressure sores, and receiving the appropriate support to eat and drink to prevent the risk of choking and maintain good nutrition. Risks to people were managed safely. The premises were purpose built and as such did not present significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEP's) in care plans which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood. Fire safety checks were carried out and this included evacuation practice. A fire risk assessment was in place and actions identified had been completed.

People their relatives and staff told us there were sufficient staff to support people safely and meet their needs in the home. We reviewed staff rotas and saw staffing was as described by the registered manager. We noted the provider used agency staff to support existing staff in their duties. We looked at the information sent by agencies to the provider about the staff they were supplying. We noted this information was relevant and up to date; it included DBS status documentation, evidence of staff qualifications, training and experience, in addition to photographs of staff for identification purposes. Safe recruitment practices were followed before new staff were employed to work with people. The relevant checks were made to ensure staff were of good character and suitable for their role.

There were safe medication administration systems in place. Policies and procedures were available to guide staff and staff completed training in safe medicine administration. Medicine Administration Records (MAR's) were completed to show people received their medicines when required. Protocols were in place to guide staff on the use of medicines prescribed 'as required'. Medicine errors were investigated and acted on

to prevent a reoccurrence. People's medicines were managed safely.

The home was clean. We did not detect any malodours during our visit. The provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves. There were hand hygiene stations around the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff had a good understanding of infection prevention and control issues; they received regular training and updates in this area.

Safety incidents in the home had been investigated by the provider and in full cooperation with other organizations such as the local authority safeguarding team. Lessons had been learnt from incidents and improvements had been made to the service to promote people's safety. For example; risks to people from falls on the stairs had been assessed and actions taken to promote people's safety in this respect. Staff training and risk assessment had been improved following an incident when a person had fallen from a bath hoist. We identified an area of the home which could present a risk to people and the registered manager took immediate action to make this safe. This approach of learning from and acting on incidents helped to keep people safe.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they received effective care that met their needs. One person's relative said "My wife was brought into the home after falling at home, she has improved since being here. The care here is excellent."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed that mental capacity assessments and best interest meetings with the appropriate parties had been carried out prior to an application for a DoLS authorisation. These records clearly outlined why authorisation was being sought.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

When people were assessed as not having the capacity to make specific decisions about their care and treatment, decisions were made in their best interests. Records showed the provider had obtained evidence that those relatives and representatives making decisions about people's care were entitled to do so, through the possession of Lasting Power of Attorney for Health and Welfare. However, we found that decisions made about the use of bed rails had not been subject to this process. Bed rails are a restraint because they have the potential to restrict a person's freedom of movement. It is therefore necessary to ensure either the person consents to using these or that a mental capacity assessment and best interest decision process is followed if they are not able to consent. We did not find that bed rails were used to restrain people, and the registered manager had considered the issue of restraint when assessing people for DoLS. Although people's capacity was assessed for most relevant decisions, an improvement was required to ensure the use of equipment that can restrict people's freedom was assessed in line with the MCA.

We asked staff about issues of consent and about their understanding of the MCA. All the staff members we spoke with could tell us the implications of DoLS for the people they were supporting. One staff member told us, "We assume everyone has (mental) capacity unless we can prove otherwise". Another staff member said, "Someone without mental capacity can still make decisions for themselves sometimes, even if they're small ones". This meant people were supported by staff who understood the principles of the MCA.

The home provided a comfortable and homely environment for people. Facilities included a quiet lounge and a TV lounge to meet people's preferences and the garden was wheelchair accessible to raised beds so people could participate in gardening activities. There was a coffee bar in the dining room that provided a social area where people and their relatives could get drinks and snacks. There was lots of natural light coming in particularly in the newer part of the home and the level into the garden provided at a good flow for people to access this safely. There were plans to upgrade parts of the older building which had some

worn carpeting and decoration. People's doors were personalised with photos or an object of interest and where people had a DNACPR (Do not resuscitate) in place this was identified by a discreet lilac banding on their door as an immediate prompt for staff and emergency services.

