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Dulverton House

Inspection report

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Date of inspection visit:
26 July 2016

Date of publication:
15 September 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26 July 2016 and was unannounced.

Dulverton House provides personal care for up to 22 older people, some of whom may be living with dementia. On the day of the inspection there were 16 people living in the home, which is located in the seaside town of Scarborough. Dulverton House does not provide nursing care.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were correctly able to tell us what they would do to ensure people were safe and how to refer any concerns to the correct agencies. People told us they felt safe at the home. The home had sufficient suitable staff to care for people and staff were safely recruited.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date in areas the registered provider considered mandatory, such as infection control, health and safety, food hygiene and medicine handling and also in specialist areas of health care appropriate for the people who lived at the home.

Staff had received up to date training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They understood that people should be consulted about their care and that they should assume that a person had capacity to make decisions. Staff understood what needed to happen to protect the best interests of people who did not have capacity to make certain decisions.

Some people told us they did not like all the meals they were offered. However, people's nutrition and hydration needs were met and some people told us they enjoyed the meals. People were offered alternatives if they did not like certain menu choices. People's clinical care needs were met in consultation with health care professionals.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with respect. Staff had a good knowledge and understanding of people's needs and worked together well as a team.

Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were supported to feel cared for and listened to. Care plans were updated when people's needs changed.

People were supported to engage in daily activities they enjoyed. Staff understood what was important to

people, their personal histories and social networks so that they could support them in the way they preferred.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. People we spoke with told us that if they had concerns these were addressed directly with the registered manager who responded quickly and with politeness.

The service was well managed. The registered manager ensured the quality of the service through a system of audits and checks. They sought feedback from people who lived at the home, relatives, visitors and professionals with an interest in the service and acted on this to improve people's quality of care.

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.

Risks to people's safety were assessed and acted on and risk assessment plans included how to maximise people's freedom.

People were protected by sufficient staff who were safely recruited. Staff had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

People were protected from the risks of acquiring infection because the service had infection control policies and procedures in place which staff acted upon.

Is the service effective?

Good

The service was effective.

People were well cared for and staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide appropriate care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA) and their best interests were protected.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring and we observed that staff were thoughtful and compassionate.

Staff respected people's privacy and treated them with regard to their dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported them to offer personalised care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

A registered manager was in place who demonstrated an approachable presence around the home.

A quality assurance system was in place to consult with people, monitor the service and inform improvements.

The culture was supportive of people who lived at the home and of staff.

Dulverton 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 26 July 2016 and was carried out by one adult social care 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. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We received a Provider Information Return (PIR) from the service. 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 used the information on the completed PIR and also gathered information we required during the inspection visit.

During the inspection visit we spoke with six people who lived at the home, one visitor, four members of staff and the registered manager. After the inspection visit we spoke with two health and social care professionals. We also spent time observing care in the communal areas of the home.

We looked at all areas of the home, including people's bedrooms with their permission, where this was possible. We looked at the laundry, bathrooms, toilets and the communal areas. We looked at five care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at the home.

Good

Is the service safe?

Our findings

People told us that they felt safe at Dulverton House. They felt there were sufficient staff on duty to care for them safely. One person told us, "Yes there are always enough staff, they are nice and work hard." Another person said, "There is always someone there for us." Another person told us they felt safe and added, "I have a lock on the door if I need to use it." We observed staff talking with a person who was distressed in a way which quickly calmed them and diverted their attention to something that interested them.

Safeguarding policies and procedures were in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us the levels were set according to the number and dependency levels of the people living at the home at any time. The registered manager told us they considered skill mix and experience when drawing up the rota. Care staff were enabled to focus on their caring role as the service employed separate domestic staff and also staff who engaged people in activities. We spoke with staff and they told us there were enough staff on duty at all times to meet people's needs and not feel rushed. Our observations on the day of inspection also confirmed there were sufficient staff to care for people safely.

Risk assessments were in place for each person who lived at the home. Care plans included instructions for staff around recognising changes in behaviour which may, for example, be due to changes in physical or mental health needs. Risk assessments covered such areas as falls, continence, individual fire risk assessments, moving and handling and supporting people to make decisions. Records showed that risk assessment plans often improved the quality of people's care experience. For example, the registered manager told us about a person who required two staff to support and encourage them to stand and walk. With two staff to assist, the person was supported to retain a level of independence without requiring a moving and handling aid or a wheelchair. We observed staff assisting the person to move in this way. They showed patience and skill in supporting them to walk safely and to retain the skills they had in this area.

