Norse Care (Services) Limited

Harker House

Inspection report

Flowerpot Lane
Long Stratton
Norwich
Norfolk
NR15 2TS

Tel: 01508530777
Website: www.norsecare.co.uk

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 4 and 5 May 2016 and was unannounced.

Harker House provides care for up to 36 people. This includes a separate wing which supports people living with dementia. The building was purpose built, offering accommodation over two floors.

There was a registered manager and a deputy in place. The deputy was responsible for the day to day management of the service. 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 benefited from being supported by staff who were safely recruited, trained and who felt supported in their work. However, we received mixed feedback about staffing levels. People who required the assistance of more than one member of staff did not always receive the care they needed in a timely way.

Staff understood how to protect people from abuse and knew the procedure for reporting any concerns. Medicines were managed and stored safely and adherence to best practice was consistently applied. People received their medicines on time, safely and as the prescriber had intended.

Staff knew and understood the needs of people at Harker House, although they did not receive regular supervision. However staff said they were in regular communication with the deputy manager and team leaders. The management team was aware of this short fall and was arranging supervision for staff, which they said they would receive on a regular basis.

Staff told us they were happy working at Harker House. They assisted people with kindness and compassion. People's dignity and privacy was maintained and respected.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. The service was not depriving people of their liberty unlawfully and worked within the principles of the MCA. Staff's knowledge of MCA was good and people told us staff always asked for their consent before assisting them.

People's care plans were detailed and individualised. They contained important and relevant information to assist staff in meeting people's needs in a way that was personalised. People and their relatives had been involved in their care assessment and care plans. People's needs had been reviewed and people's records were up to date.

The service had good links with community healthcare teams. People were supported to maintain good

health and wellbeing. Some people had complex health needs; these people's needs were closely monitored. The service reacted positively to changes in people's health and social care needs.

People and staff told us there was a lack of social activities. Some people told us they felt isolated and bored at times. The issue of staffing levels was also relevant here and sometimes contributed to people not feeling socially stimulated. The service was making efforts to address this issue by planning to increase planned activities; however people did not have regular daily social stimulation throughout the day.

People were encouraged to maintain relationships with people who were important to them, and the service actively welcomed family members and visitors to the home.

There was a homely feeling to the communal areas. The home had benefited from an ongoing refurbishment programme, which had also contributed to the light and homely feel to the service.

People felt listened to and were confident that any concerns they may have would be addressed. There were systems were in place to monitor the quality of the service. Staff and the deputy manager was very committed to providing a good service for people living in the home.

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.

There was enough staff to meet people's needs.

Staff were safely recruited to meet people's individual needs.

People were supported by staff who knew how to prevent, identify and report abuse.

People were kept safe as risks had been identified and managed appropriately. Reviews had taken place. Staff had effective guidance to support people in relation to the identified risks.

Medicines were administered and stored safely and appropriately. People received their medicines as prescribed and in a way that took into account people's individual needs.

Is the service effective?

Good

The service was effective.

People benefited from being supported by trained staff who felt supported in their roles.

Staff assisted people in a way that protected their human rights. The service was meeting its responsibilities under the Mental Capacity Act 2005 and the deprivation and liberty safeguards.

The service ensured people received food and drink of their choice. People had enough to eat and drink.

People's health and wellbeing were supported and maintained by having access to appropriate and prompt professional healthcare services.

Is the service caring?

Good

The service was caring.

Staff had good knowledge of the people they supported and delivered care in a respectful and caring manner.

People, and those important to them, were involved in making decisions around the care and support they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

There was a lack of regular social stimulation for people to capture their interests. Some people told us they felt bored.

Care and support was provided in a personalised way that took people's wishes, needs and life histories into account.

The service encouraged people to maintain meaningful relationships with those close to them.

The home encouraged people's views on the service provided.

Is the service well-led?

Good

The service was well-led.

People were supported by staff that were happy in their work and felt valued.

The service had a clear set of values and a vision for the service.

There were auditing systems in place to monitor the quality of the service.

Harker 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 4 and 5 May and was unannounced. Our visit was carried out by one inspector and an 'Expert by Experience'. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our 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 also reviewed the information we hold about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law.

During our inspection we spoke with 12 people who used the service. We also spoke with three relatives of people using the service. Observations of people's experience of the care they received where made throughout the inspection.

