Horizon Care (Greenacres) Limited

Greenacres Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 and 3 November 2017 and the first day was unannounced.

Greenacres Grange is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Greenacres Grange accommodates up to 80 people in one building. At the time of our inspection 23 people lived at Greenacres Grange. Greenacres Grange was registered with the Care Quality Commission in December 2016. This was the first rated inspection for the service.

The service is required to have 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. The previous registered manager had been de-registered in September 2017. At the time of our inspection there was a new manager in post and they had started the process to become registered with the CQC.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. However, not all staff knew how to refer safeguarding concerns to the local authority where necessary. Risks were managed so that people were protected from avoidable harm and were not unnecessarily restricted. Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices.

People received their medicines as appropriate; however, there were some gaps in the documentation recording this. People were protected against the risk of infection. Themes and trends in relation to accidents and incidents were reviewed and investigations of specific incidents were carried out.

People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination and was in line with evidence based guidance but positional charts were not always fully completed. Staff received appropriate training, support and supervision. People received sufficient to eat and drink but fluid records were not always fully completed by staff.

People's healthcare needs were monitored and responded to appropriately. External professionals were involved where appropriate.

Adaptions had been made to the design of the service to ensure they met the needs of people who used the service. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; however, the service's policies and systems did not always support this practice. Assessments of capacity and best interests' documentation were not always in place or fully completed to demonstrate that proper processes had always been followed to protect people's rights in this

area.

People were cared for by staff who were pleasant and kind; staff were mindful of how people felt and offered reassurance. People were involved in decisions about their care and support. Information had been made available in accessible formats. Advocacy information was made available to people.

Staff respected people's privacy. Staff respected people's dignity and promoted their independence. People's visitors and friends were able to visit without unnecessary restriction.

Care records did not always contain sufficient information to support staff to meet people's individual needs. Staff took steps to ensure people enjoyed meaningful activities and stayed connected to their local community.

People were involved in planning their care and support. People were treated equally, without discrimination. The manager had limited knowledge of the Accessible Information Standard, however efforts had been made to ensure people with communication needs and/or sensory impairment received appropriate support.

Complaints were not always clearly responded to and were not always responded to in line with the provider's complaints policy and procedure. Processes for supporting people with end of life care were in place and there were plans to further improve them.

Systems in place to monitor and improve the quality of the service provided were not fully effective.

A clear vision and values for the service were in place. The provider was meeting their regulatory responsibilities. People and visitors were involved or had opportunities to be involved in the development of the service.

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.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. However, not all staff knew how to refer safeguarding concerns to the local authority where necessary.

Risks were managed so that people were protected from avoidable harm and were not unnecessarily restricted. Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices.

People received their medicines as appropriate; however, there were some gaps in the documentation recording this. People were protected against the risk of infection. Themes and trends in relation to accidents and incidents were reviewed and investigations of specific incidents were carried out.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination and was in line with evidence based guidance but positional charts were not always fully completed. Staff received appropriate training, support and supervision. People received sufficient to eat and drink but fluid records were not always fully completed by staff.

People's healthcare needs were monitored and responded to appropriately. External professionals were involved where appropriate.

Adaptations had been made to the design of the service to ensure they met the needs of people who used the service. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; however, the service's policies and systems did not always support this practice. Assessments of capacity and best interests' documentation were not always in place or fully completed to demonstrate that proper processes had always

been followed to protect people's rights in this area.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were pleasant and kind; staff were mindful of how people felt and offered reassurance. People were involved in decisions about their care and support. Information had been made available in accessible formats. Advocacy information was made available to people.

Staff respected people's privacy. Staff respected people's dignity and promoted their independence. People's visitors and friends were able to visit without unnecessary restriction.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not always contain sufficient information to support staff to meet people's individual needs. Staff took steps to ensure people enjoyed meaningful activities and stayed connected to their local community.

People were involved in planning their care and support. People were treated equally, without discrimination. The manager had limited knowledge of the Accessible Information Standard, however efforts had been made to ensure people with communication needs and/or sensory impairment received appropriate support.