The registered manager told us they referred to a range of guidance to support best practice including information available for providers by CQC. We saw the tools used to assess risks to people from malnutrition and pressure sores were nationally recognised and provided a good standard of assessment. NICE (National Institute for Health and Care Excellence) recommendations were followed to check staff competency to administer medicines This supported staff to provide care and treatment in line with current best practice guidance.

The registered manager told us staff completed training in equality and diversity as part of their induction training. This helped raise staff awareness of people's diverse needs and to understand the impact of these on their everyday life. Care records included details about people's chosen faith and any support they needed to continue with this practice. Arrangements were in place for people to attend religious services within the home. When people had requested personal care by a same sex carer this had been facilitated. The registered manager gave us an example of how they had identified a person, who had not expressed a preference, but had responded more positively to carers of the same sex and this had been implemented to ensure they received the personal care they needed. Whilst people's diverse needs were considered and assessed in areas such as age, disability, gender and faith this did not include sexual orientation and people's sexuality was not included in their needs assessment or care plan. We asked the registered manager how they identified people's needs in this respect and they said although this was not directly asked about they "Built on information from the person and their family" as they got to know them.

We recommend the service finds out more about ensuring person centred care, based on current best practice in relation to the needs of people with protected characteristics under the Equality Act 2010

The service had arranged for a town councillor to visit to advise people on their right to vote. This supported people to maintain and exercise their human rights.

Staff told us they had the training and skills they needed to meet people's needs. This included induction training when they started working at the home and refresher training to maintain their knowledge and skills. The staff training records confirmed this.

New staff shadowed senior staff for at least one week when starting employment. There was also a 'mentor' system in place to ensure new staff had access to help and support from experienced staff when they needed it. All new staff completed the Care Certificate, which familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. The staff we spoke with were satisfied with this process. One staff member said, "I was new to care so it was brilliant. It was good to have someone to go to".

Staff could access training in subjects relevant to the care needs of the people they were supporting. Training was provided by a variety of methods, including e-learning, one to one and classroom based group learning. In addition to this, all staff had access to professional development training and there were some innovative training sessions planned. These included the use of age simulation suits and 'manikin' personal care training. Train the trainer training was planned so that some staff would be able to train other staff in moving and handling and medicines. This meant people were supported by appropriately trained staff.

All staff had received supervision in line with the provider's policy. The staff we spoke with were happy with

this process. One staff member said, "It's very open and honest; I can say what I like and my senior is brilliant".

People were supported to access services to maintain and improve their health and this was documented in people's care plans. This included a variety of core and specialist external services. For example, referrals had been made on behalf of people to agencies such as dieticians, speech and language therapist (SALT), the Older People's Mental Health Team, district nurses, opticians, physiotherapy and occupational therapy, two local GP's and McMillian nurses. People's health care needs were monitored and changes in their health or well-being prompted a referral to their GP or other health care professionals. A regular weekly GP visit was used for less urgent concerns.

The staff were aware of people's dietary needs and preferences. People's needs and preferences were also clearly recorded in their care plans. We saw people were served food that met their needs in relation to any special diets and consistency of food. People were referred appropriately to the SALT and dieticians if staff had concerns about their eating or drinking. For example; when people were at risk of choking or experienced other difficulties with eating.

Individual targets were calculated for people's fluid intake according to their weight and risk of urinary tract infections (UTI). Records were kept of fluids given to monitor input and support people to drink adequate amounts. People were supported with their eating and drinking needs to protect them from malnutrition and dehydration.