We gained feedback from two healthcare professionals who visited the service. We spoke with the deputy manager in charge of the daily running of the service, and a second deputy manager and the registered manager. In addition, we spoke with the cook and five members of the care staff. We also contacted the local safeguarding team and the local authority quality assurance team, for their views on the service.

We reviewed the care records of four people and the medicines records for six people. We tracked the care and support for three people. We also looked at records relating to the management of the service. These included training records, health and safety check records, three staff recruitment files and minutes from meetings.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe living at Harker house. One person told us, "I know I'm safe in here, whatever I ask them [staff] to do they'll do it for me." Another person said, "I certainly do [feel safe] because everyone's so kind and nice and looks after you, it couldn't be better, it really couldn't!" A relative of a person living at the service told us, "I have no concerns what so ever."

The staff we spoke with said they had received training on how to protect people from the risk of potential abuse. All the staff we spoke with gave us examples of what abuse looked like, which included emotional and psychological abuse. Staff told us in detail how they would identify if someone was experiencing abuse. All the staff said they would speak with the management team and team leaders if they had concerns. Most of the staff we spoke with were aware of outside agencies they could also report concerns to.

The service identified and acted on safeguarding concerns appropriately. For instance, the manager told us about a safeguarding referral they made when they had concerns about the finances of a person who lived at the service. This was reported to the local authority safeguarding team. The manager told us how they worked with the safeguarding team and the local authority social care team to put measures in place to protect this person with their finances.

The service had identified and assessed people's needs in a robust way. We could see from the records we looked at that risks had been identified. Some people using the service had difficulties with swallowing, maintaining a healthy weight and were at risk of their skin breaking down. The service had assessed the risk to each individual and had a plan of action to reduce the risk to their health and welfare. Where necessary, they had sought advice by making appropriate and timely referrals to specialist health care teams.

There was clear guidance in people's care plans for staff to follow to ensure that people's individual needs were met. One person living with dementia had a recent history of behaviour which challenged others. There was guidance for staff to follow to support this person with essential personal care routines. This included guidance about what to do in the event of the person refusing essential care. For instance, trying a different member of staff or a different time of the day. Staff were encouraged to provide support in a way which promoted and protected the person's freedom.

People were assessed prior to moving into the home by a social care professional. The deputy manager told us, in addition to this, they would also complete an assessment of a person's needs before they moved into the service. The deputy manager told us they needed to make sure they could meet a person's needs and the service was appropriate for them.

The service had methods of responding to events which affected the running of the service and people's safety. There was a list of numbers to call if there was a problem with a utility supplier or if there was a technical issue with the service. There were fire safety drills each week and staff were aware of what they needed to do in the event of a fire. The deputy manager told us of a recent event, when people's call bells were not working. The deputy manager put processes in place to ensure people were safe and could request

support, until the technical error was corrected.

The service had a system in place to respond to accidents and incidents. Staff completed accident reports and made referrals to specialist health or social care teams if needed. The team leader monitored each report to ensure that appropriate action was taken. We saw some of these reports in people's records; we could see that onward referrals had been made in response to falls, the breakdown of people's skin, and people having swallowing issues.

When we spoke with staff and people who lived at the service we had mixed views about the staffing levels. Although everyone we spoke with said their needs were met by staff, people also told us they felt sorry for staff because they were so busy. One person said, "They'll tell you often I haven't got two pairs of hands." One member of staff said they expressed their views about the staffing levels, but they didn't feel the management team heard and understood their point.

Some people told us they didn't feel there was always enough staff on shift to meet their needs. One person said, "Definitely not [enough staff], when ladies and gentlemen have to be attended to with a hoist, people have to wait a long time." Another person said, "I sit here, and I sit here, waiting for someone to come, it's painful when you're waiting, I get annoyed." One person told us sometimes a member of staff would respond to their call bell, but then have to wait for another member of staff to come in order to assist them. This person said, "We get a bit anxious, we feel for them having to wait, they have more than enough to do."

Staff spoke very positively about working at the service. However, all the staff we spoke with said that the number of staff on each shift was often lower than expected. Staff told us that this meant they struggled to meet everyone's needs in a timely way, especially those who required two carers to assist with their mobility. Staff told us agency staff were not often used to ensure that there were sufficient numbers of staff on duty. One member of staff said there had been times when there were only two people on shift at night to cover the whole home. This included the unit for people living with dementia, which needed to have one member of staff on duty at all times.

