PRIDE CARE HOMES PETERBOROUGH LIMITED

# The Malting's Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The Malting's Care Home is registered to provide accommodation for a maximum of 50 persons who require nursing and personal care. At the time of this inspection 45 people were using the service.

This comprehensive inspection took place on 30 March 2017 and was unannounced. This was the first inspection under the provider's current registration.

A registered manager was in post at the time of the inspection and had been registered with this provider since 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff knew what the types and signs of harm were, how to keep people safe and who they could report any incident of harm to. A sufficient number of safely recruited and competent staff were in place to meet people's individual care needs. People were looked after by staff whose suitability to look after them had been robustly determined.

People's medicines were managed and administered safely by staff whose competence to do this had been assessed. Risk assessments for subjects such as skin integrity, moving and handling and administration of medicines were in place and up to date. This helped keep people safe.

People's needs were met and supported by trained and skilled staff who knew the people they cared for well. People were supported with their health care needs and access to these services when required. Staff adhered to the advice healthcare professionals provided.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. People's mental capacity had been accurately determined. Although people's capacity was not always decision specific the provider was working with the local authority's best interest assessor in improving the accuracy of people's DoLS applications. Staff had an awareness of the application of the MCA and DoLS code of practice. Where people needed to have restrictions on their liberty, these had been authorised by the local authority.

People's privacy and dignity was provided by staff in a respectful way. People were involved as much as they wanted in the planning of their care. People were enabled to access advocacy services and where required had relatives who could lawfully have a say in they were looked after.

People were provided with various opportunities to help reduce the risk of social isolation. A range of pastimes, hobbies, activities and access to the community was provided. People were supported by staff to be as independent as possible.

People's concerns, suggestions and complaints were recorded and acted upon promptly. Compliments were used to identify what worked well.

The registered manager was supported by a compliance manager, nursing, senior care and care staff, catering and domestic staff. Staff had regular updates to their training, mentoring, coaching and support from management.

Most audits and quality assurance processes were effective in identifying ways to improve the service. This was due to the subjects covered and the staff who undertook this role. However, these audits did not cover all areas and this meant that the management of people's information was not robust as it could have been. People's views about the quality of the service had been sought. People, their relatives and staff were able to make suggestions. This was to improve and maintain the quality of the service that was provided.

## 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 had been trained and were knowledgeable about keeping people safe from the risk of harm.

A sufficient number of suitably recruited staff were in place to meet people's needs.

People's medicines were managed and administered as prescribed.

### Is the service effective?

Good

The service was effective.

Staff were supported with a programme of planned training and supervision. Staff knew the people they cared for well.

People's ability to make decisions had been determined. Any restrictions on people's liberty had been requested and authorised by the local authority.

People's health and nutritional needs were met and staff supported people to maintain their wellbeing.

### Is the service caring?

Good

The service was caring.

People were looked after by staff in a caring, compassionate and sensitive manner.

People's privacy, dignity and independence was supported by staff.

People were visited by relatives whenever they wanted them to.

### Is the service responsive?

Good

The service was responsive.

People's individual care plans reflected how people's needs were met.

A range of opportunities were provided to support people with pastimes, hobbies and access to the community.

People were enabled to access information about how to raise a concern, compliment or complaint.

## Is the service well-led?

Good

The service was well-led.

Not all quality assurance and audits were effective in identifying areas for improvement.

The registered manager led by example and fostered and open and honest culture. People's views were listened to and acted upon.

Staff were supported in their role in a positive and supportive manner by leadership which fostered their development.

# The Malting's Care Home

**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 unannounced inspection took place on 30 March 2017 and was undertaken by one inspector and an expert by experience. An expert by experience is someone who has expert knowledge about people who use this service and their support needs. Their area of expertise was in caring for older people and those living with dementia.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we made contact with and received feedback from local health care professionals. This was to help with the planning of the inspection and to gain their views about how people's care was being provided.

During the inspection we spoke with nine people and six relatives. We also spoke with the registered manager, the provider's compliance manager, two nursing staff, two senior staff, three care staff and the lead staff member for activities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care records, medicines administration records and records in relation to the management of staff and the service.