Most people spoke positively about the food served. Staff ate with people during lunch, the atmosphere was sociable and relaxed. People were chatting together and with staff, dining tables were made attractive with fresh flowers. One person said, "The food is lovely" and another person said "Food is fine you can't please everyone! We get plenty." One person said "If you really don't like it you can ask for something else, it is very monotonous, the same soup every night and same selection of sandwiches. They have too much pasta, I don't like pasta!" A choice of meal was not offered at lunch time. We were told by staff that people could request an alternative if they did not like the meal and we did see people were eating alternatives. However, some people living with dementia, may benefit from being shown a choice of meal at the time it is served as they may not understand a choice can be requested. Similarly, choices for evening meal were made in the afternoon, some people with short term memory loss might think the food is being served then and there and forget what they ordered later.'

Good

Is the service caring?

Our findings

People and their relatives told us the staff were kind and caring. A relative said "They (staff) know mum so well, they know if she is not in a good mood and they listen to her." One relative told us how impressed they were with the way in which staff handled the "difficult" communication from their relative. People told us their visitors were welcomed into the home and how staff respected their preferences for how they spent their time and their decisions about their care.

We observed staff interacting with people throughout the inspection. We noted staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people. There was a high level of engagement between people and staff who took time to explain their actions to minimise people's anxiety and consistently took care to ask permission before intervening or assisting. The registered manager told us they monitored staff interactions with people and said, "I am very active in the building I go out on the floor and it's not unknown for me to work alongside new staff to see how people interact".

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and could explain to us people's individual needs and requirements. For example, staff knew people's food preferences without referring to documentation. Those at risk were monitored closely but discreetly where necessary; for example, those presenting with choking risks. It was evident staff saw people as individuals, the registered manager promoted this and introduced a 'wish list' for people living at the home, whereupon people could ask for a wish to be granted. The registered manager said, "This promotes choice for people and is a good window for us to know what people want". For example, one person's wish was to see the view from the top of the Spinnaker Tower in Portsmouth, which was granted.

People and their relatives or representatives were involved in making decisions about their care and treatment. People's care plans were discussed with them along with those people who were authorised to be involved. These were reviewed and evaluated monthly, the registered manager told us the plans were read to people for them to agree or change. People and their relatives confirmed they were involved in planning care and the decisions they made about their care and treatment were respected by staff.

Residents meetings were held six monthly and the registered manager told us they planned to increase the frequency to three monthly. People could express their opinions and views about the care they received and make suggestions for improvements which were acted on. For example; people had requested that better quality toilet paper was purchased and it was. People had reported in the meetings that they were "happy" with the outings offered and that staff were kind.

People were supported to maintain their important relationships and visitors were welcomed into the home. One person told us "My husband comes to see me all different times of the day and I often go out with him." A person's relative said "I come in to see mum anytime and I am always welcomed at the door, I can have lunch if I want it." The registered manager said" We try to create a homely environment and part of

creating a family atmosphere is to invite people in, we invite people's guests to lunch at no extra costs." The home also provided family tea parties and birthday parties for people.

People's privacy, dignity and independence was promoted. Staff knocked on doors before entering bedrooms, bathrooms and toilets and waited for a response before entering. People received personal care in the privacy of their bedrooms, bathrooms and toilets with doors closed. Some people preferred to spend time alone in their bedrooms and people told us this was respected by staff. Staff and the registered manager explained other ways in which they promoted people's privacy dignity and independence. This included ensuring intimate care was provided by the persons preferred gender of carer and encouraging people to do as much as they could for themselves.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability, impairment or sensory loss can access and understand information they are given. Care plans included information on people's communication needs and any equipment used to improve communication. Staff we spoke with knew about the communication needs of the people they supported and how to meet them. The registered manager told us they had some resources available to support people's information needs such as access to large print books and audio tapes for people with a sight impairment and added "Any requests would be met". We noted that one person with a sight impairment struggled to read the activities list and said, "I often miss things, I think afterwards I should have gone". We discussed this with the registered manager and suggested a large print activities list in bolder print may be beneficial which they said they would address. The registered manager confirmed information about people's communication needs was given to other health and social care professionals as requested.

