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?	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 25 and 26 February 2016 and was unannounced.

Downs House provides accommodation and care for up to 37 older people, some of whom may also be living with dementia. At the time of the inspection, work was underway to complete an extension to the home. The extension, when completed, will provide 12 extra bedrooms with ensuite wet rooms, a new kitchen and an orangery. There were 33 people using the service at the time of the inspection and one bedroom was not in use due to the building work.

Downs House has 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.

People said they felt safe. Staff had received safeguarding training and were able to explain how to protect people from abuse and how to report suspected abuse.

People's individual risks were appropriately assessed and care plans were in place to mitigate known risks. Staff were knowledgeable about risks to people and what actions needed to be taken to keep people safe.

There were sufficient staff on duty. People's needs were met whether they were in the communal areas or being cared for in bed.

Staff recruitment and induction practices were safe. Relevant checks were carried out to ensure that suitable staff were recruited.

Medicines were stored and administered safely. Records in relation to medicines were accurate and staff had received training in medicines administration, and had their competency checked regularly.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and first aid. Staff were supported to study for health and social care vocational qualifications. Staff told us they felt supported in their role.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. We saw that staff interacted with people appropriately and kindly, appearing to know them well as individuals, and treating them accordingly.

People were asked for their consent before care or treatment was provided and the provider acted in

accordance with the requirements of the Mental Capacity Act 2005 (MCA). People made their own decisions where they had the capacity to do this, and their decisions were respected.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. For lunch a main meal was offered, with alternatives available. The chef was knowledgeable about people's individual requirements such as those people who required a pureed diet, a soft diet or a diabetic diet. We saw that staff maintained a presence in the dining room during lunch, checking that everyone was managing and offering support if needed.

People were supported to maintain good health through access to ongoing health support. Records showed that district nurses, speech and language therapists and the GP had been involved in people's care and referrals were made where appropriate.

Staff were kind and patient with people, using gentle persuasion and encouragement to support them. They took time to listen to people and understand how they were feeling. People's dignity was respected. People were supported to be as independent as possible.

People were involved in decisions about their care and were offered choices in all aspects of their daily life. Where they had capacity, people had signed their care plans showing that they agreed with the plan of care.

Staff were able to respond appropriately to people's needs because they knew them well and understood their care needs. Staff had taken the trouble to get to know people personally so they could respond to their preferences, likes and dislikes and provided personalised care. Care plans were reviewed monthly and updated where necessary to ensure that staff were always aware of people's needs.

People were able to engage in different activities, such as scrabble, yoga or listening to music. People being cared for in bed were included in activities and staff visited them in their room. Harp therapy was available for people as a soothing activity.

The provider had a complaints procedure which detailed how complaints should be dealt with. There were a small number of complaints and all had been dealt with appropriately.

The atmosphere in the home was friendly and easy going. The registered manager was passionate about the home and keen to make improvements. There was a family feeling amongst staff who were united and keen to ensure people were happy and well cared for. Staff felt valued and involved in decision-making and this reflected in the care delivered.

Feedback was sought regularly from people, staff and relatives and was responded to, ensuring continuous improvement to the home.

The registered manager demonstrated good management and leadership. She ensured she was visible 'on the floor' on a daily basis. People knew and trusted her.

Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored.

The quality of the service was closely monitored through a series of audits including care plans, the kitchen, infection control, health and safety, falls and medicines.

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 told us they felt safe. Staff had received safeguarding training and knew how to recognise the signs of abuse.

Risks were appropriately assessed and actions were taken to mitigate known risks to keep people safe.

There were sufficient staffing levels to meet people's needs.

Medication was stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training to meet people's needs and had detailed knowledge about people's individual preferences. Staff delivered care in line with people's individual needs and wishes.

People, who were able, gave consent to their care. For people who were unable to give consent, the provider complied with the requirements of the Mental Capacity Act 2005.

The provider knew about the Deprivation of Liberty Safeguards and had made appropriate applications in this respect.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff were aware of special diets and dietary preferences.

People were supported to maintain good health through access to ongoing health support.

Is the service caring?

Good

The staff were caring.

Staff treated people in a kind and compassionate way. They took time to make sure that people were safe and comfortable and

felt included.

People were involved in decisions about their care and were offered choices in all aspects of their daily life.

