Crosscrown Limited

The Chimneys Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 2 and 3 December 2015. The inspection was unannounced.

There was 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.

The service provides accommodation and personal care for up to 26 older people, some of whom are living with dementia. Twenty-five people were living at the home on the day of our inspection.

Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies. The registered manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks.

There were enough staff on duty to meet people's health and social care needs. The registered manager checked staff's suitability to deliver personal care during the recruitment process. The registered manager regularly checked that the premises and equipment were suitable and properly maintained to minimise risks to people's safety .People's medicines were managed, stored and administered safely.

People's needs were met effectively because staff received appropriate training and support. Staff read the care plans and new staff shadowed experienced staff until they knew people well and understood their needs and abilities. Staff were encouraged to reflect on their practice and to develop their skills and knowledge, which improved people's experience of care.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager had applied to deprive one person of their liberty in accordance with the Act. They were awaiting the Supervisory Bodies decision to grant the authority at the time of our inspection.

People were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs and staff understood the importance of helping people to maintain a balanced diet.

People were cared for by kind and compassionate staff who knew them well. Staff knew about people's individual preferences for care and their likes and dislikes. Staff supported people to maintain their health by seeking advice and support from other health professionals. The registered manager made appropriate arrangements to support people until the end of their life.

People and their representatives were involved in discussing their care needs and in developing a care plan.

Care was planned to meet people's individual needs, abilities and preferences and care plans were regularly reviewed.

The provider's vision and values were understood and shared by the staff. The management team demonstrated the skills and quality of leadership to inspire and support staff effectively.

The provider's quality monitoring system included consulting with people, their relatives and other health professionals to ensure planned improvements were focussed on people's experience.

The registered manager made regular quality checks of people's care and health, medicines management, meals and suitability and management of the premises. Accidents and incidents were investigated and actions taken to minimise the risks of a re-occurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff understood their responsibilities to protect people from the risk of abuse. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. The registered manager checked staff were suitable to deliver care and there were enough staff to support people safely. Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective. People were cared for by staff who had appropriate training, skills and management support. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. Meals were planned to meet people's nutritional and specialist dietary needs and choices. People were supported to maintain good health and to access other healthcare services when they needed them.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate towards people. Staff knew people well and respected their privacy and dignity. Staff promoted people's independence by supporting them to lead their lives in the way they wanted. Staff respected people's wishes for their end of life care.

Is the service responsive?

Good

The service was responsive. People and their families were involved in planning and reviewing how they were cared for and supported. Staff knew people's preferences, likes and dislikes. Staff supported and encouraged people to remain active and to make decisions about their community. The provider's complaints policy and procedure were accessible to people who lived at the home and their relatives.

Is the service well-led?

Good

The service was well led. People, their relatives and staff were encouraged to share their opinions about the quality of the

service which ensured planned improvements focused on people's experiences. The provider and registered manager operated an open culture that empowered and inspired staff. The provider's quality monitoring system included checking people received an effective, good quality service that met their needs.

The Chimneys Residential 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.

The inspection took place on 2 and 3 December 2015 and was unannounced. The inspection was undertaken by an 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.

We reviewed the information the provider had shared with us in the provider information return (PIR). The PIR 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 the information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with six people who lived at the home, two relatives and a visiting health professional. We spoke with the registered manager, three care staff, a cook and the operations director. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Most of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the

experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff. One person said, "Yes I do feel safe, very definitely." A relative told us, "Yes he is safe here – he feels very safe in this home."

Staff knew and understood their responsibilities to keep people safe and protect them from harm. Care staff told us they had training in safeguarding and knew the actions they should take if they had any concerns. A member of care staff told us, "I learnt about safeguarding and whistleblowing during my induction." There was a poster in the office to remind staff of their responsibilities and about the process for referring to the safeguarding authority. A member of care staff told us, "If people were hurting each other, or there was a change in their mood, I would refer to the manager." Care staff were confident the registered manager would refer any concerns to the safeguarding authority. People, relatives and staff told us they had never seen or heard anything to concern them. The manager had not needed to make any referrals to the local safeguarding team.