Good

Is the service responsive?

Our findings

People received care and support that was personalised to their individual needs and wishes. People's needs were assessed and a care plan was developed for all their identified needs. Care plans clearly identified the area of need, what the intended outcome was for the person and the measures staff were to take to enable the person to achieve this. Care plans focused on people as individuals taking account of their choices and preferences. For example, one person who was living with dementia, their care records stated their former occupation was a plumbing/heating engineer. To support this person's psychological wellbeing, the care plan guided staff to encourage activities and social interaction. Staff had arranged for items such as washers and other plumbing equipment to be made available to the person to promote a sense of purpose and activity.

Discussions held with people and staff and observations showed people received care and support which was responsive to their needs and achieved positive outcomes for people. For example, people's relatives told us how their relatives had improved their mobility and put on (needed) weight since coming into the home. A relative said "My wife has her weight checked regularly, they encourage her with her eating and drinking. Her mood is so much better now." We observed that staff were responsive to people's needs and addressed them promptly and courteously.

Daily handover meetings took place at each staff changeover. We attended a staff handover in the afternoon. This was person centred and relevant to people's care needs. It was not task oriented, rather it was focused on how developments in people's care needs affected them and how they perceived them. It was possible to 'see the person' from these discussions. This promoted individualised person-centred care for people.

People were given the opportunity to take part in a variety of activities within the service and in the local community. The activities coordinator organised and facilitated activities for people and this included both group and one to one activities. People spoke positively about the activities on offer in the home and told us there was a good choice of things to do and they had a choice as to whether they took part or not. A person said, "I prefer to be in my room, if there is something I want to do or watch I just let them know." A person's relative said "My father loves the drum workshop and the harpist."

Activities were developed to meet people's needs and interests, and included the opportunity for people to use their skills and experience. For example, a poetry club had been run by a person with a background in teaching English. A stage make up activity had been put on for a person with experience in the theatre. There was a gardening club where people had grown vegetables as well as flowers for entry into the local town in bloom competition. There was a resident 'Glee club' which included the opportunity for people to participate in productions as well as enjoy the entertainment.

There was a good amount of visiting entertainment provided with activities such as pet therapy, including everything from donkeys to tarantulas. An intergeneration group with visiting nursery children, visiting singers and a visiting harpist, along with yoga, games, and quizzes. Outings were also planned and this

included group outings and one to one outings such as shopping, or a coffee in town. The home provided a range of activities to support people's need for activity and stimulation.

The registered provider had a complaints policy and procedure with was made available to people, family members and other visitors to the service. There was information about how to complain displayed in the home and it was given to people on admission to the service. People and family members, we spoke with who had made a complaint told us the issue had been dealt with to their satisfaction. A person's relative told us their complaint was taken up straight away by the registered manager and "Sorted out efficiently." All the relatives we spoke with said they knew if they had a concern they could go to the registered manager or the provider. The registered manager told us that people do raise concerns in meetings and will come forward. They said "We will address these concerns as they arise, for example something about cooking will be fed back to chef immediately. We listen to people and I pride myself on sitting down and listening to people." The registered manager maintained a log of complaints made, including who made the complaint, the nature of it, the actions required and any further actions and the outcome.

The registered manager told us that when people came into the home a 'thinking ahead' advance care plan was given to people and their families. They said this was because "Its nicer for people to discuss this with their family." However, the registered manager said that families and/or people do not always complete and return this care plan. The registered manager had identified the need to continue to encourage people and their representative to discuss their end of life wishes as part of their quality assurance action plan. Training was planned for staff in palliative care and death, dying and bereavement for July and August 2018.

