Solent View Care Home Limited

Solent View Care Home

Inspection report

41-43 Victoria Grove
East Cowes
Isle Of Wight
PO32 6DL

Tel: 01983290348

Date of inspection visit:
29 March 2017
06 April 2017

Date of publication:
08 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Solent View Care Home is a privately run care home registered to provide accommodation for up to 19 people, including people living with a cognitive impairment. At the time of our inspection there were 18 people living in the home.

The inspection was unannounced and was carried out on 29 March 2017 and 06 April 2017 by one inspector.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe, however, there were not always enough staff to meet people's needs. We have made a recommendation about this.

The systems in place to monitor the quality and safety of the service were not robust. Staff were aware of the risks relating to people they supported, however people's care records did not always reflect those risks.

There were suitable systems in place to ensure the safe storage and administration of medicines. However, the medicine stock management system was not robust. Medicines were administered by staff who had received appropriate training and assessments.

Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns. Accidents and incidents were monitored and remedial actions identified to reduce the risk of reoccurrence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when engaging with people who could not communicate verbally and who used a variety of signs, noises and body language to express themselves. Staff were able to understand people and respond to what was being said.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

People and their families told us they felt the home was well-led and were positive about the registered manager and the head of care. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service. They were also supported to raise complaints should they wish to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was not always enough staff available to meet people's needs; recruitment practices ensured that all appropriate checks had been completed.

Staff were aware of the risks relating to people and the action they would take to help reduce those risks. However, this information was not always reflected in people's care records.

People received their medicines at the right time and in the right way to meet their needs. However the stock management system was not robust.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems in place to monitor the quality and safety of the service were not robust.

There was a clear management structure and the provider's values were clear and understood by staff.

People, their families and staff had the opportunity to become involved in developing the service.

Solent View 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 checked 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 was unannounced and was carried out on 29 March 2017 and 06 April 2017 by one inspector.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with three people using the service and engaged with three others, who communicated with us verbally in a limited way. We spoke with four visitors and a health professional. We observed care and support being delivered in communal areas of the home. We spoke with four members of the care staff, the cook, the maintenance man, the deputy head of care, head of care and the registered manager, both of who were also the providers.

We looked at care plans and associated records for five people using the service, staff duty records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said "I feel safe here there is always someone about if I need them". Another person told us, "Staff really look after me". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "[My relative] is safe here. I couldn't do a better job myself". Another family member told us, "Yes [my relative] is safe here, the care staff are very good". The health professional we spoke with told us they had concerns regarding people's safety because of the staffing levels. They said, "I really feel people are at risk because there is not enough staff here in the evenings and weekends".

There was not always sufficient staff to meet people's needs. One person told us, "I sometimes think there is not enough staff to help people in the afternoons". They added "At weekends they don't have the extra staff; so can be worse for activities; so weekends do tend to drag a bit". Another person said, "I have an alarm bell which I can use if I need help. You sometimes have to wait if they are busy. You have to expect that". A family member said, "I have raised concerns about lack of baths but they just say there is not enough staff".

During our inspection we observed that there were occasions when people were left on their own in the lounge for periods in excess of 30 minutes without staff being present or checking they were okay. However, when staff did interact with people in the lounge they did not rush and spent time engaging with them. One member of staff told us, "We do our best I don't think we rush people".

Staff provided a mixed view in respect of staffing levels. One member of staff said, "Yes there's enough staff. If we have end of life care then [the registered manager] arranges extra staff to sit with them". Another member of staff told us, "I think there is enough staff although it can be busy in the evenings". A third member of staff said, "There is not enough staff in the afternoon. For example if [named person who required two staff to support them] needs the toilet [they] would have to wait until [the second member of staff] has finished what she is doing". They also said, "There is up to eight people here needing two carers support. When we are [providing personal care] to those people we can be away for half an hour. You have to keep popping down to check on people". They added "It does put people at risk but we have been lucky so far". Another member of staff told us, "There is enough staff on in the mornings, particularly during the week but not enough during the evenings as there is only two. This can be tricky with someone who needs two carers. You can be away from the rest for 25 minutes. When we leave them I worry. People are vulnerable".

The registered manager told us that staffing levels had been based on the needs of the people using the service but they recognised these had changed and staffing levels needed to be reviewed. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and if necessary agency staff. The registered manager, head of care and deputy head of care were also available to provide extra support when appropriate.