The provider's policy for managing risks included assessments of people's individual risks. Care plans included assessments of risks to people's individual health and wellbeing. Where risks were identified, the care plans described the equipment needed and the actions staff should take to support people safely. For example, when one person was identified as presenting behaviour that challenged, their care plan told staff to encourage the person to move to a quiet space and to offer them a cup of tea or a relaxing bath. Care staff knew this person could be unpredictable in their behaviour and the description they gave of how they supported the person matched the care plan.

The provider completed risk assessments for the premises and took action to minimise the risks. Risk assessments included identifying potential hazards and the severity and likelihood of the hazards causing harm. The provider engaged professional experts to check and maintain the safety of essential supplies, such as water, gas, fire safety and the lift. All staff received health and safety, first aid and fire training to ensure they knew what actions to take in an emergency. Care staff told us when new risks were identified the provider took appropriate action to minimise risks to people's safety. A member of care staff told us, "The kitchen door was key coded after feedback from staff about [Name] going in there."

The registered manager told us everyone who lived at the home had a personal emergency evacuation plan and staff knew how to support people to evacuate the building in an emergency. A member of care staff told us, "I would call the fire brigade and go to the safe zone" and "We test the fire bell regularly." The registered manager had marked people's bedrooms doors to denote who needed two staff to assist them in an emergency.

The provider minimised risks involved in using equipment and in people attending events and activities at the home. Preventative actions included staff training and regular checks of equipment. Staff told us they were trained in safe techniques for handling the equipment they used to support people to move as soon as they started working at the home. They told us the equipment was serviced, maintained and always available. Staff understood the risks associated with some people's preferred activities. Care staff told us, for

example, that staff always supported people when they were cooking and always accompanied people outside to smoke.

Accident and incident records included the actions taken to minimise the risks of a reoccurrence for the individual. A member of care staff told us, "If there is an accident we write it in the book, the date, time, who, first aid given and check the person hourly afterwards and check they have their call bells or sensor mats." The registered manager analysed accidents and incidents to identify patterns or trends. The registered manager checked whether issues, such as the lighting, carpet, clothing or footwear might have contributed to the accident. No patterns were identified in the previous two months. The registered manager had sent us statutory notifications when accidents resulted in injuries, in accordance with their legal obligations.

There were enough staff on duty to meet people's needs. The registered manager had identified people's needs and abilities and given them a dependency 'score', which was used to calculate the total number of hours of care needed. The registered manager planned the staff rota to ensure there were enough staff on duty to meet all the identified needs. People told us staff responded promptly when they rang the call bell. One person told us, "The response is very quick during the day just two to three minutes. Even at night I never have to wait too long." A member of care staff told us, "There are more than enough staff to support people to get up when they like." The registered manager told us they rarely used agency staff and staff turnover was low, which ensured people received care consistently from staff they were familiar with.

Staff were recruited safely, which minimised risks to people's safety. The registered manager showed us records of the checks they made of staff's suitability for the role before they started working at the home. The manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

The registered manager showed us how they managed and administered medicines safely. Medicines were delivered by the pharmacy each month and kept in locked cabinets. The medicines folder included a list of staff trained in medicines administration and safety information about people's allergies and foods that people on named medicines should avoid because of the possibility of adverse reactions. Medicines were delivered in packs that were colour coded for the time of day to reduce the risk of errors in administration. Senior staff regularly audited the medicines to make sure they were managed safely. They checked the amount of medicine available matched the amount received and administered and that only trained staff administered them.

The pharmacist provided a medicines administration record (MAR), which was marked with the name of the person, the dosage, frequency and the time of day they should be administered. The registered manager had colour coded MAR sheets for people who were on variable amounts of medicine to ensure there was no doubt about which strength of medicine staff should administer. The three MARs we looked at were signed and up to date, which showed people's medicines were administered in accordance with their prescriptions. Staff recorded when medicines were not administered and the reason why not, for example, if a person declined to take them or the GP changed their prescription. A member of care staff told us the GP reviewed people's medicines to ensure they remained beneficial and effective. They told us one person whose medicines had recently been reviewed and changed, "Seems calmer."