The home had received many compliments from people's relatives about the care of their relative, and the support provided to the family when the person died at the home. This evidenced that although plans were not always in place people received sensitive, appropriate, caring and compassionate care at this difficult time. For example, a family had written "words cannot express the level of gratitude that we feel towards you and your amazing staff at Downs House for the care of our mother over the last 4 months" the letter goes on to describe "exceptional" care by staff. Another family wrote "Your compassion in these last few months has been outstanding and we are so very grateful to you".

Good

Is the service well-led?

Our findings

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

People and relatives, we spoke to all knew who the manager was and felt they were approachable. A person said, "If I want to know anything I ask (name) the manager." Relatives were very positive when talking about the registered manager. They told us they were confident in the abilities of the registered manager and the heads of care who they felt would act on any concerns or complaints. One relative spoke very highly of the home saying "I can't rate the place highly enough, when looking for somewhere for mum I went around places like morgues. I walked in here I was greeted and so was my mum with respect. There is always laughter here. It is lovely".

The registered manager told us they were "Completely dedicated to providing the highest quality of care". They told us how they promoted a positive approach with their staff team which included; leading by example, valuing the work of their team and sharing their values which included "If we can make the slightest bit of difference to someone, by looking at the flowers or having a laugh together. If that makes someone's life a bit better, that's worthwhile. I feel privileged to care for these people who are someone's mum or dad".

There was a clear management structure in place, with staff being aware of their roles and responsibilities. Staff felt that they could approach the registered manager with any concerns and told us that the management team were supportive and made themselves available. Comments included, "The manager is the best I've known. Really approachable and a lovely person. They will even put an apron on and help with the care, with me telling her what to do!". Another staff member said, "The manager is on the floor a lot and is always available. Things are so much better now". All staff we spoke with during the inspection said they felt listened to by the registered manager.

We looked at the minutes of recent staff meetings. There were separate meetings for day staff, night staff, senior carers and domestic staff. All were attended by the registered manager and held monthly. The meetings were well attended and issues of importance to the effective running of the home were discussed, such as medicine management, care planning and communication. There was an agenda set in these minutes, a review of previous meetings' minutes and action planning. Consequently, it was possible to ascertain from these documents if, when and by whom issues were resolved.

The registered manager told us that they were well supported by the provider and business manager who were based on-site. The provider had developed a programme of staff incentives and rewards. These included discount cards for use with retailers, long term service awards and overtime bonuses, in addition to free smoking cessations sessions and free staff meals. This supported staff to feel valued by their employer. The registered manager said, "Happy staff, happy residents, happy home."

The registered manager had systems in place to review, monitor and improve the quality of the service delivery. This included a comprehensive programme of audits. For example, audits of infection control, medicines, weights, catering, wounds and accidents. Actions for improvements were identified from audits and although not all actions had been recorded as completed on these audits, we saw evidence to support the actions had been taken. All actions from audits were collated onto the manager's quarterly audit to track and monitor progress towards completion. Audits had resulted in improved outcomes for people. For example; an analysis of accidents had resulted in a reduction of falls for people as actions had been taken to address trends such as falls at a time. Actions taken included increased staff checks on people at higher risk times and the addition of a movement sensor to alert staff that the person may be moving about and at risk of a fall.

People and their relatives were encouraged to give feedback about the service by annual satisfactions surveys, these were due to be distributed at the end of June 2018. Regular 'resident and family meetings' were held and these resulted in improvements for people based on their feedback. For example, there was a request for additional call bell points in the lounge and these had been ordered. The registered manager told us staff were asked for their feedback during supervision and in team meetings. Improvements suggested by staff were acted on for example the manager told us, "Staff came up with the idea of dividing the house for medicine rounds, this meant the round was completed quicker and to the benefit of everybody".
Systems were in place and used to gather feedback from audits, people, their supporters and staff to drive continuous improvements to the service.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events. The registered manager was aware of the Equalities Act 2010 and policies and procedures were in place to support people's rights and responsibilities in this respect.

The service worked with other agencies to support people's needs and achieve positive outcomes for people. This included, local schools and churches, community health and social care professionals