Staff described how they provided care to people and respected their dignity. People were complimentary about the care received.

Is the service responsive?

Good

The service was responsive. Staff were able to respond appropriately to people's needs due to their detailed and accurate care plans, risk assessments, daily records and handovers.

Staff had taken the time to get to know people personally so they could respond to their preferences, likes and dislikes, thereby providing personalised care.

The provider had responded to complaints appropriately and was responsive to people's views.

Is the service well-led?

Good

The home was well led.

There was a positive and open culture within the home where feedback was actively sought and responded to by the provider. Staff and people using the service said they felt listened to.

The registered manager demonstrated good management and leadership.

The provider actively monitored the quality of care and took appropriate actions where necessary to drive service improvements.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 26 February 2016 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. Prior to 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 improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During our inspection we spoke with six people using the service and three of their friends or relatives. We also spoke with the registered manager, the deputy manager, the chef, the activities co-ordinator, resident support and three care workers. We reviewed records relating to five people's care and support such as their care plans, risk assessments and medicines administration records.

Some people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation of their care and support.

We previously inspected the home in August 2014 and found no concerns.

Good

Is the service safe?

Our findings

People and their relatives told us people felt safe living in the home. One person said "I definitely feel safe. They look after me well. I haven't had any occasion when I didn't feel safe here." Another person told us "I feel safe here; they keep an eye on you. They look in on you at night. They are very helpful." One relative said "She is totally safe here. She is always saying how well she is cared for and looked after. We've never had any concerns."

People were protected from abuse. Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. One staff member told us "I've had safeguarding training. If I was concerned about a resident, I would report it to the manager. I would have no qualms about doing it." Staff were also able to explain how they would recognise signs of abuse and said they would take people's concerns seriously if reported to them. A member of staff said "If I had concerns about a resident being treated badly, I would raise it with the manager. I have no doubt the manager would act on it." The safeguarding policy was available for staff to review and relevant telephone numbers were displayed on notice boards. One member of staff told us "The safeguarding policy is in the office. I used it for my NVQ4." Staff told us they were aware that they could report safeguarding concerns to outside agencies such as the police, the local authority and the Care Quality Commission.

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage. There were specific risk assessments for each person in relation to falls, malnutrition and pressure ulcer prevention. Risks in relation to falls were carefully monitored and there were a number of ways of ensuring falls risks were mitigated. These included a falls screening tool, a falls action plan, a falls risk assessment and a falls register. Two members of staff had recently attended training to be 'falls champions.' One member of staff told us "Two of us went to Petersfield fire station to do falls champion training. The trainer told us what to look for. For example, clutter in rooms, medication affecting mobility, checking people are wearing proper footwear, glasses and hearing aids. It was a very interesting course; it has made us a lot more aware of falls risks." Support plans were written in relation to the management of each identified risk for people such as mobility or social and psychological needs. Staff described how they learnt about people's individual risks from staff handovers and care plans. There was a 'pen picture' of each person's needs in their care plan. This helped to ensure that agency staff were able to identify people's risks and needs with ease. Staff we spoke with told us they had read people's care plans and knew how to manage risks to them. During each shift, a handover sheet was prepared for the next shift. Comments and updates about each individual person were recorded to ensure that any new risks identified could be passed to the next shift. This ensured consistency of care for people.

The provider explained how staffing numbers were calculated. Although no formal tool was used to calculate staffing, the provider took into account people's dependencies such as the number of people being cared for in bed and the number of people who needed two members of staff to mobilise. We observed that there were adequate numbers of staff on duty to meet people's needs. Very few people were cared for in bed, but those that were, had their needs met. Everyone we spoke with said there were enough staff to meet their needs and that call bells were always answered promptly. One person told us "There is

always someone around. You can usually find someone. You have a buzzer in your room and they answer that fairly quickly." The registered manager told us that staff sickness was usually covered by permanent staff taking on extra shifts, although agency staff were sometimes used.

Recruitment and induction practices were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were being completed for 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 saw that a DBS check had recently been carried out for a member of staff who had worked in the home for several years. This assured the provider that staff continued to be suitable for their role.