Good

Is the service effective?

Our findings

People told us the staff supported them according to their needs and abilities. People told us, "The staff are well trained to look after me. I know all the staff well" and "They all seem well trained to look after me. They don't change very often."

The registered manager ensured staff had the appropriate skills and behaviours to deliver care before they started working at the home. A member of staff told us, "I read the policies and procedures, learnt about safeguarding, whistleblowing and moving and handling. I read the care plans, checked people's preferences and shadowed for three days. I felt competent." Staff signed people's care plans to say they had read them and understood people's needs and abilities.

Care staff told us the training they received was effective and relevant to people's needs. A member of care staff told us, "During induction I did eleven courses, including dementia and moving and handling. I've learnt things I didn't know." All staff had nationally recognised qualifications in health and social care and new staff were enrolled on the diploma training programme within two weeks of starting work. The registered manager had enrolled on the Care Certificate programme to understand the requirements of the programme and decide whether this would be beneficial for staff who were already qualified. The Care Certificate was launched in April 2015 and replaced the previous Common Induction Standards (in social care) and the National Minimum Training Standards (in health). The Care Certificate will help new members of staff to develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

The registered manager ensured staff were supported to be effective in practice with regular one to one supervision meetings. Care staff told us they felt supported by the registered manager and operations director and they were supported to maintain a work life balance. A member of care staff told us, "I have a one-to-one with the manager and support from [Name]. I get the support I need" and "I can talk about any problems. They are always here to help and to listen."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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.

The registered manager showed us a copy of their recent application for authority to deprive one person of

their liberty. The registered manager had first completed an assessment of the person's capacity to understand and consent to restrictions to their liberty for their own safety. The assessment concluded the person did not understand the risks to their safety if they went out alone. The registered manager had worked within the principles of the MCA, applied to the local Supervisory Body appropriately and was waiting for their decision. They told us they had also requested an advocate for the person, because they did not have any close family members to support them. An advocate is an independent person who is appointed to support a person to make and communicate their decisions.

Care staff understood the requirements of the MCA meant people should be supported to make their own decisions. They told us people made their own decisions about how they lived their lives, for example, when to get up, when to go to bed and how they spent their day. A member of care staff told us, "I know about the MCA. It depends on which decision. I show people their clothes and ask what they would like to wear." We saw staff asked people how they wanted to be cared for and supported before they provided care. For example, when care staff supported one person to move, we heard them say, "I need to move you from your wheelchair into the easy chair. Is that alright?" and "Can you lift your foot up?"

People were supported to eat and drink according to their needs and preferences. People told us the food was very good and they had a choice. They told us, "The food is perfect" and "The food is good. We have nice dinners." A member of care staff told us, "We ask people every day what they would like for lunch. They all understand words and have already told us their preferences." They told us the cook prepared a choice of meals every day, apart from Wednesday, which had been agreed would be 'midweek roast day', because people always ate well on 'roast' days. They told us if people did not want the roast meal the cook would make whatever an individual person suggested as an alternative. The cook showed us the list of people's choices for the previous week which included a choice of main courses and of puddings.

At the time of our inspection, the registered manager and housekeeper, who was also a qualified cook, had temporarily shared the responsibility for preparing meals since the previous cook left the week before. A new cook started work at the home on the second day of our inspection. The registered manager told us the menu was created by the previous cook, in accordance with people's stated preferences, and overseen by the provider's catering manager to check for nutritional content and seasonal appropriateness.

At lunch time people were supported to move to the dining room to eat together and make lunch a sociable event. The dining tables were laid with cloths, cutlery, napkins and condiments and everyone sat down together. The meal was unhurried and staff gave people time to savour and enjoy their meals and the meals looked and smelled appetising. Everyone who needed support to eat was supported one-to-one by staff. Staff encouraged people who were reluctant to eat and offered them alternative meals and alternative places to eat. People who chose to have their meals in their rooms told us their meals were hot when they received them.