Good

# Is the service safe?

## Our findings

People told us they felt safe because staff responded to requests for assistance. Some people did however tell us that they had sometimes been required to wait up to 30 minutes for the provision of their care. One person told us, "I chat to the staff but they're too busy to linger. Staffing seems to vary – I may struggle to find help some days." Another person said, "It can be anything up to half an hour – there's no real pattern of when. They tell me they'll be back as soon as they can then disappear again." However, one person told us, "I feel safer than at home – there's staff at the end of the bell and people around me." Another person said, "They [staff] pop and check on me all the time if [they're] passing."

We found from our observations throughout our inspection that the maximum time people waited for their care to be met was five minutes. In addition, the provider was able to demonstrate records of checks they had undertaken on how long staff took to respond and meet people's requests. These records of the call bell monitoring for the past 31 days confirmed that people did not have to wait more than a few minutes for their care.

The provider told us in their PIR that they safeguarded people from abuse and improper treatment. This was achieved by the provision of training and support from the registered] manager and directors' of the service. Staff told us that they had been trained on how to protect people from harm. This was as well as being able to contact the registered manager, provider, the local safeguarding authority and the police if they ever had a need to. We found that where incidents of harm had occurred that the provider and registered manager acted promptly and effectively in preventing any recurrence. One staff member told us, "If a person had any unexplained bruising, was very quiet or not their usual selves I would know something was wrong and I would report this to a nurse and/or the [registered] manager." A relative said, "[Family member's] perfectly safe – it's down to the general care, well looked after and good security."

We found that risk assessments were in place for subjects including safe moving and handling, nutrition, choking, falls prevention, bed rails and medicines administration. Staff were able to tell us the checks they needed to undertake to make sure people were safe in their bed. Examples included regular repositioning of people at risk of a pressure sore, checking that pressure area equipment was working properly and that people were safely hoisted. One person told us, "I need my [walking] frame and they [staff] make sure I have it and use it when I walk about." Regular reviews of people's risk assessments were undertaken including those for fire safety equipment and of people's health and safety. This was to help ensure that people's care was as safe as it could be.

A relative told us that they felt staffing was "adequate. Compared to other places I've seen, it's a bit better." Another relative said, "It doesn't matter whether it's meal times, personal care or just having a chat, there is always staff around." Staffing levels were determined by the assessment of people's health and care needs. This was undertaken by a representative of the provider and the registered manager. Where two staff were needed for people's safe moving and handling the required staffing was in place for this. We found that a sufficient number of staff were in place to meet people's assessed needs. One nursing staff member told us, "We can always cover any absences from our own staff, either those off shift, working extra shifts as well as

the [registered] manager lending a hand if needed." One care staff said, "If it gets too busy then we can ask for staff from another floor or in an emergency we can get staff from another of the [provider's] services."

People told us and we observed that requests for care were responded to promptly. One person told us, "I am safe as there are always [staff] about. I couldn't ask for anything better." Another person said, "I called using my [call bell] this morning as I wanted a drink and [staff] came quickly." One relative said, "Every time I pop in there is always staff to greet me as well as making sure my [family member] is safe." Another relative said, "I can't fault the staffing levels. My [family member] would soon tell me if things weren't right."

Records we looked at and staff we spoke with confirmed that a robust process was in place to recruit staff who were suitable to work with people using the service. Checks included a satisfactory Disclosure and Barring Service (this is an organisation which checks to see if staff have any criminal records) check , two written references and evidence of staff's qualifications and identity before they started work. One staff member told us, "I had to provide my driving licence, proof of address and sign to say that I was in good health." This showed us that there were systems in place to help ensure that only staff deemed suitable were employed.

One person told us, "They [staff] stay with me for my tablets and I have [pain relief] a few times a day too. I've my inhaler that I can take when I need it." Where people's medicines changed this was authorised by the appropriate health care professional. Records of people's medicines administration records (MAR) we looked at showed us that people had been administered their medicines as prescribed. We found that medicines were safely stored and disposed of. We observed that staff gave people the time they needed to take their medicines as well as explaining what they were for.