Complaints were not always clearly responded to and were not always responded to in line with the provider's complaints policy and procedure. Processes for supporting people with end of life care were in place and there were plans to further improve them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place to monitor and improve the quality of the service provided were not fully effective.

A clear vision and values for the service were in place. The provider was meeting their regulatory responsibilities. People and visitors were involved or had opportunities to be involved in the development of the service.

Greenacres Grange

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 1 and 3 November 2017 and the first day was unannounced.

On day one of the inspection, the inspection team included an inspector, an inspection manager, a specialist professional advisor who was a nurse 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. On day two, the inspection team consisted of an inspector.

Before the inspection we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local commissioning teams. Commissioners are people who work to find appropriate care and support services for people who need them, which are paid for by the local authority or by a health clinical commissioning group. We also checked what information Healthwatch Nottinghamshire had received on the service. Healthwatch Nottinghamshire is an independent organisation that represents people using health and social care services.

During the inspection we observed care and spoke with 8 people who used the service, 4 visitors, a visiting healthcare professional, three housekeepers, the cook, an activities coordinator, two care staff, a team leader, a nurse, the manager, the nominated individual and other representatives of the provider. We looked at the relevant parts of the care records of 10 people who used the service, three staff files and other records relating to the management of the service.

At the inspection visit we asked the provider to send a number of documents which they did. These documents included how they had responded to feedback from people who used the service, visitors and staff; care plan audits and the training matrix.

Good

Is the service safe?

Our findings

A safeguarding policy was in place and staff had attended safeguarding adults training. Accessible information on safeguarding was available to give guidance to people and their visitors if they had concerns about their safety and appropriate safeguarding records were kept. Staff were aware of safeguarding procedures and the signs of abuse. However, not all staff knew how to refer safeguarding concerns to the local authority where necessary.

We spoke with staff and they knew how to support people when they presented with behaviours that others might find challenging but guidance for staff in care plans could be more detailed in this area.

We looked at recruitment files for staff employed by the service. All files contained application forms, recruitment histories, satisfactory DBS certificates, copies of ID and all had three references (this included one character reference).

We observed the administration of medicines and saw staff administered these safely. Medicines were stored securely. However, we found gaps in the medicines administration records for five people. The provider investigated this and confirmed that medicines were given appropriately but records were not correctly signed. They have reminded staff of their responsibilities in this area. Following feedback given by the inspection team at the end of the first day of the inspection, the provider introduced a weekly spot check of medication to reduce the risk of delay in identifying gaps in medicines administration records in the future.

One person told us they sometimes received their medicines late but other people raised no concerns regarding how their medicines were managed. A person said, "I get the medicines I need." Staff told us they completed medicines administration training and competency assessments prior to administering medicines independently and records confirmed this.

Protocols were in place for most medicines which were prescribed to be given only as required, although there was variability in the quality of the information they contained. A person had access to their own medicines and we saw a risk assessment was completed to ensure they were able to take them safely. A person was receiving medicines which needed to be given at specific times to maximise their effectiveness. Staff were aware of this and the person confirmed that they received their medicines at the time they were prescribed.

People told us they felt safe living at the service. A person said, "I feel safe. The amount of care and everything I get makes me feel safe. There is no bullying." Another person said, "People are always around and I have a buzzer if I need any help." A visitor said, "Oh yes, 100% safe. Far more than at home. We are happy that [our family member] is here and is safe." The manager told us that staff received equality and diversity training and were observed to ensure that people were not discriminated against. An equality and human rights policy was also in place which stated, "We will not tolerate unlawful discrimination, victimisation, bullying or harassment …"

People told us that they didn't feel unnecessarily restricted. A person said, "You can do what you like here." The manager told us that they promoted a positive risk-taking culture where people who used the service were encouraged to take part in activities that they were interested in and not unnecessarily restricted.

Individual risk assessments were completed to assess risk to people's health and safety. We saw that the premises were safe and well maintained and checks of the equipment and premises were taking place. There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans were in place for people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

Sufficient staff were on duty to meet people's needs. People thought there were enough staff in place to support them safely and meet their needs. A person said, "I have been in homes before and this is the best for answering the buzzer and the night staff are very good." Another person said, "Staff respond quickly to the bell and there's always someone around."

