Brighstone Care Limited

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Inspection report

Brighstone Grange
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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?	**Outstanding**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 18 and 21 December 2015 and was unannounced. The home provides accommodation for up to 23 people, including some people living with dementia care needs. There were 21 people living at the home when we visited.

There was a registered manager in place. 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.

Staff followed the principles of legislation designed to protect people's rights and liberties. They sought verbal consent from people before providing care and support.

Individual risks to people were managed safely and effective action was taken to reduce the level of risk. When people had experienced falls, senior staff reviewed the risks to reduce the likelihood of further falls.

Summary of findings

Most people received personalised care from staff who understood and met their needs. However, some care records did not reflect people's changing needs. We pointed this out to the registered manager who took immediate action to address this. Care plans provided comprehensive information about the way in which people wished to receive care and support. Staff knew people well, recognised when their needs changed and responded promptly.

People told us they felt safe at the home. Staff knew how to identify, prevent and report abuse, and the provider responded appropriately to allegations of abuse. Clear systems were in place for managing medicines and stock levels tallied with the medicine administration records in all but one case.

People were cared for with kindness and consideration. Staff showed exceptional commitment to supporting people to attend events. They formed supportive relationships with people and promoted choice at every opportunity. Arrangements had been made for people to continue to practise their faith and the home hosted meetings of a local community group.

People's privacy was protected and they were encouraged to remain as independent as possible. They were involved in planning and agreeing the care and support they received and staff encouraged them to make choices about every aspect of their lives.

Staffing arrangements were robust and there were enough staff to meet people's needs at all times. Staff were suitably trained and most staff had obtained vocational qualifications or were working towards these. They were supported appropriately in their work and felt valued. The process used to recruit staff helped make sure that only suitable people were employed.

People praised the quality and choice of food and were involved in designing the menus. When people were at risk of not eating or drinking enough, staff provided appropriate support and monitored people's intake effectively.

People saw doctors or nurses when needed and staff enjoyed good working relationships with healthcare professionals, who praised the quality of care delivered. Staff accompanied people to medical appointments to help make sure their needs were communicated effectively.

A wide range of activities was available to people. These had been tailored to meet people's individual interests and included trips to local attractions in the home's minibus.

The provider maintained a high level of communication with people through a range of newsletters and meetings. They consulted people about all aspects of the service and acted on their feedback. There was an appropriate complaints policy in place; complaints were investigated thoroughly and responded to promptly.

The provider took pride in creating a homely, personal environment; staff shared this vision and were committed to maintaining a relaxed atmosphere. People liked living at the home and felt it was well-led.

There was a clear management structure in place; staff enjoyed working at the home, were motivated and operated well as a team. There were clear systems in place to communicate information between staff and they were encouraged to make suggestions for improvements.

The home had an open and transparent culture. Visitors were welcomed and there were strong links with the local community. A range of audits was conducted to assess, monitor and improve the quality of service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to identify, prevent and report abuse. Medicines were managed safely. Risks to people's health and safety were managed effectively.

There were enough staff deployed to meet people's needs. The process used to recruit staff was safe. Staff were aware of action to take in an emergency.

Good

Is the service effective?
The service was effective.

Staff followed the principles of legislation designed to protect people's rights and freedom.

Staff were suitably skilled, trained and supported in their work. People were supported appropriately to eat and drink enough. Staff supported people to access to healthcare services when needed.

Good

Is the service caring?
The service was caring.

Staff were kind, caring and compassionate. They showed exceptional commitment to supporting people in their own time to attend events and were skilled at building supportive relationships with people.

People were encouraged to remain as independent as possible and make as many choices as they could. They were treated with dignity and respect. Their privacy was protected and they were involved in planning their care.

Outstanding

Is the service responsive?
The service was not always responsive.

Some care plans did not reflect people's current needs, although most people received personalised care from staff who understood and met their needs well. Care plans were reviewed regularly in consultation with people.

People were encouraged to engage in a wide range of activities. The provider sought and acted on feedback from people, relatives and professionals.

Requires improvement

Is the service well-led?
The service was well-led.

Management and staff had a shared vision to provide a homely, friendly environment for people. There were good working relationships between the management and staff. Staff understood their roles, were motivated and worked well as a team.