The registered manager assessed risks to people's nutrition and people's care plans included the identified risks, actions to minimise risks and known allergies as well as people's food likes, dislikes and preferences. People's dietary needs and preferences were also recorded in a folder in the kitchen, to ensure their needs were catered for. Records of a recent meeting for people who lived at the home showed people had suggested 'more casseroles and home-made soup' for their evening meal and we saw the cook was making soup on the first day of our inspection.

People told us they were supported to maintain their health. People told us, "They get the doctor no problem if I need to see him" and "The district nurse comes and sees me every day and I get my feet done every few weeks. I am well looked after." People's daily records showed other health professionals, such as

GPs, audiologists and physiotherapists were involved in people's care when needed. Records included the health professionals' advice and monitored the impact of staff supporting people to follow the advice. A visiting health professional told us, "I visit twice a day, five days a week. Staff are very keen to learn. They apply creams as advised. They ask for advice and follow it."

Staff shared information about people's health during the handover meeting at the beginning of each shift to ensure all staff knew signs to look out for if people's health declined. We heard staff talked about each person in turn, sharing information about their appetites, moods and behaviours. Care staff told us they felt well informed and handover was effective because, "There is good communication." A relative told us when they raised concerns about the impact of medicines on their relation's mood, the registered manager had arranged a medicines review with their GP. This gave them confidence that staff listened and people were supported with their health needs.

Good

Is the service caring?

Our findings

People and relatives told us the staff were kind, caring and compassionate. People told us, "I am well looked after, they take their time with me" and "It's always the same staff. It feels more like a family." A visiting health professional told us, "It's like home" and "There's always laughter."

We saw people were relaxed with each other and in staff's company. Staff engaged people in conversations that made them smile and sometimes laugh aloud. Care staff recognised people's diverse needs and supported them appropriately. One person liked to walk around the home all day and we saw staff greeted them with a smile and conversation each time they passed. One person told us, "They are kind. Those girls make me laugh."

Most people were not able to explain how their care was planned and some people told us they could not remember whether they had a written care plan. However, people told us they were supported in accordance with their preferences and staff understood what was important to them. For example, one person told us it was very important to them that their clothes 'go together' and staff supported them with this. We saw this was recorded in their care plan in the section, "Things that are important to me." We saw this person had signed their care plan when it was written. A member of care staff told us, "Everything needs to be exact and in order. That's [Name's] personality and preference."

People's care plans included their life history, religion, culture, family relationships and significant events. Care staff told us this helped them to understand the person and to get to know them as an individual and to understand their anxieties and behaviours. A relative told us they took comfort from the fact that if their relation could not sleep at night, they sat in the lounge chatting with staff. Care staff told us, "The care plans say, but we get to know them anyway, during personal care and through their families." People's daily records showed they were supported to maintain the aspects of their life that were identified as important to them, such as attending religious services.

The registered manager promoted people's independence and involvement by arranging regular meetings for them. People told us they could not remember attending meetings, but records showed 19 of the 23 people who lived at the home had attended meetings in the previous three months. People had discussed things that were important to them, such as, the food, activities, care and the environment. People had made suggestions for changes to the meals and for events and activities they would like organised. A visiting health professional told us, "The manager came in at the weekend to make home-made soup because people said that was what they wanted."

People told us staff treated them with dignity and respect, which included not feeling rushed. People told us, "They are all very polite and helpful" and "I am well looked after. They take their time with me." We saw care staff were respectful of people's needs and feelings. Staff spoke discretely when offering to support people with personal care and they checked that people wanted to speak with us before we were invited into their rooms to speak privately with them. Staff kept people's personal information and records in the office where only staff could access them.

Relatives told us the staff were good and they were welcome to visit whenever they liked. A relative told us, "I come several times a week. I spend a few hours here in the lounge with my husband. They always offer me a cup of tea and a biscuit. They are very friendly." Posters in the hallway included information for visitors, for example, "Visitors – speak to us if you have any concerns" and an invitation for relatives to attend the annual seasonal party.