Staff told us that they felt that there were sufficient staff to meet people's needs and keep them safe. A staffing tool was used to calculate staffing levels and the number of staff on duty was in line with the staffing tool calculations. We observed staff respond to people's needs in a timely manner. When people needed assistance with their personal care needs or needed support with eating, staff were there to support them.

People were protected against the risk of infection. People told us that the service was clean and the laundry service was generally good. A person said, "A young lad comes in and dusts the floor with his sweeper then he does all the tops of my cupboards. He does a good job." The service was clean and staff followed good infection control practices. Staff understood their roles and responsibilities in this area and had attended food hygiene training.

Learning was identified from incidents and accidents and discussed with staff. Accident forms were completed and actions taken to minimise the risk of re-occurrence were documented. Staff understood their responsibility to report safety incidents and we saw that incidents were discussed at team meetings so that lessons were learned. A staff member said communication was good. They said they were well informed about any issues and improvements required.

Requires Improvement

Is the service effective?

Our findings

People's needs and choices were assessed and care was delivered in a way that helped to prevent discrimination and was in line with evidence based guidance. A person said, "We had a tour and we chose the room we wanted." Another person said, "They came to see me in hospital and were very nice and accepted me here." A visitor said, "The manager came to the hospital and met us. They assessed what my relative was able to do. It was nice to meet them before we went to the home. They even let us stay a night earlier than planned."

People were involved in the assessment of their diverse needs, including in relation to protected characteristics under the Equality Act. This helped to ensure people did not experience any discrimination. For example, where people had a particular faith this was recorded and staff told us about arrangements in place for those people to continue to practice with their faith communities.

Where people required specific assessments associated with their health conditions we saw referrals had been made so the assessment could be made by the appropriate professionals and in line with their professional standards.

Staff provided care to people who had skin damage or were at risk of skin damage in line with guidance. However, we saw that two people's repositioning charts were not fully completed to show that staff had supported people to change their position as frequently as stated in their care plan. This meant that there was a greater risk that people were not receiving care that met their needs. We raised this issue with the manager who agreed to remind staff of their responsibilities in this area.

Staff received appropriate training, support and supervision. People spoke positively about the skills and knowledge of the staff. A person said, "[Staff] do know what they are doing and they are very good. They know if I don't get what I want I will let them know." A visitor said, "Staff are brilliant. I like their attitude, they've obviously been trained." We observed that people were supported safely and competently by staff.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. A staff member said, "It is a really good company to work for. They want to develop people."

Staff told us they received regular supervision. A staff member said, "You can talk about anything confidentially and management are responsive to issues." Training records showed that staff had attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training and received regular supervision and appraisal.

People received sufficient to eat and drink. Feedback on the quality of food was positive. A person said, "The food is great. You have lots of choice. We are asked the night before what we want the next day and we can always change our mind." Another person said, "We can have special foods. I like the food. It's very good." A

visitor said, "The food is good. It's nice how they don't mix it all together. Even though it's a soft diet, the potatoes and meat and veg are separate." We observed lunch being served. Food was appetising and portions were generous. Where people required assistance from staff with their meals, this was provided.

A person said, "I ask for milk and they bring it me I prefer it to tea." We saw people receive drinks throughout our inspection. Fluid records were in place to record people's fluid intake where this required monitoring. However these records were not always well completed and a fluid target was not always identified. This meant that there was a greater risk that any concerns around a person's fluid intake may not be promptly identified and acted upon.

Nutritional risk assessments were completed and care plans were developed which provided information on the person's dietary and support needs. These provided key information, but information about their preferences was limited. One person was at risk of malnutrition and their care plan stated they should be offered snacks between meals and had a reduced appetite. Their food charts were not always well completed and as a result, it was not clear that they had been receiving nutrition in line with their care plan.