Environmental risk assessments were in place and entry to the home was controlled by keypads on the exit doors for people's safety. Health and safety checks were regularly carried out as part of the quality monitoring system and any required actions were acted upon.

We looked at the recruitment records for four staff which showed that safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring

Service (DBS) for each member of staff. DBS checks assist employers in making safer recruitment decisions by ensuring that prospective care workers are not barred from working with certain groups of people. This meant that the home had taken steps to reduce the risk of employing unsuitable staff.

Staff told us that they had received training in the control of infection and training records confirmed this. They correctly described how to minimise the risk of infection, such as through using the correct aprons and gloves and washing their hands between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry were kept separate to minimise the risk of cross infection.

Medicines were stored safely in a locked trolley attached to a wall. Controlled drugs were stored separately and administered according to policy and procedure. Medicines were supplied to the home in a Monitored Dosing System (MDS). MDS is a medication storage device designed to simplify the administration of solid oral dose medication. We found appropriate arrangements were in place for the ordering and disposal of all medicines.

The registered manager told us they made regular checks on stocks and recording to ensure people received their medicines safely and at the time they needed them. We saw the results of these medicines audits. These had highlighted areas for improvement with action points in place and a timescale for completion. Previous action points had been completed in a timely way. This oversight of medicines reduced the risk of error.

We looked at the Medication Administration Records (MAR) for two people. The MARs were accurately completed and medicines were signed for. We also checked a sample of boxed stock levels which tallied with the records kept.

Staff told us that they received regular medicine training updates and records confirmed this. This meant that people benefitted from being cared for by staff who were trained in best practice around handling medicine.

Good

Is the service effective?

Our findings

People told us that the care they received was good. One visitor said, ""This is much better than the place [the person] was [living] before and [they are] much happier here." People said that they were consulted about their care. One person said, "They do ask us about what we want to do and they explain things." People gave mixed views about the food. One person said the food was "quite good," and another said the food was "only average." Two other people said, "The food is horrible," and, "It is not very well cooked." One person said, "The chef tries hard but sometimes it seems to have been pre-frozen and has not much taste to it." People told us that that the registered manager was quick to consult with health care professionals.

Staff had received induction and training in all areas the registered provider considered mandatory (core training). Staff told us they shadowed other more experienced staff when they were first recruited and only began working with people unsupervised when they were confident and the registered manager felt they were competent. Training was provided through a range of provision. Some was online, some was face to face in a classroom setting and some was through meetings and informal learning. All staff training was completed and up to date and a plan was in place for when this needed to be renewed. In addition to the core training, the registered manager had sourced training in areas such as behaviour which may challenge others, care for people who were living with dementia, palliative care, skin care and effective communication. Staff also received training in respecting diversity and treating people with equality. Staff told us that this supported them to offer personalised care for people.

Staff told us they received regular supervision and appraisal which they told us supported them to offer appropriate care. Records confirmed that supervision and appraisal regularly took place.

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

People's plan of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing their ability to make decisions. The service also had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should always assume capacity and support people to make their own decisions. People had signed their consent to receive care, and for photographs to be used to support them with medicines and personal care.

Staff were able to tell us about when a Best Interests Decision may be made and who might be involved in

this to protect people. A Best Interest Decision is made when a person does not have the capacity to make a decision for themselves and involves a multidisciplinary team. We saw records of Best Interests Decisions which had been carried out involving the person concerned and other relevant people which formed a multidisciplinary team. The registered manager told us in the PIR that DoLS for almost all the people living at the home had been applied for and granted. These were subject to review. Records confirmed that these had been applied for and put into place appropriately and that the decisions had been made in the person's best interests.

People's consent to care and treatment was recorded along with their capacity to make decisions about their care. Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures. Information about advocacy services was available to people and advocates were appointed when needed. One person had an Independent Mental Capacity Advocate (IMCA) to support them with making decisions about their care.

Needs relating to nutrition and hydration were recorded in people's care plans, and risk assessments and plans were available. Staff were able to tell us about people's nutritional needs, for example, how people required their food to be presented and whether people had allergies. People's likes and dislikes were recorded and staff were aware of what these were.