People were supported at the end of their life to have a comfortable and dignified death. The registered manager had created a 'Rest in perfect peace' display which showed the photos and important dates of those who had passed away in the last 12 months. This showed respect for those who had lived at the home and their relatives and supported people to remember them. We saw many of the thank you cards were from relatives of people who had passed away at the home. The registered manager told us they had responded to people's needs and wishes to remain at the home until the end of their life rather than to go into hospital. Ten staff had already received end of life care training and another nine staff were scheduled to attend. A member of care staff told us, "I am doing a course in end of life care. We make the person as comfortable as possible, respect their dignity and wishes."

The registered manager told us, "We put additional staff on and the staff plan is amended to ensure the same two staff make half hourly checks or stay with the person if they have no family." They told us, "Not everyone wants to talk about it so we have created an end of life booklet that explains the passage of life" and "We can train to meet individual cultural, end of life wishes." We saw that care plans included options for known religions, including information about recognised rites and traditions.

Records showed people and their families were invited to discuss their wishes in a section of the care plan called, 'Future wishes", but not everyone wanted to discuss this. For example, one care plan we looked at for a person who lacked capacity to decide was marked, 'awaiting family input'. In another person's care plan the section entitled, "Specific wishes in event of death" was marked "[Name] does not wish to discuss."

Care staff told us there were suitable arrangements in place to allow them to support families and to take time out themselves at the end of a person's life. One member of care staff told us, "There is talking therapy for people, families and staff in a private room when someone passes away." An external health professional had written to the registered manager complimenting the whole team on their excellence shown in end of life care. In recognition of the staff's role in good end of life care, a local funeral director had made a presentation to the member of care staff nominated as 'Carer of the year' by the registered manager.

Good

Is the service responsive?

Our findings

People told us staff responded to their needs appropriately. People told us, "I always ask the carers for things I need" and "If I need anything like a shower they always help me."

Care planning was centred on the individual and their personal needs and abilities. A member of care staff told us, "It's down to the individual. We do an assessment, find out about their likes and dislikes. One lady does not like to discuss anything. She says it is in her care plan." This was recorded in the person's care plan, in accordance with the person's wishes.

Most people were not able to explain or remember the information they had discussed with staff when they moved to the home. The registered manager told us they found out about people's preferences at their initial assessment and from their families. People's care plans recorded their preferences for care as well as their hobbies and interests. Care staff told us they got to know and understand people well because they read the care plans, talked with people and watched how people responded to their care and support. One member of staff told us, "Families tell us about people's previous occupations and lives. It opens our eyes. We have reminiscence sessions."

We saw people were supported to do the things that their care plans and meeting minutes said they enjoyed or would like to engage in. Some people spent time chatting with staff while they had a manicure and some people were engaged in playing or watching ball games, such as skittles and carpet bowls. We saw people were engaged in the game, commenting on each other's scores and eager to have a turn. Several care staff took on the role of 'Cheerleaders', which encouraged people and made them smile.

The registered manager and staff took action to ensure people were not isolated socially. A visiting professional told us, "Staff are always busy, helping people with nail care and popping to the shop with people. I see people involved in cleaning out the chinchilla and there was a Halloween party for people and their relatives." The registered manager told us they arranged events according to the preferences people shared at meetings and in conversations with staff. They told us the whole house was decorated for Remembrance Day and people sat out the front and watched the procession and marching band.

Some people preferred to spend time alone in their own rooms, watching television or listening to the radio. Staff respected people's choices, but kept them informed about opportunities to engage in activities and crafts. For example, a member of staff told us, "[Name] likes watching television and liked cooking. [Name] doesn't want to cook now, though she did accept the opportunity to do flower arranging."

The registered manager reviewed people's care plans every month and updated them when people's needs changed. Care staff told us if people's needs and behaviours were variable, they kept charts to monitor the frequency and intensity of their moods. Care staff told us monitoring helped them recognise if a person's needs changed significantly and they would share this with the manager to arrange a full care review with external health professionals.

People knew they could make a complaint if they needed to and were confident it would be resolved effectively. People told us they did not have any complaints about the service, but they would either speak to the manager or their relatives would deal with it for them. The provider's complaints policy and procedure was explained in a poster in the hallway for anyone to read and in the service user guide in people's bedrooms. The registered manager told us they had not received any complaints for over 12 months, but they showed the complaints logging and monitoring system they would use if they received a complaint.

