Barchester Healthcare Homes Limited

Westergate 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

We inspected Westergate House on 23 October 2018, in light of information of concern that we had received in respect to people's care. However, at this inspection we found that these concerns were unfounded. Westergate 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. Westergate House is registered to accommodate up to 76 people, some of whom were living with dementia and other chronic conditions. Westergate House is comprised of main house connected to a newer building known as the annex. There were 69 people living at the service during our inspection.

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 and associated Regulations about how the service is run.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with dementia and palliative care (end of life). Staff had received both supervision meetings with their manager, and formal personal development plans were in place.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and

people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People's end of life care was discussed and planned and their wishes had been respected.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people in their rooms, bingo, exercise, quizzes and themed events, such as reminiscence sessions and visits from external entertainers People were also encouraged to stay in touch with their families and receive visitors.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision. People's individual needs were met by the adaptation of the premises.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good

The service was effective.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them. People's end of life care was discussed and planned and their wishes had been respected.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff spoke highly of the registered manager. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Staff had a good understanding of equality, diversity and human rights.

Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

Westergate House

Detailed findings

Background to this inspection

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

This inspection took place on 23 October 2018 and was unannounced. We carried out this inspection in light of information of concern that we had received. However, at this inspection we found that these concerns were unfounded. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Westergate House was previously inspected on 25 July 2017 and was rated as good overall.

On this occasion, we did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we observed the support that people received in the communal lounges and dining areas of the service. Some people could not communicate with us because of their condition and others did not wish to talk with us. However, we spoke with six people, 10 relatives, a visiting healthcare professional, three care staff, a registered nurse, the chef, an activities co-ordinator and the registered manager.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including six people's care records, four staff files and other records relating to the management of the service, such as health and safety and safeguarding paperwork, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "Yes, I'm safe. I'm happy here, it's nice here". A relative said, "I've had no concerns, I know [my relative] is safe when I leave". Another relative added, "It's very safe and we're happy, they would deal with things of there were any problems".

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. At certain points of the day, we were aware of malodorous smells in some areas of the service and this was fed back to us by some visiting relatives. However, these smells were temporary and staff were continually cleaning and refreshing the service. The service and its equipment were clean and well maintained and regular 'deep' cleaning of the service had taken place. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. A relative told us, "It's a very good home. There's never any smells, it's very clean". Another relative said, "[Relative] is incontinent and there's no smell in his room". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves were readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The registered manager told us that infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

We looked at the management of medicines. Registered nurses were trained in the administration of medicines. A registered nurse described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed a registered nurse giving medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "They bring it to me in the mornings, they are very polite". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that agency staff were used when required. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "They're all right

[staff]. You ring and they're there". A relative added, "Sometimes they do get a bit short, but usually it's very good really. If someone isn't able to get in, they fill in for them". Staff agreed with this, and a member of staff said, "It gets busy, but they always get cover if anyone calls in sick". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had an up to date registration with the nursing midwifery council (NMC).

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan (PEEP). There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Good

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "They all seem to know exactly what they're doing. They are very good at caring for people". A relative said, "From what I've seen, they seem to be able to handle any situation". Another relative added, "[My relative] is calm, she wasn't at home, so the staff must be doing something right". A visiting healthcare professional told us, "The training around dementia for staff is very good, they really understand dementia".

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We saw this was the case and staff knew the correct procedures to follow and were aware of their responsibilities under the Act.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people ate in the dining areas or could choose to eat in their bedroom or a lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People were complimentary about the meals served. One person told us, "It's good plain food, we're never hungry and it's nicely presented and it's always quite hot". A relative said, "It's brilliant and they feed them loads and it's good". Another relative added, "We've been for Sunday lunch, it was fine, very good. The variety and choice are really good". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Specialist diets were catered for and staff stated that any specific diet would be accommodated should it be required.

Staff liaised effectively with other organisations and teams and people received support from specialised

healthcare professionals when required, such as GP's, chiropodists and social workers. Access was also provided to more specialist services, such as opticians and podiatrists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "If I need a doctor, they will call one". A relative added, "The doctor has come a couple of times recently". We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

Staff had received training in looking after people, including safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the care of people with dementia and those at the end of their life. Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff and the registered manager confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and understood. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. A member of staff told us, "We always treat everyone the same".

People's individual needs were met by the adaptation of the premises. Hand rails were fitted throughout the service with bumps at each end to alert people who were visually impaired where the hand rail stopped. There were slopes for wheelchairs and other parts of the service were accessible via a lift. There were adapted bathrooms and toilets.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "I can't fault the staff on the whole. We have a laugh, they're all right". A relative added, "The staff are very, very good".

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. One person told us, "I was upset and I spoke to one of the staff and they explained I didn't have to worry about it. They haven't spoken to me about it since then, but I know they know, so it's all right now". We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food and drink. Most staff also knew about peoples' families and some of their interests.

Throughout the day, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. One person told us, "We have a little joke with them [staff]". A member of staff added, "I'm passionate about the residents, we like to sit with them and have a chat".