The registered manager referred people for specialist support when this was needed. Charts for monitoring people's food and fluid intake, continence and their moving and handling were completed when necessary. These were recorded accurately with no gaps. The registered manager told us that monitoring information was shared with health care professionals so that they had the information they needed to advise staff appropriately.

We observed a meal time. People received food which was served in good portions and looked appetising. The registered manager told us that if there was a meal people did not like the cook would ask whether they would prefer an alternative. Lunch time was a sociable occasion and people had the opportunity to chat with each other. The dining room was clean and spacious and the atmosphere was pleasant. We observed that staff assisted people when they required this in a kind way, sitting at the same level with people, talking with them, and supporting them at their own pace. We noted that drinks and snacks were available mid-morning and in the afternoon.

We spoke with the chef who told us that they listened to people's views about the meals and offered choices in line with their preferences. They asked people in advance what they would prefer for the next day's meals and prepared extra in case people changed their minds. There was a choice of two main meals and desserts. People could choose breakfast options ranging from a full cooked breakfast, poached egg to cereal, porridge and toast. At tea-time there was always a hot option, with sandwiches, soup and home-made cakes also on the menu. People were served a light supper with a choice of cheese and crackers, cake or sandwiches. The chef told us that they provided softened or liquidised meals when this was required and that when they did this, they kept each type of food separate so that people were able to experience different tastes and colours on their plate. The registered manager was aware that a number of people were not satisfied with the quality of the food, but that they were working to improve and act on people's wishes.

The registered manager told us how they monitored people's mood and behaviour. Care plans included instructions for staff around recognising changes in behaviour which may, for example be due to changes in physical or mental health needs. Information from care plans, reviews and daily notes was shared with mental health professionals when they were advising staff on individual people's care.

The registered manager told us that other medical conditions which required monitoring were managed in consultation with health care professionals and that risk assessments were in place. They told us that the staff handover between shifts was a useful way of ensuring staff understood any changes in people's care needs and whether there was any involvement or advice to pass on to them from health care professionals. GP and other health care professionals visits were recorded separately which meant that communications around people's health were easy to find and monitor. Care staff kept clear notes about consultations. The support guidelines from professionals were written into care plans with people's involvement and consent where relevant.

Staff routinely supported people to attend GP and hospital appointments. Care plans showed that people had been seen by a range of health care professionals including GPs, dentists and district nurses. During the inspection visit we witnessed staff taking note of a person who appeared unwell and saw that they called for a GP to visit. Staff were reassuring to the person while they waited for the GP to arrive and they also confirmed and explained to the person what the GP had said after the visit. The person appeared reassured and chatted with staff about what the GP had said. A health care professional confirmed that the staff at the home were quick to refer to them and that they consulted them appropriately

The registered manager explained that the home did not offer hoisting for people who lived there. This was because they considered the home was unsuitable for large lifting equipment. They told us that they explained this to people during the assessment process and that if people's needs meant they required a hoist then they were consulted about moving to a service which could meet their reassessed needs. We saw that the statement of purpose explained that hoists were not used within the home.

Some rooms for communal use had few pictures or items of interest, particularly for those people who were living with dementia. The pictures decorating the upper corridor were dark and unappealing. The registered manager told us they planned to change these as a matter of priority. However, the environment had some adaptations for the needs of people who were living with dementia. For example, people who agreed to this had had photographs of the person on their room door to support them to identify it. There were signs to support people to recognise key rooms and areas of the home and some areas had attractive, bright pictures which made these parts of the home more cheerful. The registered manager explained that the dining room had recently been decorated and that this was why there were no pictures present. They planned to consult with people on their preferred pictures for this area.

The garden was attractive and had raised bed areas so that people could assist with planting flowers and shrubs. The registered manager had planned a summer house with sensory equipment for people's benefit after consultation with them about the way they wanted the garden area to be developed.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, "Staff do their best and are very helpful." Another person said, "They take time with you." The person who had been feeling unwell and who had received a visit from the GP said, "They listen. They are nice to me." People told us that staff responded quickly when they asked for help and that they did so in a kind manner.

The staff and people we spoke with told us that the home encouraged visitors at any reasonable hour and we observed that a visitor was greeted by staff in a friendly way. A visitor told us that the staff always offered them refreshment and that they were made to feel very welcome.