People's healthcare needs were monitored and responded to appropriately. People told us that they had good access to healthcare and could use their own doctor and chiropodist if they preferred. Few people had seen a dentist. A person said, "The chiropodist comes and I see my own optician and doctor when I need them." Care records indicated that people had access to health professionals and other services when needed such as the falls team, GP, tissue viability nurse. A visiting healthcare professional told us that staff made appropriate referrals to them.

Adaptations had been made to the design of the service to ensure they met the needs of people who used the service. Some people told us they found it easy to get around the service. The building layout was designed in small suites of between eight and ten bedrooms with shared communal areas. The nominated individual told us that the focus was on creating a small household to support orientation, personalisation of space by people who used the service and unique identities for each suite as they developed. Large clocks and clear information regarding the day of the week were also in place and supported people to orientate themselves to the day and time.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; but policies and systems in the service did not support this practice. A person said, "Staff always explain what they want to do." We saw staff asked permission before assisting people, giving people choices and respecting them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

When people were being restricted, DoLS applications had been made and no decisions had been received

regarding the applications at the time of our inspection. However, the requirements of the MCA were not being fully followed. When people were unable to make some decisions for themselves, some people's care plans indicated they lacked capacity to make decisions about their care and that care should be provided in their best interests. However, we did not see a mental capacity assessment and documentation to demonstrate how the best interest decision was made for the use of bedrails for one person and we did not see best interests' documentation for the use of bedrails for a second person. In a third person's records there was one mental capacity assessment for 10 areas of care, with no identification of which specific decisions were required. There was also no best interest documentation to identify who was involved or consulted in the decision making process, the alternative options considered or the specific decisions made.

A staff member we spoke with lacked full knowledge of the implications of the MCA for their practice and said they would not be confident to undertake mental capacity assessments themselves. However, they said training was being provided later in the week. The manager had a very good understanding of this area and told us that they had identified a lot of work needed to be done and had arranged further MCA training which would be taking place the following week.

Good

Is the service caring?

Our findings

People were cared for by staff who were pleasant and kind; staff were mindful of how people felt and offered reassurance. People told us that staff were very kind and friendly. One person said, "The staff are nice. They have time to listen to you. Sometimes they are busy but they do what they say they are going to do. Another person said, "[Staff] are very good towards older people." A third person said, "The staff are very kind I cannot complain they will do anything for you." A visitor said, "Staff are very kind."

Staff were attentive to people's needs and had a good rapport with people. When people were anxious and required reassurance staff provided this in a supportive manner. Advocacy information was available for people if they required support or advice from an independent person. Information was also available in different formats where required.

People were involved in decisions about their care and support. A person said, "I have my care plan here. I had it printed off for me." Another person said, "Yes I've seen my care plan. I'm happy with it." A visitor told us that were involved in their family member's care and said, "You only have to say something and it's done."

People told us their privacy and dignity were respected. A person said, "They're very good and they always knock first." We observed that care records were stored securely at all times which respected people's right to privacy. However we observed two areas of the home where people's information was not fully secure. We raised this with management and actions were promptly taken.

People told us their independence was encouraged by staff. A person said, "I go shopping every week to the supermarket and sometimes into town, I get a taxi." We observed that people were supported to eat their meals and mobilise independently where appropriate. A person required adapted cutlery and crockery to enable them to eat independently and staff provided these.

A visitor said, "I can come any time at all, I generally come in the day. You can visit in the evening too you just need to press the buzzer and the receptionist lets you in." Another visitor said, "There are no set visiting times here. We can come when we like and we came the other night for an event." We saw relatives visiting people throughout the inspection. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

Requires Improvement

Is the service responsive?

Our findings

People felt they received personalised care that was responsive to their needs. People told us that they could make decisions about their bedtime, waking and how to spend their time. They told us they could have regular baths and showers. We saw people being able to make choices about food, drink and activity participation. A person said, "We can get up when we want. A lot of people stay in bed there is no routine here." Another person said, "I can make choices about when I get up or wake up and when I do my exercises." A third person said, "The staff usually come as quick as they can when I call them."