We spoke with the manager about the staffing levels. The manager said the home was not full at the time of our visit and therefore the full quota of staff was not required. The manager told us they did use agency staff if there was a shortfall of staff. We looked at the last three weeks rotas from the date of our visit and could see the full quota of staff had been used. This figure included the use of agency to cover staff absences.

There were safe recruitment processes in place. These ensured that only those who were suitable to work in care were employed. Staff and the deputy manager said people who were successfully appointed to work in the service had to wait for their Disclosure and Barring Service (DBS) checks before they could start working at the home. We looked at staff personnel files and saw staff had references, photographic proof of identification and the appropriate security checks had been completed.

Medicines were administered and managed in a safe and effective manner and people received them as prescribed. We observed a member of staff administering medicines. This member of staff clearly had a good knowledge of people's medicines and people's health needs. The medicines were stored securely throughout and after the administration process.

We looked at the medicines administration records (MAR) of six people and found they had been given their medicines as prescribed and these were clearly signed by staff. We completed an audit of medicines and found that the correct amounts of medicines were stored. Medicines were stored at the correct temperatures and we could see the service monitored this daily.

Good

Is the service effective?

Our findings

People received effective support from staff who were well trained. One person said, "Oh yes, I feel they're well trained." Another person said, "They (staff) know what they're doing and I'm happy with that." We spoke with a relative about staff knowledge and skills, they said they were, "Brilliant!"

Staff told us they felt they had sufficient training to perform well in their roles. One member of staff said they recently had training on how to support people whose behaviour may challenge others. The staff we spoke with said they had received training in moving and handling, first aid, safeguarding, fire safety and supporting people with mental health needs. Staff told us they had also recently had training in the administering medication.

We looked at the training plan for the service and saw that training was up to date. The service was in the process of installing a new training programme. We could see staff had been allocated new training dates on areas such as 'dementia awareness' and safeguarding. Staff we spoke with were aware of this new programme and said they were completing online courses at home and within work.

Staff told us they felt confident and able to start work after their induction period. Most staff had a two week induction period, which included shadowing experienced staff. However this was dependent on the level of experience a new member of staff had. The deputy manager told us they would make a judgement on how long a new member of staff's induction period was, by looking at their previous experience. The deputy manager said new staff would be observed before they began working independently. One person living in the service said, "We have a lot of new women coming, who have got to learn, they come with someone who shows them what to do… It's ok."

The service was recruiting new members of staff, who would be completing the 'care certificate' course as part of their induction and probation period. This is a set of national standards of care new staff must meet. We were shown one new member of staff's course work who was close to successfully completing the course.

Staff told us they had not received regular supervision. One member of staff told us they had been appointed a year ago and had not had supervision. However, all staff said they felt confident in speaking with the deputy manager and team leaders whenever there was an issue or they needed advice. One member of staff said they often had lengthy conversations with the deputy manager. The deputy manager said they were aware of this issue and were starting to arrange monthly supervisions and yearly appraisals. Some members of staff we spoke with said they had been told this, one member of staff said, "Mine's next month."

We observed staff communicating effectively and professionally with one another throughout our visit. Staff spoke discreetly with one another about what they were doing, when they were in the communal areas. We observed two members of staff transferring a person in a hoist. Staff spoke with the person throughout the process reassuring them and telling them what they were doing. They also spoke clearly and discreetly with

each other when they were assisting this person.

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 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 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.

The deputy manager and staff had a good understanding of the MCA. Staff and the deputy manager understood what mental capacity meant. Staff told us how they encouraged people who lacked capacity to make their own decisions. We looked at the records for people who lived in the 'Swan Lane wing' which was an area of the home supporting people who were living with dementia. We saw that mental capacity assessments had been completed. The service had made appropriate DoLS applications to the local authority.

For people who lacked capacity to make decisions the service made best interests decisions on their behalf. A member of staff had told us how the staff supported a person who often refused care. The service had consulted with a professional, who agreed staff should offer support at three different times before they made a best interests decision to provide support. The professional advised the service what the best interest decision would be at this stage. This approach was detailed in the person's care record.

During our visit we observed staff asking for people's consent and offering choice. All the staff we spoke with said they always asked for people's consent when they supported them. One member of staff told us how they offered people choice with what they wanted to wear. Staff said they always asked people if they wanted to take part in activities in the home. One member of staff said, "We are here to help the people who live here, not tell them what to do."