Good

Summary of findings

There was an open and transparent culture in the service. Staff worked well with external professionals and visitors were welcomed.

Quality assurance systems were in place to assess, monitor and improve the service.

Brighstone Care Limited

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 18 and 21 December 2015. It was conducted by one inspector and was unannounced.

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. We reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home, two family members, two visiting doctors and a visiting community nurse. We also spoke with the provider's representative, the registered manager, the deputy manager, the head of care, four care staff, a member of kitchen staff and a staff member responsible for arranging social activities.

We looked at care plans and associated records for five people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

The home was last inspected on 22 November 2013, when we identified no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "There is nothing that worries me here; I feel completely safe." Another person told us "I'm satisfied I'm as safe as I can be." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. They told us they were encouraged to raise concerns and were confident action would be taken. One staff member said, "[The registered manager] always listens to any concerns and always does something about it. Records showed the registered manager and other staff responded appropriately to allegations of abuse. These had been investigated thoroughly and in cooperation with the local safeguarding authority.

The risk of people falling was assessed in detail. Factors including the person's mobility; their medicines; the likelihood of them developing infections that could cause confusion; and the lighting levels in their rooms were considered and measures taken to reduce the risk. One person who was at risk of falling out of bed could not use bed rails, so a special bed had been obtained which could be lowered to the floor. The person liked sleeping at floor level and this had kept them safe. Other people had been referred to their GP or specialist services, such as occupational therapists to be assessed for mobility aids and for advice on fall prevention strategies. When people had experienced falls, senior staff reviewed the risks and took appropriate action in most cases to reduce the likelihood of further falls. This had not been done for one person and we raised this with the registered manager who agreed to review the risks involved and implement any identified safety measures.

Other risks to people were managed effectively. For example, equipment such as bath hoists, lifts and wheelchairs were checked and serviced regularly. When staff used hoists, they did so in pairs and in accordance with best practice guidance. Environmental risks including people's rooms had been assessed and measures taken to reduce them. For example, alarms had been fitted to first floor fire exits, so staff would be alerted if someone opened one and put themselves at risk. Part of the driveway had also been repaired to make it safer for people to walk on.

Staff showed they understood people's individual risks; they assessed, monitored and reviewed these regularly and people were supported in accordance with their risk management plans. Clear guidance was available to staff about how to protect people who were at risk of skin breakdown, including through the use of special cushions and mattresses, which we saw being used. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, one person chose to have a heavy picture above the head of their bed. Staff had pointed out the risk of it falling on them and they had signed a risk assessment to accept the risk as it was important to them to have the picture in that position.

Suitable arrangements were in place for the ordering, storing, administering and disposing of medicines. The service had developed their own Medication Administration Records (MAR) which had been praised by other professionals for their clarity. The MAR charts were used to record the administration of all medicines and were signed by staff to confirm they had been given as prescribed and at the required time. The registered manager used a clear system to check medicines were given correctly by auditing stock levels when new medicines arrived or when discrepancies were found. We conducted random checks of six medicines and found all but one was properly accounted for and had been given as directed.

Information about when staff should administer 'as required' (PRN) medicines, such as sedatives and pain relief, had been developed to help make sure people received these consistently. A clear system was in place to monitor the use of topical creams to help make sure they were not used beyond their 'use by' date. Medicines were administered by staff who had been suitably trained and assessed as competent. In an effort to reduce medicine errors, the number of staff who administered medicines regularly had been reduced, so they would become more familiar and competent with the process. When staff administered medicines they explained what they were for, checked the person was ready to receive them and offered them drinks before and after they received them.

People told us there were enough care staff to meet their needs at all times. One person said, "I choose to stay in my room but I'm not at all forgotten [by staff]. They pop in regularly and respond quickly if I press my bell." Another person told us staff "respond quickly to whatever I need."

Good

Is the service safe?