We saw that people received care that was responsive to their needs. Call bells were answered promptly and staff responded well to people's requests for assistance. A staff member said one of the strengths of the service was that care was very person-centred. They said, "We don't go round and get everyone up, people get up when they want to. People do what they want to do, when they want to do it."

People's views were positive of the activities provided at the service. A person said, "I have been on trips and I used to go to church. Now the nun comes every Tuesday and gives communion to those who want it. A girl comes every month to do my nails." Another person said, "I do some of the activities. I did a bead workshop and I am interested in poetry and we did a poetry workshop too. I have brought some indoor bowls to play with I think they are getting a carpet [for the bowls]." People using the service were a wide range of ages and a person felt that the activities were not always appropriate for their age. A visitor said, "They had a Halloween night. We were invited and it was great for the residents. The food was very good." Another visitor said, "Activities are absolutely marvellous, lots of themed events: American, 40s nights."

We spoke with the activities coordinator who told us that she worked with people to find out about their interests and hobbies and what activities they would like to do. She told us of people with similar interests who she had introduced to each other and gave examples of where she had supported people with their specific hobbies and interests. A person had told her that they were always interested in going to America. As a result, she put on an American themed night with an outside entertainer who sang American songs and American food was put on for people.

An activities programme was in place with scheduled activities for morning, afternoon and evenings seven days a week. Regular themed events also took place. During our inspection we saw activities taking place which included musical entertainment from an outside entertainer.

Not all people we spoke to could recall being asked about whether they wanted support from a particular gender of carer. However, the one person who had expressed a preference told us they had their wishes respected by staff. A person said, "I ask for a lady to do my personal care and they provide that for me. There was one occasion when the staff had to swop floors so that I could have a lady care for me."

An initial physical and social assessment had been completed before people were admitted to the service. The service involved people in discussions about their care. This helped to ensure any communication needs associated with their health and wellbeing were identified and met in a responsive and individualised

way. The manager had limited knowledge of the Accessible Information Standard (AIS), however efforts had been made to ensure people with communication needs and/or sensory impairment received appropriate support. The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS.

Care records we reviewed contained a range of care plans for each person to identify their care and support needs. However, most of them lacked personal detail and information about the person's preferences in relation to their care. For example a person's personal hygiene care plan did not contain any information about their preferences such as whether they preferred a bath or shower, the amount of assistance they required or any toiletries they liked to use.

Some important information was missing from some care plans. For example, a person's pressure ulcer risk assessment outcome plan stated they should be assisted to re-position every two hours, and were provided with a pressure relieving mattress and heel protectors. However they did not have a pressure ulcer prevention care plan and their skin care plan did not give any reference to these interventions.

Another person had a catheter in place. This was identified on their catheter, bladder and bowel assessments. They had a catheter care plan, but there was no indication of the type and size of catheter used, what to do if the catheter blocked or any care of the site. The care plan stated, "Qualified nurses are to ensure the catheter is changed within the guidance from the hospital and continence team," rather than stating what that guidance was for this person.

People were aware of how to make a complaint and were comfortable making a complaint. Most people told us that they would be listened to. A person said, "I would feel comfortable complaining." Another person said, "I've made a complaint and it was listened to and changes were made." A relative said, "If I had a concern I would speak to the manager."

Complaints were not dealt with consistently. The provider had a complaints procedure in place but this was not routinely followed. There was no consistent evidence that complaints had been robustly investigated and that service developments had been pursued as required. People were sometimes updated by telephone or by letter but this again was not consistent or in line with the complaints policy. There was limited evidence about whether people had been consistently and regularly kept updated about the progress of their complaint or whether they had received a timely response. However, this was difficult to fully explore and evidence as information was spread between a paper file, an electronic system and employees' personal computer folders. Neither system was consistently used nor was it not clear from records whether people were satisfied with the outcome of their complaints. There was no evidence in the complaints that we reviewed that learning or improvement had been made to the service as a result of complaints.

Guidance on how to make a complaint was in the guide for people who used the service. Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint. A staff member said that if a person wanted to make a complaint they would encourage them to express their concerns and then relay them to the manager and ask the manager to talk with the person.