We raised our concerns regarding staffing with the registered manager who told us they were aware of the concerns, as a result of feedback from the staff meetings, and was exploring options regarding the provision

of an extra staff member in the afternoons.

We recommend that the provider seek advice and guidance on developing a systematic approach to determining staffing levels to ensure people are safe at all times and take action to implement it. We will check on this at the next inspection

Staff were able to explain the risks relating to people and the action they would take to help reduce those risks from occurring. However, the records did not always reflect that risks to people, in respect of their care and treatment, had been assessed or the action necessary to reduce those risks. For example one person was at risk of having seizures, which led to a risk of falls within the home. Staff were aware of this risk and were able to explain the pre-cursor signs displayed by the person before a seizure occurs. However, the care records for this person did not contain a risk assessment relating to their seizures and their falls risk assessment had not been updated with the information regarding seizure related falls. Other risks such as those relating to the use of bedrails, environment, equipment and the running of the home had been assessed and action identified to minimise those risks. We raised out concerns with the registered manager and they took action to ensure all of the risk assessments were reviewed and updated. We saw this process had commenced before the end of our inspection.

Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. One person said, "They do my tablets for me. I have never known them to miss [my medicines]". Another person told us, "They [staff] do my tablets three times a day; I am diabetic and the nurse comes in and does my insulin". Staff had received appropriate training and their competency to administer medicines had been assessed by the deputy head of care to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine.

There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. However, the medicine stock management system was not robust and we identified three occasions where there were discrepancies between the amount of tablets recorded and the actual amount of tablets in stock. The deputy head of care was unable to explain these discrepancies. We raised our concern with the registered manager who initiated a full stock check and review to ascertain why the discrepancies had occurred.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff knew how to raise observed concerns and to apply the provider's policy. One member of staff told us "If I had a safeguarding concern I would speak to a senior or speak to senior management. I have previously had to raise a safeguarding in a previous job; if I had to whistle blow I would". Another member of staff said, "If I had any safeguarding concerns I would go to management and they would sort it out.". The registered manager explained the action they would take when a safeguarding concern was raised with them and the records confirmed this action had been taken

when a safeguarding concern had been identified. The registered manager had reported these concerns to the appropriate authority in a timely manner.

Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. Each person's care plan contained the information necessary for health professionals to support that person should they be taken to hospital in an emergency.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff had received first aid training and were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective and that staff understood their needs and had the skills to meet them. One person said, "The staff are good here". They added "Staff are definitely well trained". Another person told us, "They look after me well". A family member said, "They know mum very well; she's been here 10 years". Another family member told us they were, "Happy with how [my relative] is looked after. I admire them [staff] really". A health professional told us, "Staff understand people's needs".

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). 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. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, a best interest decision had been made in respect of one person who lacked capacity to consent to the care they were receiving. Other best interest decisions were made in respect of personal care, medicines, the use of bedrails and other restrictions to people's lives.

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. DoLS applications had been made to the supervisory body with the relevant authority for most of the people using the service. The registered manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; where DoLS had been authorised they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and were the least restrictive option.

People and their families told us that staff asked for their consent when they were supporting them. One person said, "I can get up or go to bed when I want; if I didn't want to get up you just say to them and they let you stay in bed. A family member told us, "If [my relative] doesn't want something then they try again later".

Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. We observed staff seeking consent from people using simple questions, giving them time to respond. One member of staff told us, "I ask people to do something but sometimes they won't do it. It's their choice. I leave them and will try again a bit later". Another member of staff said, "You've got people's best interest and give them a choice and things. People are able to talk to us and make their wishes known". Daily records of care showed that where people declined care this was respected.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. A new member of staff told us, "The training is good and I did my care certificate". Another member of staff said, "I have just started my NVQ 2; have done my care certificate online it was really good".

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, pressure ulcer awareness, dementia care, end of life care, Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence. A member of staff told us, "One thing here they are up to date with training all the time. I've done medication training, dementia, manual handling, which was hands on, fire training, end of life and diabetes". They added "The training is good you never know it all you're learning all the time". Another member of staff said, "The training is good I feel confident I have got the skills to look after people. I have my yearly medication assessment".

Staff had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. A new staff member told us, "I've had two supervision's and been to the staff meeting". Another member of staff said, "Staff are a good team. I have supervision's and we have staff meetings". A third member of staff told us, "We have supervision's twice a year I like them because if you have any concerns they are on to it straight away".