People were supported to have enough to eat and drink. One person said, "The food is wonderful, you can choose what you want." Another person told us for breakfast, "I have orange juice, porridge, brown toast and delicious butter and Seville orange marmalade." Another person said, "The lamb casserole was beautiful, it's freshly cooked, puddings, crumble, rice pudding."

We observed lunch and breakfast and saw people were offered choice in what they ate and were given the opportunity to change their mind and go 'off menu' if they wanted to. People were offered a choice of drinks with their meals. At breakfast people were asked if they wanted additional servings. Food times were appropriately spaced and people were offered snacks and drinks in between meals. One person told us, "You can have a drink anytime you like, and they always offer my visitors a drink."

Some people had complex needs with eating and drinking. We observed these people receiving appropriate support with their meals. We looked at their records and saw that referrals had been made to a specialist team to give individual advice, to support these people with their eating and drinking. The cook showed us a report they were given daily updating them as to people's dietary needs.

We could see from some people's records that they were at risk of losing weight. These people were being weighed on a regular basis and staff were recording how much they were eating and drinking. The records showed that staff had made contact with the GP to raise their concerns about weight loss. From this intervention we could see people had gained weight, but they continued to be monitored.

People received support to access health care services and received ongoing health care support. The service had good links with the local GP surgery and the GP visited once a week, as a minimum. They would also visit people in addition to this time, if further health input was required. As part of a local health pilot, the service had a registered nurse who visited the service twice a week, or more if required, particularly for people over 75. We spoke with the nurse and a visiting GP who both said the service responded well to changes in people's health needs. They added that staff had a good knowledge of people's current and historical health needs.

Good

Is the service caring?

Our findings

People said they were treated with kindness and compassion. One person told us, "They're [staff] absolutely perfect, happy and caring – I'm very lucky." Another person said, "They're [staff] perfect, they're ever so good." A person's relative told us, "They [staff] are very caring towards [name], I can't speak highly enough of them; I really can't."

During our visit to the service we observed staff treating people in a caring way. Staff spoke with people at their physical level, often with a reassuring hand gently placed on the person's shoulder. When supporting people with their mobility staff were unhurried and gentle with people. One person was sitting on their own at breakfast and a staff member asked if this was what they wanted. On three occasions different members of staff were seen talking with this person. We observed staff supporting people to eat and drink. They were attentive to their needs and spoke with them as they supported them.

All the staff we spoke with talked about the people they supported with real affection and warmth. In our conversations and general observations of staff it was clear to us staff knew the people they supported. We could see from people's care records that the service had made every effort to get to know people, their histories and what was important to them. Staff told us they read people's care plans and assessments.

We could see from looking at people's records that people had been asked if they wanted to be part of the reviews of their care. People's records also showed that relatives had been extensively consulted with. We spoke with one relative who said staff kept them up to date with what was happening with their relative.

People told us their privacy and dignity was respected. One person said, "They're very dignified, all of them, they treat residents with dignity, they're very good." Another person told us, "They [staff] knock on the door, at night time they come in and check on me." A relative told us they visited their relative on a regular basis, "I can see they [staff] treat everyone as human beings, they care." We observed staff discreetly asking people if they required certain medicines and staff knocked on doors before entering people's rooms. The staff we spoke with told us that treating people with respect and protecting their dignity was important to them. One member of staff said, "I treat people how I want to be treated." People told us they chose if they stayed in their rooms or went to the communal areas for meals and activities. The service had smaller communal living rooms for people to spend private time in. There was also a telephone room for people to make private phone calls.

People were encouraged to be as independent as they could be. Some people accessed the community as they wanted to. We observed some people going to the basement and collecting their mobility scooters and going into town. Some people had decided to sit outside on the day of our visit and we observed staff putting chairs outside and finding hats for people to wear. One person told us, "You can come and go as you want to." The manager told us, "The door is open during the day, as long as people tell us where they are going, and they are safe to go out alone, this is fine." Staff told us about two people who ordered their own medicines and about one person who administered their medicines independently.

Relatives told us they were free to visit whenever they wanted to. On the day of our visit we observed five relatives visiting during different times of the day, including meal times. The relatives we spoke with felt very welcomed. One relative said, "It's a homely atmosphere."

Requires Improvement

Is the service responsive?

Our findings

People benefited from having assessments which were individual and responsive to their needs. There was detailed information about people's needs, their personal histories, and how they wanted to live their day to day lives. There was detailed information about what was important to people. Their social and spiritual needs, the people who were important to them, and subjects which irritated or frustrated people. In people's assessments there was further detailed information about people's eating and drinking needs, their mobility, and their morning and evening routines. This was not generic but individual to the person in question. These assessments and care plans were person centred and gave a whole picture of how to care for these individual people.