A 'supernumerary person' was scheduled to work each day in addition to the rostered care staff. This was a senior member of staff who could cover short-notice absences caused by sickness, for example. This helped make sure there were always enough staff on each shift and staff told us the system "works well". The registered manager assessed staffing levels based on their observations and feedback from people and staff. They told us "We recognised that tea-time was becoming challenging, so we introduced a [3:00pm to 7:00pm] person to help. They prepare and serve the teas and help keep an eye on [a person at risk of choking on their food]." The registered manager also used a 'dependency tool' that gave an indication of each person's level of need and made changes to the staffing arrangements accordingly. When planning staff duties, they took care to maintain an appropriate skill mix on each shift and ensured there was always an experienced member of staff to take charge.

The process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home. People had been offered the opportunity to become involved in the recruiting process for new staff. None had chosen to do this, but the registered manager had developed the process to allow them to observe how potential recruits interacted with people while they were being shown around the home. This had helped them assess the suitability of potential staff for the role.

A new fire alarm system had recently been installed to make it easier for staff to identify the location of a potential fire. All staff had undertaken training in the new system, had taken part in a fire drill and were aware of the action they should take in emergency situations. A person was nominated to act as a fire marshal on each shift and this was clearly shown on the duty sheets. Fire safety plans had also been discussed with people and they were aware of how to leave the building if the fire alarm activated and where to assemble outside.

Good

Is the service effective?

Our findings

Staff followed the principles of the Mental Capacity Act, 2005 (MCA) and its code of practice. 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Most people living at the home had full capacity to make day to day decisions. However, the care records for two people showed they were not able to make decisions about the care and support they received. Staff had discussed some decisions, including the provision of personal care, the administration of medicines and the use of bedrails, with family members and had then made decisions on behalf of people. However, these had not been documented to show why they were in the person's best interests. We brought this to the attention of the registered manager, who agreed to enhance the recording of such decisions.

Staff were clear about the need to seek verbal consent from people before providing care or support and we heard them doing this throughout our inspection. A staff member told us "[One person] isn't keen on washing so we always give her the choice. If she refuses we leave it for half an hour and go back later. If she says 'stop' then we do; we put her back in her chair and make her comfy."

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. No DoLS authorisations were in place, but an application had been made for one person and the registered manager had discussed a potential application for another person with the supervisory body.

People praised the quality and variety of food. One person said, "The food's very good and we always have fresh vegetables." Another person told us "The chef is excellent; the puddings are lovely and there are home-made cakes every afternoon." People told us they could choose where to take their meals. Some took them in their room, some in the dining room and some varied depending on how they were feeling at the time. Menus were provided in people's rooms to allow them time to choose their meals. One person preferred their main meal of the day in the evening and said staff had always accommodated this.

People were offered a variety of nutritious meals appropriate to the seasons, including cooked breakfasts daily. Alternatives were offered if people did not like the menu options of the day. Drinks were available and in reach throughout the day and staff prompted people to drink often. Care staff recognised that people's appetite and ability to eat varied from day to day and assessed their needs at each mealtime so they could provide suitable support. Most people were able to eat independently and some were given occasional help, for example to cut up their food, or were offered plate guards to make it easier for them to use the cutlery. Kitchen staff were clear about the people who need special diets and presented these in an appetising way. One person needed a thickening agent added to their drinks, to prevent them from choking, and we saw this was done routinely. Other people had been provided with fridges in their rooms, so they could buy and eat some of their own food and drinks if they wished.

Nutritional care plans had been developed for each person which identified their dietary needs and their food and drink preferences; they also assessed the risks of people becoming malnourished or dehydrated. People's food and fluid intake were monitored appropriately and effective action taken if they started to lose weight. For example, one person had been referred to their GP and had been prescribed a food supplement. This had been given and their weight had stabilised. When the supplement was stopped, staff continued to encourage the person to eat to help make sure they maintained a health weight.

People received effective care from staff who were suitably trained. One person said of the staff "They really are good. They know exactly what they're doing." Another person told us "You'd have a job to beat this place; we're very well looked after". From discussions with staff, it was clear they had a good understanding of the needs of people living with a diagnosis of dementia; how to care for them; and how to communicate with them. One staff member said, "If they have dementia you have to engage them by giving them time, talking more slowly and making eye contact so

Good

Is the service effective?

they can read your body language." We saw they did this effectively when a person became distressed. They positioned themselves where the person could see them clearly, talked to the person calmly and used touch appropriately, together with the person's name, to reassure them.