People were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "Food is good. They always ask you what you want for lunch. If you don't want something they will do something else". They added "There are plenty of drinks; they are always filling my jug up. I just press my bell and they come in and refresh it or bring me a cup of tea or coffee if I want it". Another person told us, "The food is excellent, I get asked what I want. I can have a snack in the evening; if I don't want what they have, they will do me something else". A third person said, "I love my dinners loads of vegetables; I sometimes have an omelette" They added "I have plenty to drink, too much really, you can have what drink you like".

Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. The cook told us, "I try to give everyone the same food. I adapt it to meet their dietary needs". One person who was diabetic said "They do my food the same as everyone but make sure it is diabetic".

The cook told us they "followed a 28 day menu cycle, and a buffet menu throughout the year as people enjoyed finger food". There was a pictorial menu to help people understand what choices were available them. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. People were provided with a choice of food and an alternative was available if they did not want what was offered. Drinks, snacks and fresh fruit were offered to people throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. A family member told us, "They keep me updated with [my relative's] health. They call the doctor if [my relative] is bad. [My relative] saw [named doctor] last week".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person who was mostly cared for in bed said, "They have a laugh and joke with me. They tell me what they've been doing so they bring the outside in here to me". Another person told us, "I like it here. Staff are very patient with people, caring and look after them very well". Other comments included, "They are very understanding", "They're lovely girls", "I like it here very much" and "The staff are polite". Family members told us staff at the home were very caring. One family member said, "Staff are patient and caring; we're very happy with the care [my relative] receives". They added, "[My relative] knows them [the staff] that's important". Another family member told us, "[My relative] couldn't be in a better place".

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. One person told us, "They help me with my personal care and getting dressed. They are very polite you would think it was your mother helping you". Another person who was visually impaired said, "Staff knock on the door and say who they are because they know I can't see". A third person told us, "They respect my privacy and knock on my door. They always knock before they come in even if they have gone out to get something and are coming back in". A member of staff said, "I make sure doors are shut; cover people up and close curtains. I knock on doors and I would ask the family to leave [if I was doing personal care]. I do for them what I would want done for myself". Family members told us they did not have any concerns regarding staff treating their relatives with respect. A family member said, "They respect [my relative's] dignity and always ask before doing things".

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. One person told us, "They try and get me to do things; she came in this morning and said did I want to do something but I would sooner watch telly". A member of staff said, "We help people to choose; I show them a couple of jumpers and ask them to choose".

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. A member of staff told us, "People lead, we don't force them. We just support them to do the best they can".

People were encouraged to be as independent as possible. One person told us "I wash myself I can do quite a bit and then they help me with the rest". Another person said, "I can do a lot for myself but need help sometimes". They added "I can transfer by myself but they help me with my shower and things". Other

examples of people being encouraged to be independent included when staff supported a person to monitor their own blood sugar; and when people mobilised, staff encouraged them to do as much as they could by themselves.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. One person, who was cared for in bed had a phone in their room to allow them to speak with their family on a regular basis. Another person told us, "I can go out with my friend when I want". Family members said they could visit their relatives whenever they wanted. One family member told us, "We can phone up any time and asked what is happening with [my relative]". They added "When we come they always ask if we would like a cup of tea".

The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing. A person who was cared for in bed told us, "I love my music, I have CDs in my room and ask staff to put it on for me so I can sing along".

Information regarding confidentiality formed a key part of the induction training for all care staff. Confidential information, such as care records was only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. One person said, "I take my own blood sugar, if the reading is high they [staff] do something about it. They give me a drink; they worry about me a lot". Another person told us, "Some days I can do things for myself and other times I can't. Staff are there when I need them". A third person said, "I can get up and go to bed when I want to. I wasn't feeling very well a couple of weeks ago, so stayed in my room. Staff kept coming and checking I was okay and asking if I wanted a drink". A family member said, "Staff seem to understand [my relative] they know when she doesn't want to be touched and that sort of thing". Another family member told us, "They take care of [my relative] they know her well". They added "They [staff] are very good with the ones who wander. Very patient".