Processes for supporting people with end of life care were in place and there were plans to further improve them. A person told us that the nurse had been very supportive regarding end of life care arrangements. Policies and procedures were in place and some staff had received training in the use of equipment used to administer medicines to people receiving end of life care.

The manager told us that staff consulted external healthcare professionals when necessary, regarding people's end of life care needs and the use of appropriate equipment to make them comfortable. They also told us that family members were offered a room at the service and food and drink if they wanted to stay with a person who was near to death.

Staff told us that they had not attended end of life care training. The manager told us that care plans were being reviewed and end of life care training was being considered for staff.

Requires Improvement

Is the service well-led?

Our findings

We found that the quality of recording throughout our inspection required improvement, with care records having insufficient information for staff to know how to care for people effectively; or to consistently provide the personalised care people preferred.

The provider had a system to regularly assess and monitor the quality of service that people received. However, it was not effective as it had not identified and addressed the issues we found at this inspection. These issues included incomplete care plans, incomplete positional change, food, fluid and mental capacity documentation, an inconsistent approach to complaints management and gaps in medicine administration records.

We saw that audits had been completed by staff working at the home and representatives of the provider. Audits were carried out in a number of areas including infection control, medication, care plans, laundry, kitchen, dining room and health and safety. However, where issues had been identified, the people responsible and timescales for actions had not always been recorded.

A clear vision and values for the service were in place. People told us that there was generally a happy atmosphere. A person said, "It's alright here. They tell you when things are going on and what's happening." Another person said, "It's nice and friendly. I love the residents. I like most of the staff. It's like a nice big family. It's a nice atmosphere with nice people." A visitor said, "All the staff are friendly, helpful and interact with visitors. You feel as if you should be here." However, another visitor said, "It's fine here but when there is something wrong you can cut the air with a knife."

The provider's detailed values and philosophy of care were in the guide provided for people who used the service and the provider's statement of purpose. The provider's Statement of Purpose stated, "The service aims to: offer skilled care to enable people who live here to achieve their optimum state of health and well-being." A Statement of Purpose sets out clearly what the service intends to do and how.

Part of the philosophy of care stated, "All people who live and work at the service and all people who visit will be treated with respect at all times." Part of the provider's values stated, "Enable our clients to live happy, fulfilled and safe lives." We observed staff were acting in line with the provider's values and philosophy of care.

Some people told us that the manager was often visible and very approachable. Others had not seen the manager and not spoken to her at all. A person said, "[The manager] is brilliant and listens." Staff were positive about the manager. A staff member said they saw the manager regularly. They said, "She is down to earth and supportive." Another staff member said, "The manager is really nice and responsive to issues."

Staff told us staff meetings were held regularly and they were encouraged to raise issues at the meetings. We saw that staff meetings took place and the manager had clearly set out her expectations of staff. Staff told us that they received feedback in an open and constructive way. A member of staff said they were encouraged

to contribute their ideas for improving the service and the quality of care provided.

The previous registered manager had been de-registered in September 2017. At the time of our inspection there was a different manager in post and she had started the process to become registered with the CQC. The manager felt supported by the provider to ensure the service provided a good quality of care for people. Statutory notifications had been made where required.

People and visitors were involved or had opportunities to be involved in the development of the service. Some people told us they had attended meetings and some had the minutes from the last meeting for people who used the service. A person said, "They have meetings quite often so you can tell them what you think." A visitor said, "There are meetings once a month. You can bring any points up and staff act on them."

Two people told us they had received a survey. People also told us that they had been asked for their views in informal ways by staff asking if they liked the food or whether they were happy during daily conversations. We saw that meetings for people who used the service and visitors had taken place and surveys had also been completed by people who used the service and visitors. Staff told us of actions they had taken in response to comments made.

A whistleblowing policy was in place and contained appropriate details and staff told us they would be prepared to raise issues using the processes set out in this policy. People told us, and records confirmed where other professionals had been involved in their care and treatment. Any information provided by other agencies had been used to inform and develop people's plans of care to ensure good outcomes for them. The service worked in partnership with other agencies.