The registered manager was a trained occupational therapist and senior staff had a wealth of experience in caring for, and supporting, people. Care staff had completed a wide range of training relevant to their roles and responsibilities. They praised the range and quality of the training and told us they were supported to complete any additional training they requested. A high proportion of staff had also completed, or were undertaking, vocational qualifications in health and social care. Following feedback from staff, the provider had arranged for more training to be delivered face-to-face using an external training company, and less to be delivered through the use of workbooks. A staff member told us "We didn't like the workbooks; face-to-face is much better as you can ask questions to check you understand it."

Staff were supported appropriately in their role, felt valued and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Staff who had worked at the home for more than a year also received an annual appraisal which assessed their performance. A staff member told us "I've learned a lot about myself through supervisions. They've been very helpful and I'm more aware of how I can come across to people now." Another staff member said, "This is one of the best homes I've ever worked in. We're all treated equally and I feel very supported." A further staff member told us "I've had to take time out due to [illness in the family] and [the registered manager] has been very supportive. She supports you in and out of work."

Newly recruited staff worked with experienced staff until they had been assessed as competent to work unsupervised. They also undertook a comprehensive induction programme. Arrangements were in place for staff new to care to gain the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. The registered manager told us new staff learnt at different speeds and they gave new staff as much or as little time as they needed. They said, "One staff member needed a lot of support due to [personal difficulties], so we gave it them; their communication with residents has come on in leaps and bounds. It's been very rewarding."

People were supported to access other healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. The registered manager had recently secured the services of a visiting dentist and a visiting optician, which they said had proved popular with people. A visiting doctor said, "I would be happy to live here. Staff refer appropriately; we have a good working relationship and have confidence in their judgement. If they say someone needs to be seen, then they probably do. They look after people well and are very caring." A visiting community nurse told us "Staff call us early and take on board our advice. I don't have any concerns as to whether things will be followed through; we have a good rapport with staff."

Outstanding ☆

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person told us, "I feel comfortable here. They're good people; they treat me with respect." Another person said of the staff "They are very kind and go out of their way to help us get to appointments and go out on trips." A comment about a person in a survey conducted recently by the provider praised staff and stated, "I have seen my friend smile again and love life."

Staff showed exceptional commitment to supporting people to attend events. For example, the registered manager told us a number of staff had volunteered to accompany people in their own time to a Christmas event at a nearby stately home. They said, "We took about 15 people and it just wouldn't have been possible without [the staff who volunteered]." Staff also arranged for their own children and grandchildren to act out a nativity play at Christmas. A staff member told us "Children from [a local school] used to do it, but one year they couldn't come; so we all got together and brought our own children in to do it for the residents. They all love it."

Without exception, all the interactions we observed between people and staff were positive and it was clear that staff knew people very well. A person told us "I get on with all of the staff. I have a good relationship with them; they are all good fun." Staff told us they particularly enjoyed reading information in people's care plans about their lives and backgrounds. One staff member said, "I like to go through their histories. It helps you understand what their lives were like so you can talk to them on a more personal level." Staff used their knowledge of people to strike up meaningful conversations and build relationships. Another staff member said, "Some conversations with [one person] don't make much sense, but she has photo albums and loves to talk about her sons. When you mention her sons' names, her face lights up." Another staff member told us they liked viewing the photo album with the person as it "makes her happy".

Staff were committed to supporting people to keep in contact with friends and family members. One person's family lived abroad and arrangements had been made to keep in touch with them through a computer based video link. Another person was supported to communicate with their relatives via email. Staff also helped people to form supportive relationships with the family members of people who used to live at the home. Some continued to visit long after their relatives had passed away. Two family members in particular had formed friendships with people living at the home who they had met when visiting their relatives and staff invited them to attend organised events in order to promote and maintain these friendships.

The provider had introduced novel ways of supporting people to continue to practise their faith when they were no longer able to attend services or meetings. For example, to make it easier for people to continue to attend a local bible studies group, staff had invited the group into the home and started hosting its meetings. The registered manager told us "People used to go out to the meetings; now they come here. It's like them inviting friends to their home." In addition, representatives from two faith groups visited the home on a regular basis and were popular with people.