Medicines were administered and signed for by staff who had been trained and assessed as being competent to do so. We saw that nursing and care staff managed and administered people's medicines safely. Records of the quantities of people's medicines held tallied with those which had been administered. One person told us, "I have Paracetamol twice a day – they [staff] tend to leave them with me as they know I'm an ex-nurse, so trust me." Risk assessments were in place where people managed their own medicines. Another person said, "The girl [nurse] stays with me – I'm [health conditions] so have to take my tablets."

Good

# Is the service effective?

## Our findings

We found that a comprehensive assessment of people's care and support needs had been undertaken and plans had been put in place on how to meet these. The aim of this assessment was to help ensure the skills that staff needed were in line with the care people wanted. For example, people's preferences for what they did and when they chose to do this, mobility and nutritional support and health care.

One person said, "I like them (staff) – they look after us well." Another person told us, "[Name of staff] knows I'm scared of dogs so she makes sure I'm elsewhere when the therapy dog is here." One relative told us, "They [staff] definitely know what they are doing. They are busy but skilled at managing their time to help my [family member] with their [health care] needs." Staff were provided with mandatory training that included subjects such as dementia care, food hygiene, moving and handling and health and safety. Where required, staff had additional training on subjects including the use of syringe drivers to manage people's pain, diabetes and people who required support with their nutrition.

One person told us, "They [staff] handle everything very well. The senior [name of staff] on the ground floor is particularly efficient. I've got confidence in it (staff's knowledge) all here." Records viewed confirmed that updates to staff training had been provided. This meant that staff's good practice in care was kept as up-to-date as practicable. A programme of training that supported staff to retain current skills and learn new ones was in place. This helped care, and nursing, staff develop their skills based upon their role.

One staff member told us, "I have had training on safeguarding, moving and handling and the Mental Capacity Act 2005 (MCA)." The registered manager also told us that new staff were subject to an induction and probationary period where a programme of training, mentoring with experienced staff and supervision was provided. All staff we spoke with confirmed that they had one day's training set aside each month so attendance at training was very good.

The registered manager and their compliance manager confirmed to us that staff were supported on a day to day basis as well as having clinical supervision. This was planned to keep nursing and care staff's skills current and based on good practise. Staff were supported with formal supervisions. One member of staff told us, "My [supervisions] are absolutely two way. I can comment on any help I need such as training or coaching. I can always call senior staff or the [registered] manager at any time. I am supported in a positive way."

The 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. We checked whether the service was working within the principles of the MCA.

We found that staff were aware of the MCA and its code of practice. As a result of this we saw that lawful arrangements were in place for those people who required to be supported and cared for in their best interests and in the least restrictive way. For example, through the Deprivation of Liberty Safeguards (DoLS) process. Although people's capacity was not always decision specific the provider was working with the local authority's best interest assessor in improving the accuracy of people's DoLS applications.

Staff's knowledge of when, and when not, to support people with their decision making showed us that peoples choices would be respected when this was safe. For example, through any person with a Lasting Power of Attorney for subjects such as health and welfare. One person told us, "My [family member] makes all my health care decisions. I can trust them even if I lose the ability to make choices myself." Improvements to the way people's mental capacity was determined were being implemented. The compliance manager said, "We work very closely with the best interest assessors. Sometimes people's capacity improves, especially once they settle in."

One person told us, "They [staff] always ask me, 'can we make the bed or are you ready for your bath?' and things like that." Another person said, "My bedtimes are all up to me. They'll (staff) come back if I say I'm not ready for a wash. I get to choose my food and drinks too." A relative told us, "They ask [family member] first before lifting [them] or taking [them] somewhere." One staff member said, "If a bed rail restricted a person too much we can use a sensor mat. This is to keep people safe if they get up during the night and we know straight away they need help." Another staff member told us, "If we have to make decisions for people they have to be in the person's best interests. We would involve the GP, social worker, relatives and staff if this was the case.