People who lived at the service and their families were involved in their assessments. People's records we looked at included detailed personal histories. We looked at some people's records who were living with dementia. These included topics and subjects the person enjoyed, as well as areas which would distress the person if discussed. These were very personal to each individual. We spoke with one relative who said their relative had always enjoyed clothes and being fashionable. The relative told us their family member could no longer communicate or express what they wanted to wear. However, we saw that the person's care plan gave detailed information about how they wanted to look. On both days of our visit the person was dressed in this way.

We observed staff explaining what people's medicines were for. For example one person wasn't sure they wanted to take their anti-biotics. We observed a member of staff spending time with this person explaining the benefits of taking this medication and why the doctor had prescribed them. This person was given time to think about it. Another member of staff said they had this conversation with this person later on, and they agreed to take their medicines.

When we visited the Swan Lane wing we could see the service had tried to make it a familiar and homely environment. The deputy manager told us that people had told them the communal areas had reminded them of their own bungalows before they moved to the service. There were tactile objects for people to feel and items of furniture you would expect to find in a person's private home. On the walls there were reminiscent objects with the aim of reconnecting people with their pasts. There was also a lively pet budgerigar. When we visited the Swan Wing we observed people knitting with a member of staff and one person was singing and dancing to music while they were washing up. Staff told us they tried to make it, "Very homely." People's rooms were personalised by containing objects, pictures and photos which were important to them, as confirmed in people's records.

However, the majority of times when we entered the Swan Lane wing people were either asleep or watching television. With the exception of knitting we didn't see any other activities taking place. One member of staff was completing paper work but it was some time before they noticed one person had fallen asleep in their recliner chair, at an awkward angle. The member of staff eventually responded by gently putting a cushion under the persons shoulder and head.

In the main area of the home some people told us they felt there were enough activities. One person said, "I think I know most people here, invariably there's something on in the dining room. Monday's bingo, oh yes, I like bingo, exercising, that's good! Lady singers, there's a man comes singing - I'm quite satisfied, I think they do quite well really." A relative told us, "[Relative] goes down to different things, extend exercises, knit and natter, I think there's more nattering than knitting, [name] comes in once a month to do Zumba, [relative] thoroughly enjoys it."

However other people told us, "We get a little bored at times, there's very little to do at the moment." One person said, "I feel I'm not ill enough, I feel a bit bored – I join in with bingo, I just feel a bit fed up…They're nearly always asleep, but what can you do?" Another person told us, "All I do is watch telly, eat and fall asleep. I haven't been out since I came here, 18 months."

We observed throughout our visit to the service the TV was on in the communal area. One person was actively watching the TV and commenting on the programmes they were watching, but most people were asleep, and most people could not see the TV.

People who were independently mobile and who didn't need support or assistance from a member of staff to go into the garden or into the town were more positive about their level of social stimulation. We spoke with some people who said they would like to go out, but that staff were too busy to support them with this. We spoke with some members of staff who told us they had come in on their day off to take a person into town, but also said they couldn't do this all the time. One member of staff said, "I worry about them sitting around all day." Other members of staff said they tried to encourage people to join in with the planned activities, "But people just don't want to do them." Another member of staff said a big challenge for the service was, "Occupying people's minds and motivating people."

We spoke with the deputy manager about this. They told us the service was advertising for an activities co-ordinator and that they did have activities in the service. The deputy manager told us about a party for the Queen's birthday and at Easter time they had baby chicks in reception. We saw photos of these events and a trip out to the Suffolk coast, which took place last year. We observed the entertainment on one afternoon, when music was played from the 1950's and 1960's which people had asked for at a recent 'residents meeting.' However, although the music was playing, there was no engagement with people and most people were asleep. Staff told us they tried to support people with activities but were often asked to assist other people in the service.

Although the service was making efforts to look at increased planned activities, we felt that most people in the service were not experiencing regular social stimulation on a daily basis, in a way which engaged them. Stimulation did not take the form of staff chatting, spending time with people, having meaningful conversations with people, which were not task orientated. We observed that staff did not have time to provide this additional support, although staff were motivated to do so. Although the service had made efforts to know what people's interests were this knowledge was not put into practice. This knowledge was not used in a way which engaged people and helped them maintain their interests. We concluded from this that the service was not always responsive to people's social needs and this was an area which the service needed to improve.