Staff were highly sensitive to people's feelings and treated them with consideration. When people moved to the home they were offered a choice of a male or a female staff member to assist them with personal care. One person had signed a form to say they did not have a preference, but staff suggested this was reviewed after the person showed a reluctance to accept a bath from a male staff member. The registered manager told us "We sensed that [the person] really preferred a female carer, so we changed it." The person confirmed that a female staff member now assisted them with their baths and that they preferred this. Staff acknowledged people as they met them in passing and engaged with them when supporting them to mobilise, for example. People were clearly relaxed in the company of staff and we heard numerous conversations during which each readily shared information about their respective families and their plans for the Christmas period.

People's privacy was protected. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Staff also treated people with dignity and respect. For example, they described practical steps they took when delivering personal care, such as closing curtains and doors, and keeping the person covered as much as possible. When a person became anxious because they thought they had a nose bleed, staff quietly reassured them that it was "just a runny nose". They got a tissue for the person and helped them blow their nose. The person visibly relaxed and thanked the staff member.

Outstanding ☆

Is the service caring?

Staff took a personalised approach to encouraging people to remain as independent as possible. For example, staff asked people where they wished to take their meals, where they wanted their drinks, and where they wished to spend their time. People who were able to mobilise without support were encouraged to do so. A staff member said, "It's also about giving people choice, to allow them to do as much as they can themselves. [One person] likes to try and do the buttons up on her dress, so we let them do as many as they can before we offer to do the rest."

Choices were offered at every opportunity and staff did all they could to meet people's individual preferences. People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing to help make their rooms feel homely. One person, who was a keen reader, told us the provider had installed a bookshelf unit in their bedroom to store all their books. Communal areas were also furnished with items that made it feel welcoming. Another person told us "The atmosphere is similar to my house and it felt like home straight away." A new laminate floor had been laid in one person's room, before they moved into it, but they found this did not suit them. In response, the provider installed a new carpet on top of the laminate to make the room more pleasant and homely for the person.

Staff were keen to support people when they were admitted to hospital. A senior member of staff routinely accompanied them in order to make the experience less distressing and advocate on their behalf with hospital staff. This helped make sure that their needs were communicated and understood, which improved the likelihood of positive outcomes for people. Care staff also accompanied people to routine medical appointments and were able to use the home's disabled access vehicle as transport.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going. People's preferences were known and recorded, and staff took care to make sure they were met. One person said, "I've seen my care plan and it is discussed from time to time." When decisions were made about resuscitation, people were involved in discussions about this. A discreet symbol was used in people's rooms to inform staff when such a decision had been made, to help make sure they followed it.

Requires improvement

Is the service responsive?

Our findings

Most people received personalised care from staff who understood and met their needs well. One person said of the staff, "They do everything I would want them to do; when I have a bath, they get everything ready for me, it's lovely." Another person told us "There's no set routine; we can please ourselves and ask for help if we need it."

Care plans provided comprehensive information about how people wished to receive care and support. For example, guidance on the support people needed with personal care was clear and specified the order in which people liked to wash and dress; what time of day they preferred to bathe; when they liked to get up in the morning; and the signs they showed when they were ready for bed.

However, some care plans did not reflect people's current needs. One person was no longer able to mobilise independently; although staff were aware, and supported the person appropriately, their care plan did not reflect this. Another person was recovering from hip surgery and needed to build up their leg muscles; there was no information available to guide staff about how to do this, and staff were not clear about the extent or type of exercise that would be suitable. The care plan for a further person, who had a catheter, did not contain sufficient information to help staff manage and monitor its use appropriately. We brought these issues to the attention of the registered manager who agreed they were areas for improvement.

Reviews of care were conducted regularly by the registered manager or the deputy manager. As people's needs changed, people's care plans were developed so they remained up to date and reflected people's current needs. People and their relatives were consulted as part of the review process and their views were recorded.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed; how and where they spent their day; and how often they chose to have a bath or a shower. One person said, "I choose to have breakfast in bed; they asked when I wanted it and where; I asked for it at 8:00am and it's always there at 8:00am."