Those people who were not able to verbally communicate with staff, were able to demonstrate their understanding about what they were being asked and could make their wishes known. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. However, although care plans were detailed they did not always reflect people's current needs. For example the records for one person did not provide clear guidance to staff on how to support them when they declined food and drink for a 24 hour period. We raised these concerns with the registered manager and by the end of our inspection they had sought medical advice and taken action to ensure the records were updated.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required when mobilising at different times. This corresponded to information within the person's care plan. Handover meetings were held at the start of every shift and supported by a communication book. These handovers provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

People were encouraged to take part in activities. One person said, "We have activities here [the activities coordinator] will do your nails for you. The other day we did stuff for Easter". They added "I go out to the Riverside as a volunteer. So they come and pick me up. I'd try and organise as much as I can for myself". A family member told us, "[My relative] sometimes doesn't want to engage in activities but staff pop in and chat to her". They added "There is often a member of staff sitting with [my relative] when we come. They are very good with her".

During the inspection we observed people taking part in a group craft activity and we saw that those people

who wanted to were actively engaged in the activity. However, we saw that the activities coordinator was also included in the care staff team to cover for staff shortages. This meant there were days when no structured activities took place. Where people did not want to engage in activities this was respected and staff interacted with them on a one to one basis. One person told us, "I like to stay in my room so staff keep popping in for a chat and to check I am okay". Another person who was cared for in bed said, "[The activities coordinator] comes in sometimes and we do a quiz". A family member said, "[My relative's] door is always open and staff say hello as they go past". A member of staff told us, "We get some time to do activities with people and check them between tea and supper".

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People had access to advocates who were available to support them if they were unhappy about the service provided. One person told us, "Overall I am very happy, I have an advocate who supports me".

The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. One person said, "[The registered manager and the head of care] pop in often they are nice people. They ask me how things are and if I am happy. A family member told us "[The registered manager] comes down a lot and asks for feedback we have also done a feedback form in the past".

The registered manager also sought formal feedback through the use of a quality assurance survey, which were being done with people's families on a face to face basis. We looked at the feedback from the latest survey, from March 2017, which was all positive in respect of the care people received. Comments included 'Good care' and 'Homely and nice'. The registered manager explained the action he would take if concerns were raised.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Local Government Ombudsman. The registered manager told us that people had the support of family members or access to independent advocacy services if they needed them. One person said, "I know how to complain if I needed to but I have never needed to. I would speak to [The registered manager and the head of care] they are very helpful". All of the family members knew how to complain but told us they had never needed to. The registered manager told us they dealt with minor issues straight away but they had not received a formal complaint since the home was last inspected. They were able to explain the action that would be taken to investigate a complaint if one was received.

Requires Improvement

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. One person said the management team were very approachable and involved with people. They added, "I would recommend the home to others". Another person told us, "[The registered manager and the head of care] come and see me, they have a laugh with me". All of the family members we spoke with also said they would recommend the home to their families and friends. A staff member told us, "I would recommend the home to my family to come here I know they would be looked after well". Another staff member said, "Everybody is well cared for; the home is well run".

However, the systems in place to monitor the quality and safety of the service provided were not robust and did not identify the concerns we found during the inspection regarding the lack of up to date risk assessments and the inaccuracies within the medicine stock management processes. There were concerns about staffing levels but improvements were yet to be implemented. The registered manager carried out regular audits which included, staff records, falls, accidents and incidents, infection control, the cleanliness of the home and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety. They also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created. We raised our concerns with the registered manager who agreed that there were areas for improvement and took action to review their auditing process.

There was a clear management structure, which consisted of a registered manager and head of care, who were both directors of the company, the deputy head of care and senior care staff. Staff were confident in their role and understood the part each staff member played in delivering the owners' vision of high quality care. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One member of staff told us that, "The management is approachable. [The registered manager and head of care] do a good job".

The owners were fully engaged in running the service and their vision and values were built around promoting the maintenance of people's health and independence "to give them the best day they can have". Staff were aware of the owners' vision and values and how they related to their work. One member of staff said, "The philosophy of care here is supporting, caring, and helping people to be as independent as they can". They added "I love coming to work here".

Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the owners values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member told us, "We have staff meetings monthly we all have our say they go around the room for any concerns". Another member of staff said, "If you raise something they do listen and get things done". A third member of staff told us, "It is a very happy friendly home; clients are lovely; it is a nice place to come to

work".

The registered manager had an open door policy for the people, families and staff to enabled and encouraged open communication. People told us they were given the opportunity to provide feedback about the culture and development of the service. People all said they were happy with the service provided.

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. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of their registration. They also understood and complied with their responsibilities under duty of candour.