Medicines were stored safely. Medicines were stored in a locked medicines trolley which was secured to the wall. Medicines which were used 'as required', known as PRN, or any that were in excess of the amount stored in the trolley, were stored in a locked cupboard in a locked room. Storage arrangements met the legal requirements for the storage of controlled drugs. Controlled drugs are medicines which require a higher level of security. We checked records in relation to controlled drugs and found them to be accurate. Medicines which needed to be stored in a fridge, such as eye drops, were stored in a fridge in a locked office. Fridge temperatures were recorded on a daily basis.

Medicines were administered safely. Records in relation to medicines were kept for each person using the service and included a photograph of the person and their date of birth, a list of any allergies, a list of their medicines and how they should be administered. There was a protocol in place for each person that received 'as required' medicines, known as PRN. This meant that staff were aware of when these medicines should be administered. Medication administration records (MAR) were kept for each person. We reviewed a sample of the records from the day of the inspection, which showed that medicines had been administered as prescribed. The provider carried out a medicines check every month. We reviewed quantities of medicines (including controlled drugs) in relation to records and found these to be accurate. Blister packs of medicines showed that all medicines had been administered on the day of the inspection up until the time of our review. People told us they received their medicines appropriately and on time. One person said "If I'm due my tablets, the come and find me, wherever I am. I never miss my tablets. They always wait. They won't go until I've swallowed them."

Staff, who administered medicines, had received training and their competency to administer medicines was checked twice a year. One member of staff said "We get competency checks from the manager. I had my last competency check last year." Medicines were disposed of appropriately following the medicines disposal policy.

Good

Is the service effective?

Our findings

People told us that staff met their needs effectively. On person said "I never get anything I don't like. They know what I like."

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and first aid. Some staff had also received training in palliative care and nutrition. Staff told us they had received sufficient training to meet the needs of people living in the home. There was a requirement for staff to attend training in order to keep their knowledge relevant and up to date. The registered manager told us she regularly checked to ensure staff kept up to date with their training. Staff were supported to study for health and social care vocational qualifications.

Staff had regular supervision meetings with the registered manager or deputy manager and all staff had had an annual appraisal. Staff told us they felt supported in their role and felt able to discuss any concerns with the registered manager at any time.

Staff were knowledgeable about people's needs and how to support them. Staff said they knew about people's needs from handovers, care plans, risk assessments, people themselves and their families. Staff described people's individual needs and how they supported them. For example, one member of staff told us that "We find out about people's interests from family and friends. We try to carry on with people's interests. For example we have a person who used to attend dance classes. On Wednesday she was teaching us all the tango."

We saw that staff interacted with people appropriately and kindly, appearing to know them well as individuals, and treated them accordingly. For example, we heard staff talking to one person in French. The person's care plan described that sometimes the person liked to be spoken to in French.

People were asked for their consent before care or treatment was provided. One person said "They ask permission before they do anything. They knock before they come into my room." Another person said "They always ask before they do anything. They are polite like that." People told us they were offered choices such as what time they would like to go to bed. One person said "They are wonderful about my choices. They listen and are very understanding." People had signed their care plan to consent to their written plan of care.

Where people lacked capacity to make specific decisions, the home acted in accordance with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. Where 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. Mental capacity assessments had been completed which were decision specific. For example, a mental capacity assessment had been carried out for one person about their decision to live in

the home. We found that staff had received training in the MCA and were able describe the principles. People were supported to make their own decisions where appropriate. One member of staff said "We give people as much support as possible to make decisions. We have one person who can't communicate. It doesn't mean they can't decide. We look at what they used to do and their preferences. We also look at their body language and facial expressions. We still ask permission, ask if they like things and offer decisions." This showed that the registered manager and staff had understood the MCA and had abided by its principles.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked 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 that the registered manager understood when an application should be made and relevant applications had been submitted for people.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. Drinks were readily available throughout the day and staff encouraged people to drink. We saw people had easy access to drinks and people who were nursed in bed had drinks which were in reach. Drinks, biscuits and cake were served mid-morning and mid-afternoon. Drinks were offered during and after lunch and hot chocolate in the evening. One person said "I am offered drinks regularly." Another person said "We get a cup of tea and a biscuit in the morning and afternoon. In the evening we get a Horlicks."