People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "There's always someone to help me dress and to put me to bed. They are all quite nice".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "I'd ask if I wanted anything and they'd try to get it". Another person said, "I tell them what I want, they've told me to. I'm not rushed at all". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We always ask people and give them options". Another added, "We offer choices around food and drink and what they want to wear".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. One person told us, "I don't need a lot of help, I can still do a lot for myself, but if I needed help, it's there". A relative added, "They encourage [my

relative] to walk and use her frame". Care staff also informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "We encourage people to move around the home and come to the dining room. I encourage people to eat, I will help with one bit and then see if they want to eat the next bit by themselves". We saw that one person was given some soup in a cup, rather than a bowl, as this enable them to eat it independently.

Staff encouraged people to maintain relationships with their friends and families. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and we saw that staff engaged with visitors in a positive way. People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one.

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences. Staff told us how they adapted their approach to sharing information with some people with communication difficulties. One member of staff told us, "We get to know people and understand what they want". This was echoed by a relative who told us, "[My relative] is a private person, but they've made relationships with staff. It's hard with [my relative]. They interact well with her. She doesn't really speak anymore, but they ask the right questions and she can respond. She has simple facial reactions and they pick up on them". Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "Any troubles and they'll rectify them and talk to you. If you are concerned, any mishap, they try to rectify it". Another person said, "They just all know what to do and know me really well". A relative added, "They make sure they are doing what my [relative] wants". A further relative said, "I know what [my relative] needs and I know she's getting the care she needs".

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. A relative told us, "My [relative's spouse] was asked at the beginning. He definitely was". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "I read all the care plans, they have enough information. We also get to know the families as well". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. People were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plan.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

We saw a varied range of activities on offer, which included, bingo, exercise, quizzes and themed events, such as reminiscence sessions and visits from external entertainers. People told us that they enjoyed the activities. One person told us, "It's quite good. They have quizzes and someone plays the guitar and sings. She asks each person to choose a song and if she knows it, she'll sing it. They come and give a concert. A lady comes and talks. She takes a subject and talks about it. She talked about public houses, it was very interesting. The knowledge that came out, it was amazing. We all like those sorts of things". Another person said, "I love the quizzes. There's one today, I will go to that. There's little walks in the summer and we went to a place for a cup of tea". A relative added, "There's lots of variety. We're here for long periods, for a couple of hours each time and there's always something going on. They're always having memory games and quizzes". Staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff set aside time to sit with people on a one to one basis in their rooms.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "I would speak to one of the ladies if it was a small thing and they would put it right. If it was a major thing, I'd go higher". A relative added, "I've had no complaints, but I've got phone numbers and I'd complain if I needed to". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Technology was used to support people to receive timely care and support. The service had a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time. Staff also took advantage of online training courses to enable them to complete training at a time that suited them.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff ensured that the communication needs of people who required it were assessed and met. People and their relatives supported this, and one relative told us, "[My relative] can't speak properly, but they've learned what she wants". We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these.

Good

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the registered manager and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. One person told us, "[Registered manager] is very good, very cheery. He cheers everyone up. He's always got a smile and a joke". A relative said, "I've spoken to [registered manager] a couple of times. He seems to know what he's doing". A person added, "We haven't found anything we didn't like".

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management, including any issues in relation to equality, diversity and human rights. Management was visible within the service and the registered manager took an active approach. A member of staff told us, "I can approach the managers 100%, I have nothing but praise for them". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff told us, "We communicate well and have regular meetings". Another member of staff said, "We always help each other out, we don't leave anyone to struggle". This was echoed by people and one person told us, "I've asked one or two [staff], they say they love it. They say it's not just a job". A relative said, "They do a good job. If they're not happy, I don't think they would choose to stay here for too long".

We discussed the culture and ethos of the service with people and staff. One person told us, "I think that it's very good here". Another person said, "I've definitely felt a lot better since I've been here". A relative added, "[My relative] has been here four years, so it's like a well-oiled machine". A member of staff said, "I think we definitely meet people's needs. We give good care. I would have a relative live here". Another member of staff added, "I love it here, I love the residents and I'm always happy with my team". There was also a clear written set of values displayed in the service, so that staff and people would know what to expect from the care delivered.

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. There was a suggestions box, and meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided. One person told us, "We went to [a meeting] last month to discuss the refurbishments, asking us what we thought. And about the grounds, about putting down paving to make it safer if people are falling". Another person said, "They do have them here [meetings]. My son or daughter goes. One of them always goes". A relative added, "We've done two or three [surveys]. I think they act on them".

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety, infection control and medication. The results of which were analysed in order to determine trends and introduce preventative measures. Up to date sector specific information was also made available and we saw staff had also liaised regularly with the Local Authority and

the Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery. Additionally, staff engaged with other organisation such as the national activity providers association (NAPA). They also accessed the local community, for example, representatives from local churches visited the service to spend time with people.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice for both people and staff living and working at 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 had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.