A staff member told us "I believe everyone should be given a choice, whether they have dementia or not." They explained how they offered choice while supporting a person with their personal care. They said, "I offer her the flannel and sometimes she will do her face. I ask what she wants to wear and sometimes she can point to clothes she wants. It's about getting to know them." The care plan for another person stated: "Sometimes likes to get up and dressed before breakfast and sometimes likes to catnap in their armchair in their dressing gown before having a cup of tea"; the person confirmed they were always given this choice. They told us they could choose where they took all their meals and we heard staff offering them a range of options. The person had also opted not to have regular checks made on them by staff, stating that they would "ring for assistance if they needed it." Records of daily care showed people received all the care and support that was planned, and that the choices they made were respected.

The provider used a key worker system. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for monitoring that person's care and liaising with family members. People were able to select their own key workers, who had a set of regular tasks to perform including: discussing any changes to the care and support people received; checking the person's weight, footwear and spectacles; doing any shopping the person wanted; and cutting their nails.

Staff knew people well, recognised when their needs changed and responded promptly. For example, one person became "chesty" and their mobility "shaky". Staff responded by supporting the person to mobilise with a stand aid and contacted their GP for advice. In the interim, they started encouraging the person to drink and monitored their fluid intake in case the changes were caused by an infection. Another person had a condition which meant their mobility varied greatly from day to day. Staff understood this and supported the person accordingly. A staff member told us "[The person] has good days and bad days. Sometimes they can walk with a frame and sometimes they can't. Sometimes they need help to eat and sometimes they manage OK; so we have to see how they are and be led by them." We observed that when the person became restless, staff recognised they may have been hungry, so offered them an early tea which they accepted.

Staff used a recognised pain assessment tool to help identify when people who were unable to verbalise pain needed pain relief. Care plans contained information about the signs and symptoms people displayed when in pain,

Is the service responsive?

such as their body language and facial expressions. One person had a tendency to tamper with items when they became anxious, so staff had provided a special blanket with items stuck to it with tape that could be repositioned. This allowed the person to interact with something tactile. A staff member told us "[The blanket] makes her happy; she used it this morning and it made her very relaxed."

Staff recognised when they were no longer able to meet people's needs, when these became too complex. They liaised with care managers and other homes to identify suitable placements for people.

People were encouraged to take part in activities to prevent them from becoming socially isolated and care plans contained information about people's 'life and social care'. This explained people's interests, hobbies and activities they enjoyed. The provider employed two social activities coordinators to organise activities. One of them told us "We speak to each person to see what they like doing and base activities around them. Some like group activities and some prefer one-to-one activities, like doing quizzes, puzzles or talking about soap operas we watch. One person is very tactile and likes having their nails done."

One person told us "There's quite a lot of things going on. I like talking about books. I told [staff] I liked reading biographies and they just appeared with two or three for me to choose from." Another person said, "We made a snowman; we do a tree with the festival in the church; we had Christmas lunch at [a local pub]; we had a party where we can invite our families; wherever there's a birthday they make a cake; it's just amazing what they do for us." Frequent trips in the home's minibus were also arranged to local attractions and were popular with people. One person was unable to travel in a group, so arrangements had been had to take them out on their own.

Time was built into the staff rota to allow staff provide one-to-one time with people, including those who preferred not to engage in group activities. A staff member told us "It's good, because it gives us time to just talk to people. [One person] gets upset sometimes and talking to her really helps." A staff member told us "If anyone ever wants to go out for a coffee, the management just say 'take them' and we do."

The provider maintained a high level of communication with people about events at the home. A monthly newsletter was produced for people and their families to inform them about planned trips, people's birthdays and staff changes. A 'manager's newsletter' was produced twice a year to update people about strategic changes to the service, including changes that had been made in response to feedback. In addition, 'residents' meetings' were held every two months. These were used to seek ideas from people about activities or any changes they wished to see in the way the service was provided. Minutes of the meetings showed people were continually reminded of all the choices they were free to make. The meetings were attended by the chef, who sought people's views about menu options and adapted the menu to suit their wishes.

The provider sought and acted on feedback from people. Annual surveys of people, their relatives and health professionals were conducted. Results were then analysed and an action plan developed. Following feedback, an anonymous suggestions box had been placed in the reception area to allow people to make suggestions more easily.