We could see from looking at people's records and speaking with staff and visiting health professionals, that people's needs were regularly reviewed and care plans were updated.

The service had developed opportunities for people living in the service to raise concerns and complaints. There was a 'feedback form' for people who stayed for a short period of time. People told us they would

speak with a member of staff if they wanted to raise something which concerned them. The manager had created a 'compliments form' which was due to be implemented in the coming weeks. There was a recent staff and separate resident survey. The service also subscribed to a website for people to share their experiences of the home. We were shown the comments on this website and they were very positive.

The manager told us about a person whose needs had changed to the point they felt they could no longer meet their needs and keep other people safe. The deputy manager had involved a social care professional to look at ways to reduce the risks to other people. The service put these suggestions in place and monitored the person's needs. When this person's needs changed again the deputy manager requested a review from the social care team. It was agreed (with involving family and staff) this person would benefit from going to a different home which would meet these increased needs. This demonstrated to us the service supported people to move onto different services in an appropriate way. A visiting GP confirmed this by telling us about their experience of how the service understood when they could not meet people's needs, and the way in which people were supported to transition to different services.

Good

Is the service well-led?

Our findings

Staff were very complimentary about the deputy manager. All staff said that the deputy manager was, "Very approachable." More than one member of staff said "She's a lovely person."

There was a registered manager in post who was also a registered manager for another service for the same provider. There was a deputy manager who was responsible for the day to day running of the service, which was overseen by the registered manager.

People told us they attended resident's meetings. We could see from looking at notice boards and reading the minutes these meetings took place on a regular basis. The meeting minutes showed that people were contributing and making suggestions.

The manager told us they were planning a, "Relative's newsletter" to keep relatives up to date about general issues in the service. Relatives were also going to be invited to events held in the service and the, "Residents meetings."

There was an open culture at the service, the staff and other people we spoke with were transparent about their views and feelings about the service. People who lived in Harker House said they felt comfortable speaking with the deputy manager. We could see the deputy manager was engaged with the daily running of the service. People responded positively to seeing the deputy manager and staff told us the deputy manager was "Very present." Although, the deputy manager told us they felt their office was, "Hidden away," but they were in conversation with the provider to have an office near the central part of the home.

However, staff had raised the issue of the level of staffing with the deputy manager the deputy manager had not investigated this further. They told us how they believed the service was not fully occupied and therefore there were sufficient numbers of staff. The deputy manager had not considered the impact this was having on the people living at the service and investigated this.

There were some links with the community and health and social care professionals visited the service on a regular basis. There was a monthly church service and there were volunteers and a college student who was currently on a placement at Harker house. The deputy manager told us they recognised the links with the wider community needed to be improved. The deputy manager said they were trying to develop these links. For example, the service was holding a 'craft fair' which would be open to the public. We spoke with the second deputy who said they were trying to make links with the local schools.

Staff told us they felt very comfortable in raising concerns with the deputy manager. The deputy manager told us about a situation when a member of staff had raised a practice issue about another member of staff. The deputy manager told us how they dealt with this issue to prevent it from happening again.

We asked staff what the values of the service were. Staff spoke of encouraging people to be as independent as they could be, to be caring and compassionate, to give people good quality care and to treat people with

respect and dignity. When we spoke with the deputy manager they shared these values. We concluded the service had a clear set of values. We also observed these values being put into practice.

The deputy manager told us they reviewed the day to day culture and practice of staff through being present and approachable, observing day to day practise, staff observations, and overseeing accidents and incidents.

We could see there were planned meetings for 'care staff' and 'team leaders' which took place every two months. We looked at the minutes of team meetings which confirmed the meetings took place. The staff we spoke with said they found them useful and were able to share their views and experiences.

The provider had completed a recent audit of the service and the deputy manager was leading on the action plan that had resulted from this audit. The deputy manager said they had regular supervision and attended manager's meetings held by the provider. The deputy manager said they felt supported by the provider.

The deputy manager understood their responsibilities to the people living at the service. We could see from the information we held about the service, the deputy manager reported incidents to the CQC as required.

When we visited the service we could see there was a building improvements programme underway. Some bedrooms were being up dated and we could see that communal areas, including small living rooms, had been recently refurbished and updated into bright and welcoming spaces. From what staff and the deputy manager had told us we could see a lot of improvements to the building had taken place, since the deputy manager came to the service.