The chef told us that menus were worked out in line with people's preferences, ensuring healthy balanced meals. She told us that each day a main meal was offered, a second choice was available which included food such as jacket potatoes, omelettes or fish. One person was vegetarian and the chef discussed their food choices with them on a daily basis. On the day of the inspection they had chosen an omelette. The chef was knowledgeable about people's individual requirements such as those people who required a pureed diet, a soft diet or a diabetic diet. One person required a lactose free diet. Records of these requirements held in the kitchen matched with people's care plans, staff knowledge and what people ate. One person said "Sometimes they give you a dinner and I tell them I can't eat that, they give me something else. There is plenty to eat." Another person said "If I want anything special, they will usually bring it in. They come round regularly and tell you what's on the menu." We observed lunch to be a sociable occasion, with lots of chatting and banter between staff and people. Tables were laid with cutlery, napkins and fresh flowers were on the tables. People who required support to eat were appropriately supported by staff.

People who were identified as at risk of malnutrition, through risk assessment tools, received food supplements. Weight was monitored monthly by the registered manager. Where people had lost significant weight the registered manager had taken appropriate action such as informing the GP. Food and fluid monitoring charts, required improvement as they were not always kept up to date by staff. However, we were able to determine that those most at risk had drunk sufficient and that monthly weight monitoring mitigated the risk of malnutrition to people. The registered manager produced improved food and fluid monitoring charts for use by staff during the inspection. Weight records showed that some people had gained weight. One person said "They weigh me regularly. I've put weight on." One relative reported positively about their family member's increased appetite. They told us "She loves the food. There's plenty of food and drink here. It's been a positive experience. She is much better than she was at home. She wasn't eating much at home, her appetite has improved here."

People were supported to maintain good health through access to ongoing health support. Records showed that district nurses and speech and language therapists had been involved in people's care and

referrals were made where appropriate. One person told us "I went to the opticians yesterday. A carer went with me." Another person said "I had an appointment at the hospital. The staff took me." People told us that a GP was called whenever they were not well. One person said "They get me the doctor promptly if I need to see one." During our inspection the GP called at the home to see some patients. He told us that he did not have any concerns about care in the home. He said he had a good working relationship with the registered manager and other staff. He was positive about the way the staff in the home communicated with him; he felt this was important as he required the support of staff to make an assessment about when to visit a patient. This positive relationship ensured that people received appropriate care and treatment from the GP when they needed it.

Good

Is the service caring?

Our findings

One person told us "On this floor we are all very friendly. It's more like a family than a home." Another person said "If you want something and it's possible, they will do it for you." A member of staff said "It's their home, they live here, they have to feel safe, comfortable and happy."

Staff were kind and patient with people. One person was being supported to eat by a care worker. They waited between mouthfuls to ensure the person was ready for the next one asking"OK, are you ready?" They also made conversation with the person, who had no verbal communication, for example "Did you watch the football last night." This ensured the person felt included in the process. A relative said "The staff are very respectful. The youngsters here are nice and kind. They don't rush them at dinner time. They are patient and caring."

Staff respected people's feelings. One member of staff said "We had a lady who was very confused and crying. She felt her family had gone and left her. We spent extra time with her to help her settle. We also approached her family to get as much detail about her background and what she liked to do, to help her in settling." Another member of staff said "(a person) is the only person who can't communicate in any way. I go and sit with (them). I talk to (them) and hold their hand." One person said "They will give you a cuddle if you want. They are all lovely. I couldn't fault any of them."

Staff were caring and understanding. One person said "They know me by name; the staff are very nice. I like it here very much." A relative said "They always pop in to see her. Last week she didn't want to go to communion downstairs. The priest came up and did it in her room. It was very inclusive. We have no concerns about her here."

People had positive views about the staff and demonstrated that they liked them. One person said "The staff are a happy bunch. We were dancing yesterday morning. We have yoga exercise on a Wednesday morning." Another person said "I am sure the staff do understand me. We have good laughs together. They have taught me a few words of Polish and Bulgarian. I pick them up if they mispronounce English words."

People were involved in decisions about their care and were offered choices in all aspects of their daily life. The registered manager told us that care plans were discussed and agreed with people before they signed them and that relatives were also included in the process. A member of staff told us they always gave people choices. Where people weren't verbally able to choose, staff said they used other ways of understanding people's choices. For example, by observing their facial expressions and body language. One member of staff said "We promote people's dignity by respecting their choices. For example, if they want to stay in bed; even if we don't agree we have to respect their choices."