We observed that the lunchtime experience for people was relaxed, calm and people were engaged in general conversation. People were supported with their nutritional needs by the provision of home cooked produce offering them a healthy balanced diet. We were provided with mixed comments about the food such as one person saying, "Occasionally we get a nice meal but I can't recommend it. The main course is set. It's a different menu every day but not always tasty. The dessert is sometimes good." Another person told us, "The roasts are okay but not huge portions." A third person did however tell us, "I don't like spice or heat in food with my [health condition]. They (staff) usually do me an alternative – I asked for bacon and fried bread instead of meatballs today so I'll like that. I like the puddings usually."

Our observation at meal times showed that if people wanted an alternative they had this provided. A sufficient quantity of food and drink was provided to meet people's individual needs such as a diabetic diet or fluid restricted diet. Where people were at an increased risk of malnutrition we saw that advice had been implemented from community health care professionals such as a dietician or district nurses. Updates from the speech and language therapist (SALT) had been incorporated into care plans and staff adhered to this guidance. A SALT had fed back to us that "the staff follow our specific training guidelines which are based on National Institute for Health and Care Excellence. The food provided at The Malting's follows current national descriptions for people who require any type of soft food diet and the food is also presented in an attractive way." One person told us, "The chef is wonderful I can't swallow well so have the soft food diet. They (staff) sit here and ask me what I fancy. I have the soup then something soft."

People's healthcare needs were met by prompt requests for health care professional support. People and their relatives told us that the provision of health care support was always provided when requested. One person said, "I have the respiratory nurse coming in for checks on my health. I've already seen the chiropodist and hairdresser and I've only been here two weeks." A relative told us, "They (staff) were quick to spot her [health condition] a few weeks ago and got the doctor in. The activity lady took her out to the dentist recently in a taxi. She's being referred on to the hospital for [treatment] so she can eat better."

People were assured that their healthcare needs would be responded to.

Good

# Is the service caring?

## Our findings

People told us that most staff were kind, friendly and helpful. We observed staff being affectionate with a cuddle or holding a hand to reassure people and generally responding in a compassionate manner to people. During our inspection we observed that where people were uncomfortable, in pain or requiring personal care that staff were sensitive and caring in the way they responded to people's needs. One example we saw was where staff helped a person to eat with one to one support in an unhurried and calm manner with good interaction by holding the person's hand.

People could be assured that staff would treat them with the care and compassion they deserved. However, the impact on people's privacy as a result of surveillance equipment had not been assessed. This had the potential to infringe people's right to a private life. The provider and registered manager provided us with evidence before we published our report that they had acted on this point. We were not able to confirm that this improvement had been sustained.

All relatives we spoke with provided us with positive comments about the care that was provided such as, "I would live here if the need arose…"The service is very friendly" and "They're [staff] very kind and so good with us." The provider told us in their PIR, "To ensure the service we provide is caring, we treat our residents with dignity and respect in a manner that allows each person to be treated as an individual. One person told us, "They [staff] knock and ask if they can come in, as my door's usually open. But when we're washing, they shut it and the curtains." Another person said, "I can lock my door to stop people wandering in. The staff always knock and peep round the door first to see if I'm okay." Staff described to us the circumstances they needed to be mindful of when providing personal care such as covering people up as much as possible and running the bath before taking people to the bathroom.

People told us that the reasons that they felt well cared for. One person said, "I have a few (staff) favourites but I feel ok with them all helping me out." Another said, "There are staff I pick for my bath, as there's a few I don't feel as comfy with." They confirmed that this was purely down to personalities. A third person told us, "It's lovely and the girls (staff) are so wonderful. We often laugh." Several people did however tell us that they struggled to understand some staff whose first language was not English. This had the potential to limit people's involvement in their care.

People's care plans described them in a respectful manner and people confirmed that they, or their relative, had been involved in developing their care plan. One relative said, "I saw [family member's] care plan last week when we did a review so I feel well involved." One person told us, "My family take care of most of it (care planning) and my brother has power of attorney. They (family) ask my say about decisions though, about my care." A health care professional had fed back to us, "The staff that I have dealt with, which are usually on the nursing unit upstairs know the residents history and the residents likes and dislikes. I feel that they know their residents well.