Good

Is the service well-led?

Our findings

People told us they were happy living at the home. People said, "I am happy here" and "We are warm, food is adequate and the bed is comfortable." A relative told us, "I have no concerns. He is well looked after. Staff are good."

Following a recent care review meeting a social care professional had commented in the person's care plan, "[Name] is very happy and contented. Staff can take full credit for this." The registered manager had displayed recent thank you cards from people's relatives in the hallway where anyone could read them, and which ensured staff knew they were appreciated. A relative had been so pleased with the care their relation received, they had nominated the home for the Skills for Care Accolade in 2015.

People told us they could not remember how their views were known to the provider, but records showed the provider's quality assurance system included an annual survey of people who lived at the home, their relatives and visiting health professionals. The results of the most recent survey, which showed 99% of respondents were satisfied with the service, were posted in the front hall where everyone could read them. An accompanying letter included the positive and negative comments people made, which demonstrated the open culture of the service. People's comments included, "I love the gaffer" and "It's a lovely home" and "Satisfied with everything."

The registered manager understood the responsibilities of their registration and notified us of the important events as required by the Regulations. A member of care staff told us, "The manager is very hands on. She always knows what is going on." The provider was proactive at keeping us informed of issues or concerns raised by relatives and other health professionals, in accordance with the provider's policy of openness and transparency. People and relatives were given information to make them feel familiar with the service. For example, staff's photos and names and a copy of our previous inspection report were displayed in the reception area for all to see.

The provider's mission statement and philosophy of care were displayed in the hallway, along with information that explained how the philosophy worked in practice. For example, the provider's belief in 'Pets not pills', was enacted by having a resident cat and chinchilla and regular home visits from a Shetland pony. Visitors were encouraged to "Share any concerns" on one poster and there was information about advocacy services and a suggestion box.

All the staff understood the provider's vision and values, "Respect privacy, dignity, care, love .. as for our own family." We saw staff upheld these values in their interactions with people by delivering care centred on the individual. Staff told us everyone who worked at the home had the same goal, which was to support people to live the lives they wanted. One member of staff told us, "It is really important to put a smile on their faces, to encourage them, to lift their spirits."

The manager led by example and championed improvements in the home. A relative told us, "[Name] is approachable. I have no worries about sitting and talking it over." Staff told us they appreciated the

provider's open culture of management. A member of care staff told us, "The manager is nice and helpful and listens." The provider had signed up to the 'Dementia Pledge'. The registered manager told us, "The dementia pledge gives us access to resources on their website. We are considering dementia champions and to make opportunities to work with lone carers and prepare them. We are creating a booklet for families about the reasons for dementia and coping strategies."

Staff understood their own responsibilities and were supported to improve their practise and professional development through regular meetings with the registered manager. A visiting health professional told us, "Staff are very keen to learn" and were proactive at suggesting ways to improve people's outcomes. The registered manager had written a training manual about good skin care management. The manual was detailed and explained the physiology of skin, the practical steps staff should take to minimise the risk of people acquiring sore skin and included photos of the possible impact of poor skin care. The registered manager planned to use the manual in training all staff to better understand the importance of preventative measures they should take.

The registered manager's quality assurance system included regular checks of people's care plans, medicines administration, the premises, equipment and environment. The registered manager sent monthly management reports to the provider and when issues were identified actions were taken. For example, when a bedroom was identified as 'in need of redecoration' the provider had redecorated it.

The registered manager made sure staff understood how they could improve the quality of the service by sharing the results of their quality checks and observations at team meetings. Records showed they reminded staff about the importance of checking people every half an hour when they were unwell and stayed in their bedroom, of wearing their uniforms and of arriving punctually. The registered manager implemented additional risk prevention measures in response to changes in people's needs and abilities. For example, staff on each shift were instructed to test the alarm sensor mats and to sign to confirm they were in working order, to ensure staff were aware when people at risk of falls got out of bed independently.

The registered manager told us their greatest achievement was, "Keeping people safe, well and happy. Making sure they have good outcomes." They told us this included ensuring people's wishes for end of life care were known, understood and respected.