People were supported to be as independent as possible. One person said "They are very helpful. But if I can do things I would rather do it myself. They understand that." Another person said "They certainly encourage me to do as much as I can for myself." A member of staff told us "I let people do as much as they can for themselves by supporting them to go for days out. (A person) goes to Winton House on Mondays; we arrange

a lift for her." During lunch we observed one person being supported by a member of staff. The person was offered a plate guard to enable them to eat their meal and a spoon instead of a knife and fork. The member of staff helped the person by putting food on the spoon for them. The person was then able to use the spoon to eat their lunch. This level of support ensured that the person was able to remain as independent in eating as they could be. Staff had an understanding of people's abilities and supported their independence as much as possible.

People's privacy and dignity was respected. Staff were courteous and knocked on people's doors before entering. One member of staff said "I do think the residents are treated with dignity and respect. I've seen that staff knock on doors, and ensure people's doors are closed to maintain their privacy." People were appropriately dressed. Staff had taken time to know people, which showed they respected them as individuals.

Good

Is the service responsive?

Our findings

Staff were able to respond appropriately to people's needs because they knew them well on a personal level and understood their care needs. Staff had taken the trouble to get to know people personally so they could respond to their preferences, likes and dislikes and provided personalised care.

Care plans contained information about people's abilities, their desired outcomes and the support they required to achieve them, including any identified risks. People's personal histories were included in their care plan and their choices and preferences were reflected. Where other people had been involved in discussing a plan of care, this was recorded. Care plans were reflective of people's needs and wants.

Staff were knowledgeable about people's needs and preferences, for example, the moving and handling equipment they required, what they liked to eat and wear and where they liked to spend most of their time. Staff knew who liked to stay in their room, who was friends with whom and what activities people preferred. One member of staff told us about a person who was at risk of choking and required thickened fluids. They knew how to mix the thickened fluids to the right consistency and also that the person required repositioning every two hours to reduce the risk of pressure ulcers. People who had been assessed to be at high risk of acquiring pressure ulcers had their skin checked twice daily to identify any red areas. This ensured they were treated appropriately before their skin started to break down. For any areas which had been identified as red, staff were required to record what action they were taking as a result.

Care plans were reviewed monthly and updated where necessary. Comments were recorded each month, in each part of the care plan, as part of the review showing that each part of the care plan had been considered individually. Weekly keyworker updates were opportunities for people to discuss if they would like their care provided differently. This meant that care plans were up to date and staff were always aware of people's needs.

People were looking forward to the completion of the extension. The new rooms were larger and all with an ensuite wet room. One person said "I have applied for a bigger room with a ceiling hoist in the new extension." The provider told us that people already living in the home would be given first refusal for the new rooms. There were plans for the orangery in the new extension to include a coffee bar and coffee machine for people and their families.

People were able to engage in different activities. A plan of the month's activities was given to each person at the beginning of the month so they were able to plan which activities they wanted to attend. The activities co-ordinator kept records of preferred activities to ensure that planned activities incorporated everyone's preferences. A part time member of staff had been recruited to provide 'resident support'. They told us they talked to people; played scrabble and took one or two people out to lunch. We observed them playing scrabble with people during the inspection. Staff told us that people who were nursed in bed were visited by staff to ensure they felt included in activities. The activities co-ordinator told us "I've found out about the residents here by sitting and chatting to them. I've got a list of what they enjoy. I do one to one's with people who stay in their rooms. I pop in daily. When the pony visits we take it up to visit people in their rooms, and

they get to have a chat. They love animal visits. We've had owls, donkeys and we have a pat dog." They went on to say "I invite everybody to join in the activities. I have just gone into the library service. They are coming once a month. Residents have newspapers daily, as some are avid newspaper readers. Some residents have their own newspapers, but there are also communal copies in the lounge."

People told us they engaged in a wide range of activities. One person said "I can choose what I want to do. Yesterday we had arranged a game of scrabble. However, we heard the man on the accordion and decided to go there instead and sing. We have a pony who goes round bedrooms. They bring him in each room to see everybody. When I tell people all the things that go on they say it doesn't sound like an old people's home." Another person told us "Once a week we have an outing. If it is miserable we still go, they take a flask of tea and coffee and biscuits. We take in the views; it's a change of scenery. In nice weather we've been to All Hallows and had drinks and ice cream; some walked down to the sea. We go to garden centres quite a lot as they are indoors." People were involved in community activities. The chef made cakes for a drop in café which one person visited weekly. This was important to the person as they used to volunteer in the café. One person said "I have some good friends in the town. I go out often; I visit art galleries and the theatre." The person also told us about a poetry club they had arranged in the home which was attended by some of their ex-students. The registered manager told us that people were receiving harp therapy. Harp Therapy is a general term used to describe the various therapeutic applications involving harp music. Harp music is soothing and calming and recognised as a healing instrument in some cultures.