People told us that staff usually encouraged them to be independent and also participate in their personal care. One person told us, "They (staff) leave me to shave and go to the loo alone." Another person said, "I get

help if I'm stuck but otherwise I'm a free agent."

We saw that throughout our inspection that relatives were able to visit freely and this was evidenced by the number of relatives we saw and spoke with. One person said, "There are no set times – my family pop in and out whenever." One relative told us, "We can come and go to suit us."

Good

# Is the service responsive?

## Our findings

The provider told us in their PIR, "We also ensure we are responsive by adopting a person centred care approach in the method care is delivered to our residents. This means that we treat our residents as individuals and respond to their individual needs." We saw that prior to using the service people's needs were determined. This was achieved by speaking with the person, their relatives, health care professionals and others associated with determining what worked best. As, or when, people's needs changed regular reviews were undertaken. This was to help ensure that the service was able to meet people's needs based upon their most up-to-date information.

One person told us, "I'm looked after well and have my favourites in the staff who I feel happier with and understand me. [Name of staff] is going to try and take me to the cathedral to play the organ – I'm very excited about that." Another person said, "They're (nursing staff) working with the respiratory nurse so I get the care when I need it." A third person told us, "They don't take offence when I need to get food reheated as they understand me and my quirks." One relative said, "It's fine here – [family member's] got everything she needs and the attention." We found and saw that people, their relatives or appointed representative, had been consulted and involved in determining the person's care needs. People's life history helped staff to determine those subjects that people had an interest in.

The registered manager told us that care plans were reviewed every month by each person's key worker (a staff member with particular responsibilities such as keeping relatives informed about their family member's care). Formal reviews were completed annually or sooner should anything urgent require attention. For example, a change in the equipment people used such as a pressure relieving mattress or sling to hoist them.

During our inspection we saw that staff responded promptly to people who required assistance such as with cutting up their food, going outside or with personal care. The speech and language therapist fed back to us that during mealtimes, people who were at risk of choking were supported for as long as was necessary with their eating and drinking. This is what we observed.

One person told us, "[Name of staff] gave me a monthly list of what's on, so I can choose to join in. I've got my computer and TV though so am okay in my room." Another person said, "We play cards – like whist and all sorts. A third person told us, "I'm playing the piano in the foyer this afternoon for people. I love my music and the theatre." We saw that this was an occasion which many people enjoyed and showed their appreciation with their applause.

People were supported to participate in an active lifestyle. This was by the provision of outings to a museum, dementia friendly café, local coffee shop and a garden centre. There was also musical entertainment and a monthly exercise class and a hand massage and sensory therapist visit. The activity co-ordinator told us she held a weekly musical movement session to encourage 'practice' for the exercise session. Art and craft, baking, quiz and games sessions were also regularly held. She told us that one-to-one activity involvement with residents in bedrooms was offered as often as possible.

A process was in place to record and respond to people's concerns and complaints. Information about how to complain was available for people and this was located so that they did not have to ask for it. This information also contained details about who to contact outside the organisation. This was as well as using compliments to recognise what worked well. Only one family we spoke with could recall having felt a need to complain and this had been resolved. One person said, "I've not had to complain yet. I'd see a nurse if I wasn't happy." Another relative told us, "I complained after a delay in checking [family member] regularly, as I could see it on the [staff records of when care was provided]. So I asked for more frequent care and it seems to be working now." We saw that people's complaints had been resolved to the complainant's satisfaction in line with the provider's policies.