There was an appropriate complaints policy in place, which was prominently displayed, discussed with people during 'residents' meetings' and advertised in home's newsletter. One person told us "If I had any complaints, I'd just talk to [the registered manager]; she's very easy to talk to." Records showed complaints were investigated thoroughly and promptly. At the end of the process, complainants were given comprehensive responses, covering all of the issues raised.

Good

Is the service well-led?

Our findings

People liked living at the home and felt it was well-led. One person said, "[The registered manager] is very conscientious and the place is well-run." Another person told us the home was "well-organised". A community nurse said of the home "They have an excellent manager and they are on the ball with everything."

The provider's representative told us they had a clear vision to provide a high quality service in a small, homely setting. They told us they had been encouraged to expand the business, but had chosen not to, so that they could maintain a personal, friendly atmosphere. They said, "People see it as a homely place, not an institution. We are proud of the family atmosphere we've created and the praise we get from people and their families. We have a very good reputation." This vision was understood and shared by the staff, who were committed to maintaining a relaxed environment and were attentive to people's individual needs. People told us they enjoyed the relaxed atmosphere at the home. One person said, "It's as near to home as you could be."

The registered manager told us they received a high level of support from the provider. They and the provider's representative were active members of the local care homes association where they served as committee members. This gave them access to external training events and helped them to keep up to date with changes in best practice. It also gave them access to peer support. The registered manager told us "That's where I get my supervision; it's great." The provider also belonged to a trade body that provided legal advice and support on employment related issues.

There was a clear management structure in place, consisting of the registered manager, a deputy manager and a head of care. They had complimentary skills and worked well together. All staff understood their roles, were motivated, committed and worked well as a team. One member of staff told us "I enjoy coming to work and there's good team work. It would be difficult to meet people's needs if you didn't work as a team." A "Bright ideas" scheme had been introduced recently to reward staff for innovative ideas.

Staff enjoyed working at the home and told us they felt supported by management. A staff member told us "You couldn't wish for a better manager. She's always there for you and even pops in at weekends." Another member of staff said, "This is one of the best homes I've ever worked in. If there's an issue, it's sorted out straight away. We're all treated equally, we feel valued and people are given lots of choices." It was clear that there was a close working relationship between management and staff. This was helped by the office being accessible, in the centre of the home, and an open door policy which meant management, staff and people could interact easily and seek mutual support throughout the day.

Clear systems were in place to help staff communicate information. These included memos posted on the staff notice board and a 'handover diary' which highlighted incidents, events or changes in people's needs. A staff member told us this was "helpful and well-used." Short meetings were held at the beginning of each shift, so staff from the previous shift could pass on any important information about people. In addition, staff meetings were held regularly and provided opportunities for staff to make suggestions and raise concerns. Staff described these as "interactive". One staff member told us "[Management] are very open to new ideas and discussions. We are listened to and good ideas are implemented."

There was an open and transparent culture within the home. The provider notified CQC of all significant events and there were good working relationships with external professionals. A community nurse told us "We have a good rapport with staff and trust each other." The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. The provider had recently introduced a 'Duty of Candour' policy. The policy was followed on one occasion when a person did not receive their medicines; this led to an investigation being conducted and a written apology being given to the person concerned.

There were strong links to the local community and visitors were welcomed. A person told us "I can have visitors any time; [staff] make them feel at home and they are immediately offered tea and coffee." Local groups were welcomed, including local faith and singing groups. The registered manager told us "We always invite relatives and our day-care residents to join our social outings and

Good

Is the service well-led?

special occasions, especially people who we know would otherwise be alone at Christmas." The home also hosted an annual summer fete and provided a venue for an open-air church service for people from three local villages.

Audits of key aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly to assess, monitor and improve the quality of service. When concerns were identified, changes were made to enhance practices. For example, quarterly reviews of care plans had identified updates that were needed and we saw these had been completed. Improvements to infection control procedures had also been made in response to the most recent infection control audit. In addition, complaints and investigations were analysed to identify actions that would reduce the likelihood of a recurrence; these had included the introduction of unannounced, spot-checks by managers to monitor staff practices.