The provider had a complaints procedure which detailed how complaints should be dealt with. Everyone had been given a copy of the complaints procedure. We found that all written complaints had been dealt with appropriately and in a timely manner. Staff confirmed they would go to the manager if they had any concerns and people were given opportunities to raise concerns either through residents meetings, keyworker reviews or just by talking with staff. Records were also kept of cards and letters of thanks. There was evidence that the registered manager had been responsive to issues raised during residents meeting. At the last resident's meeting people had requested different toilet paper, and this request had been responded to. One person told us "I raised an issue about the quality of the toilet rolls, they were like tissue paper. They actually changed the toilet paper to a better quality." People also said they would like some different vegetables, other than peas. During the inspection we observed that courgettes were served with lunch.

Good

Is the service well-led?

Our findings

There was a positive and open culture within the home. Staff said they felt able to raise concerns, and were confident they would be responded to. One member of staff said "If I did raise an issue with the manager, I think she would listen. I've been here for 13 years, under four managers; she is one of the best ones. She's fair, she listens to us and she doesn't have favourites." Staff said they were actively encouraged through meetings and appraisal to give feedback about the service. A noticeboard in the staff room encouraged staff to post up ideas. One member of staff had suggested taking people swimming and this was currently being looked into. One member of staff said "I think there is an open culture. I could raise concerns. I raised concerns with the manager due to staff speaking in their own language on shift. The manager was very good and dealt with it immediately. She didn't single anybody out, but spoke to staff as a group." Another member of staff said "It's a very fair and open culture here, residents could raise issues." One person told us "I think they care well for people. I know the manager; she is approachable if I needed to speak to her. I get the impression they are fair here."

The atmosphere in the home was friendly and easy going. The registered manager was passionate about the home and keen to make improvements. There was a family feeling amongst staff who were united and keen to ensure people were happy and well cared for. Staff felt valued and involved in decision-making and this reflected in the care delivered. One member of staff told us "The manager makes me feel valued and motivated." Another member of staff said "I know what is expected of me, that is to support the residents here, to enhance their lives."

Minutes of residents meetings were available which documented that people were asked for feedback and suggestions in relation to activities, trips and food. People were also kept informed about developments in respect of the extension. Staff also had opportunities to feed back during supervision meetings and regular staff meetings. Staff said they could raise any issues or concerns with the manager at any time.

The registered manager demonstrated good management and leadership. She ensured she was visible 'on the floor' on a daily basis. People knew and trusted her. She told us that sometimes she helped 'on the floor.' On the day of the inspection she supported one person to have a bath. This showed she supported staff and ensured the smooth running of the home. She felt that good communication and a good relationship with outside professionals was key to providing a quality of care. She was open about the service during the inspection and highlighted areas she felt could be improved. The registered manager was knowledgeable about the notification requirements for the Care Quality Commission (CQC) and appropriate notifications had been submitted. A notification is an important event which the service is required to tell us about by law.

Policies and management arrangements meant there was a clear structure within the home which ensured the service was effectively run and closely monitored. Policies included staff recruitment, safeguarding, bullying, confidentiality, complaints and a code of practice. Core values of privacy, choice, dignity, independence, inclusion and fulfilment were also described within the policies. Our observations around communal areas in the home, reviewing care plans and speaking to staff and people showed that care

within the home was delivered within the core identified values. This was particularly reflected in the caring nature of staff.

The quality of the service was closely monitored through a series of audits of care plans, the kitchen, infection control, health and safety, falls and medicines. The registered manager also completed an audit which monitored the outcome of the other audits and ensured that appropriate actions were recorded and completed. This meant the provider was identifying and responding to any improvements required. Incidents and accidents were reviewed on a monthly basis to identify possible trends in relation to time, people and place. This meant the provider was identifying and responding to learning from incidents.