Good

# Is the service well-led?

## Our findings

The provider had a robust audit programme for clinical aspects of people's care such as wound management, health conditions and visits by health care professionals. Other audits covered subjects such as care plans, safeguarding and people's nutrition. However, we found that a privacy impact assessment had not been completed (this is a requirement of the Data Protection Act 1998 to help protect people's privacy). Details about how this information about people was managed had not been subject to audit. Although people had, where appropriate, consented to the use of their photographs there was no specific agreement for people's information to be video recorded when in the gardens. In addition, it was not clear how long information was held for and who had access to the recordings as well as who could delete them. This meant that people were subject to surveillance that they had not consented to. This was as well as not being consulted or informed what about what happened with their information and the impact on their privacy. The provider and registered manager provided us with evidence before we published our report that they had acted on this point. We were not able to confirm that this improvement had been sustained.
A registered manager was in post and they were supported by a team of staff, which included a compliance manager, nursing staff, senior care staff, care staff, a chef and housekeeping staff. The registered manager told us that the good aspects of the service were seeing staff develop their skills. They told us, "I have worked here since the home opened and it has been nice to see all the hard work paying off. There have been challenges such as building a staff team, which staff are proud to be part of." The registered manager told us that they needed staff with integrity and the right attitude. We found from records viewed, speaking with staff and our observations that this was the case.

Staff were provided with opportunities, such as at daily handover meetings, to discuss and review each person's care. Information from these meetings was collected by the compliance manager who analysed this for any trends or changes in people's health and wellbeing. This enabled prompt action to be taken such as referral to the most appropriate health care professionals. One staff member told us, "I also have a formal supervision with my senior. I can talk about any help I need as well as being praised for what I have done well." Nursing staff maintained their professional membership of the Nursing and Midwifery Council as well as being supported with their revalidation and reflective practise. The leadership of the registered manager supported staff in a positive way.
Most people we spoke with told us they would raise any concern with a senior care staff or nurse initially. Relatives told us that the registered manager was available to talk and approachable. We saw that the registered manager spent time around the service interacting with people and staff as well as observing the standard of care that was provided. One person said, "I've not met her yet. I'd talk to any of the nurses (if a complaint was necessary)." Another person told us, "I know her [registered manager] quite well as she used to be manager at another home I was in. She's very easy to talk to (if concerns needed to be raised)."

Feedback from a tissue viability nurse included, "The records that I look at when at The Malting's, are the health professional contacts, and weight charts. I am always able to find recent weights for the residents I visit." The provider told us in their PIR that they had recently employed a compliance manager who is also a nurse practitioner. Their role was to raise standards and practices through effective training and development. As a result of this staff's role they had introduced a programme where one day per month was

set aside for staff training. This had resulted in a much better level of staff attendance. Improvements were learned from accidents and incidents such as people experiencing a fall. These changes also included the nomination of some staff as champions who were to be a role model and lead role for subjects including dignity, dementia and diabetes. These staff told us that they were "looking forward to having more in depth knowledge and training on these subjects."

Regular meetings were held with people, their relatives and staff. Subjects covered at residents' meetings included meal choices, visits by entertainers, Pets as Therapy dogs, musicians and events such as a summer barbecue. One person said, "I love the musicians and listening to singers." Another person told us, "They [the service provider] have lots of meetings but I can't sit long enough to go but my nephew comes." A relative told us, "There is always something going on but [family member] can chose to take part or not. They (staff) encourage [family member] to attend."

Other less formal occasions were used as an opportunity to gauge people's satisfaction as to the quality of their care such as in day to day conversations with the registered manager or provider. One person said, "I don't see her (registered manager) very often but the owner comes and chats to me for ages." A relative added, "I see [registered manager] around when I arrive and she's very easy to raise things with." All of the people, relatives and staff we spoke with told us that the communication from the registered manager was very good and that they felt listened to. A health care professional fed back to us, "The [registered] manager is very approachable" and "wound charts, assessments and repositioning charts are all completed. This always appears to be an organised, happy place to be in.

People were supported to keep community contacts and to remain in touch with friends and family. One person told us, "I can go out when I want. I go for my newspaper." Other trips out included outings to a museum, dementia friendly café, local coffee shop and a garden centre. One relative told us we take [family member] out to lunch." Another person told us, "My [relative] takes me out to places of interest such as local parks and we have a visiting library with large print books too." This showed us that people were helped to access the community and reduce their risk of social isolation.

Staff were aware of the whistle blowing policy and when to use it. One staff member said, "I would only ever expect to see staff care for people as if it was their nearest and dearest. If I did see anything of concern I would report this immediately." The registered manager had fostered an open staff culture and this had empowered staff to feel confident to whistle blow if ever they had a need to.