We spent time with people in the communal areas of the home and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. Staff gave the impression that they had plenty of time and spoke with people who were sitting so that they were on eye level with them. They reassured people with a touch on the arm or hand where this was appropriate. We observed that staff were talking with people about their lives, who and what mattered to them and significant events. Staff were good at communicating with people, anticipating needs and making people aware of what their choices were. Staff interacted well with people who were observed to be more withdrawn and included them in conversations. People who were sitting quietly became more animated and smiled when staff were speaking with them and appeared to enjoy the interaction.

Staff understood the importance of respecting people's privacy and dignity and we observed a number of examples where this happened during the day of inspection. We noticed that staff knocked on people's doors and waited for a response before entering. When people were being supported with all types of personal care, staff always did this in private and people's doors were closed to respect their privacy. People were approached discretely with regard to their personal care needs. Staff gave people time and responded to them in a way which respected their view of what was happening.

When we asked the registered manager how people were placed in the centre of importance they told us that they had regular meetings to discuss whether people's needs had changed. People were consulted around these meetings. Small adjustments in approach were often needed to reduce anxiety or to increase people's comfort. For example staff gave the example of offering to go out into the garden with one person who enjoyed walking around in the open air when they were feeling anxious. We observed staff talking with one person, kindly explaining why they were living at the home and the process for assessing the suitability of returning to their home in the community.

The registered manager explained a number of examples where staff had noticed signs which concerned them, such as people being short of breath, appearing withdrawn or looking for reassurance. Staff told us they observed people for signs of pain or distress and acted quickly to alleviate this. Our observations confirmed that staff were kind and responsive to people's emotional needs.

Some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, and these were

correctly completed and regularly reviewed to ensure they were in line with people's current wishes.

Staff told us about the way people were cared for in their final days. Staff had received training in palliative care and the registered manager told us that they liaised with the district nurses to ensure people received the care they needed. Staff emphasised the need for close liaison with palliative care professionals and attentive monitoring to ensure people did not suffer pain. They also spoke about the importance of supporting relatives, the people who lived at the home and each other when that difficult time arrived.

Good

Is the service responsive?

Our findings

People told us that the staff understood their needs and that they were well cared for. One person told us they enjoyed activities such as bingo, dominos, crossword and board games. Several people said that they had a daily newspaper delivered so they were able to keep up to date with the news. People told us that they could express their views and knew how to complain. One person told us, "They will listen to what you say and try to put things right." Another person said, "They know I like to make things and walk in the garden and we do the things I like." People told us that the staff took their concerns seriously and acted on them. We observed a number of occasions when staff responded to people who appeared to be withdrawn, asking them if anything was wrong or if they needed anything.

Staff told us they focused on promoting people's independence and on what people could do for themselves. One member of staff told us about how they encouraged people to fasten clothing, or work towards goals such as walking a little further. The service had slide sheets and turning discs to enable people to retain the independence they had with moving around the home. People's personal objectives were written into their care plans so that these could be reviewed regularly.

The main points of review discussions with individuals were recorded. It was clear from the records that efforts had been made to involve the person and those they wanted to be consulted in this process either through people signing or by staff writing records of what the person had said and preferred.

When people were unable to respond verbally, care plans contained details to guide staff such as , "Mrs [name] communicates with facial expressions. If [they] don't want to do something, [they] will grimace and pull away." Where people did not have the mental capacity to communicate their choices and preferences, efforts had been made to consult with those who were important to them or with Independent Mental Capacity Advocates (IMCAs). Reviews focused on wellbeing and any improvements which could be made to people's care. Records were detailed and gave clear information about any changes to people's care needs, their achievements and the goals they had reached. For example, one review record gave details of how a person's mobility had improved during the month, another about how a person was getting out of the home more often for outings. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care

Relevant specialists were consulted for advice at reviews. For example we saw that the Speech and Language Therapy Team (SALT) had been involved for one person and a district nurse for another. The registered manager told us about reviewing a person's mental health with appropriate professionals to ensure they were receiving the right service for their needs.

People had identified areas of interest, likes, dislikes and preferences within their care plans. For example, one person's file included the information that they preferred a female care worker and staff knew about this and acted on it. People's life histories were recorded in detail with their permission, and included information such as previous occupations, hobbies, family and friendships, spiritual needs and preferred ways to spend time. For example we learned of the varied and interesting life of one person who lived at the

service. Staff told us they were able to chat with this person about their previous sea adventures and support them along with their relatives to decorate the home with boats and images of travel. Some people had photographs of activities they had been involved in on their bedroom wall which staff told us they used as a conversation starter.

Staff knew about people's interest and life histories and were enthusiastic about telling us how people they cared for had been involved in such areas as choral singing, playing musical instruments, lecturing, and other jobs people had held.

The registered manager told us that there was a specific activities member of staff who was a volunteer. During our inspection visit, the activities organiser visited the home and we saw that people enjoyed singing and moving their feet to music. The registered manager told us that this person visited the home twice a week for an hour, and that they engaged people in a number of activities usually with a musical theme. When the activities organiser was not present staff told us they had time in the afternoons to carry out other activities. For example, during our visit we saw staff engaging with people in hand eye coordination games such a throwing and catching. Staff told us they accompanied people into the garden and we saw a number of people in the garden during the day. Staff said that some of the people who lived at the home enjoyed gardening in the raised flower beds.

The lounges had books, magazines and jigsaws for people to use. Staff told us that for people who spent time on their own they visited them in their rooms for a chat and to prevent them from feeling isolated. We spoke with a person who chose to spend their day in their room and they confirmed that staff did often check that they were okay and whether they needed anything. People's engagement was recorded in a 'quality time' record. We saw entries such as "Enjoyed a game of hoopla", "Chatted about life history," and "Had a game of darts." Staff told us about one person who had read a novel and had asked for staff to purchase the film of the book and that they and other people had enjoyed this.

The registered manager told us that some people attended day facilities which provided them with a change of scene and different stimulating activities such as baking or craft work. They also went out on short trips, for example to the local theatre or out for lunch accompanied by staff. Some people went out with relatives and friends and staff told us they made sure people were dressed as they wished and were ready for these trips when they took place.

People were consulted about their preferences on a one to one basis or in the regular residents meetings. For example, the registered manager told us how people had been involved in making decisions about the plans for the garden and the summer house with a sensory room. Work was beginning on this in the near future.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw that the service had a complaints procedure and staff told us this was followed. One person told us, "I would go to the manager if there was a problem and they would listen." We saw a record of complaints and the outcomes with timescales to monitor how these were managed.

Good

Is the service well-led?

Our findings

People were positive about the registered manager. One person told us, "I see [them] every day and we always have a chat." Another person told us "I have never had any problems, and [the registered manager] is lovely." And, "You can have a proper talk with [them] and [they] are nice with the staff."

The home had a registered manager in place who was qualified for the role and who was registered with CQC. The registered manager held regular resident meetings. Meetings were used as opportunities to listen to people's views and to pass on information. Recent minutes of meetings showed that people had expressed their preferences for outings, menu changes, and preferred furnishings for their rooms. Records of outings showed that people's preferences had been taken into account. Menus had changed in line with people's suggestions and the registered manager told us that they had sourced extra furnishings such as a new bedside cabinet, a table lamp and a fan for people who had requested these.

Staff told us that the manager was open and positive with them, and that they felt supported in their role. They had regular staff meetings which gave theme information and guidance to care for the people who lived at the home and to offer staff the opportunity to raise any issues and share good practice. Minutes were kept and identified actions recorded.

The service was a member of the Independent Care Group, (ICG) which provided weekly updates and training opportunities relevant to staff. This showed that the manager sought advice and support from external organisations.

The registered manager carried out a range of audits to ensure that the service provided people with safe and good quality care. These included risk areas such as medicines, health and safety, and infection control. They also monitored the quality of meals, activities and care plans. Where shortfalls were identified, an analysis was carried out with actions in place to minimise future risks. Lessons learned and reflections for future learning were discussed in staff meetings.

People had been surveyed for their views about their care. For example, people had been surveyed about the activities and menus on offer. This had resulted in the home developing a plan and this had been communicated to people through the residents meetings and in one to one conversations with people. People we spoke with told us that the registered manager often called on them for a chat and that they were approachable.

The registered manager carried out several daily walks around the building where they identified any issues, and spoke with people and staff. The registered manager told us that this supported them to be more visible around the home and to pick up on things which needed attention.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager

and staff consistently reflected the culture, values and ethos of the home. This placed people at the heart of care.

Notifications had been sent to the Care Quality Commission (CQC) by the service as required to ensure people were protected through sharing relevant information with CQC.