Mr & Mrs Y Charalambous

Westcott House Nursing 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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Westcott House is a well-established Nursing Home providing care and support for up to 60 people with a past or present mental illness and people living with dementia. The home is owned by Mr and Mrs Charalambous and Mrs Charalambous is also the registered manager. Accommodation is arranged over several units and there are ample communal lounge and dining areas provided. The home is located in Westcott Village and within easy access to local amenities. There were 60 people living in the home on the day of the inspection.

The registered manager/provider was present for the duration of our inspection. 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 and associated Regulations about how the service is run.

Medicines were managed in a safe way and recording of medicines was completed to show people had received the medicines they required.

There were sufficient numbers of staff on duty to meet people's care needs. Staff recruitment procedures were safe. Employment files contained all the relevant checks to help ensure only appropriate staff were employed in the home.

Staff met with their line manager on a one to one basis to discuss their work. Staff said they felt supported and told us the registered manager had good management oversight of the home.

Staff were aware of their responsibilities to safeguard people from abuse and were able to tell us what they would do in such an event and they had access to a whistleblowing policy should they need to use it.

People were encouraged and supported to be involved in their care as much as possible. People had individual care plans. These were informative and updated regularly. They also contained information for staff to enable them to be able to respond to people's needs effectively.

People and staff interaction was relaxed. It was evident staff knew people well and understood people's needs and aspirations. Staff were very caring to people and respected their privacy and dignity.

People were provided with a range of nutritious foods to maintain a healthy diet. People told us the food was very good and home cooked. We saw people had access to drinks and snacks throughout the day and staff provided support for people to eat and drink when required.

People had risk assessments in place for identified risk of harm. The registered manager logged any accidents and incidents that occurred and put measures in place for staff to follow to mitigate any further accidents or incidents.

Staff had followed legal requirements to make sure that any decisions made or restrictions to people were done in the person's best interests. Staff understood the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain good health. They had access to a wide range of health care services and the input of health care professionals.

Staff received a good range of training specific to people's needs. This allowed them to carry out their role in an effective and competent way.

The registered manager operated an open door policy and we saw several examples of this throughout the day when staff, relatives and people who used the service sought their support and advice.

If an emergency occurred people's care would not be interrupted as there were procedures in place to manage this.

Systems and audits were in place to monitor the service provision and best practice, in order to improve outcomes for people who used the service.

A complaints procedure was available for any concerns. This was displayed in the home. People and relatives had been provided with a copy of this when they were admitted to the home.
People and their relatives were encouraged to feedback their views and ideas into the running of the home.

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.

Medicines were administered and stored safely.

People's individual risks had been identified and guidance drawn up for staff on how to manage these.

There were enough staff to meet people's needs and appropriate checks were carried out to help ensure only suitable staff worked in the home.

Staff knew what to do should they suspect abuse was taking place. There was information for relatives and people living in the home regarding this should they need it.

There was a plan to keep people safe in case of an emergency.

Is the service effective?

Good

The service was effective.

Staff had the opportunity to meet with their line manager on a one to one basis to discuss aspects of their work.

Staff received appropriate training which enabled them to carry out their role competently.

People's rights under the Mental Capacity Act were met. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were being met. People were asked for their consent before care was undertaken.

People were provided with nutritious food and fluid to keep them healthy. Staff provide support to help people eat when the required this.

People had support from external healthcare professionals to help them to remain healthy.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and dignity.

Staff were caring and kind when supporting people.

People were encouraged to be involved in their care as much as possible.

Relatives and visitors were able to visit the home at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not everyone was able to take part in the activities provided.

Care plans were hand written and sometimes were not easy to follow.
Staff responded well to people's needs and their relatives were knowledgeable about their care plans and involved in any reviews.

A complaint procedure was available for people and relatives.

Is the service well-led?

Good

The service was well-led.

The registered manager had maintained accurate records relating to the overall management of the service.

Audits of records relating to people's care and the management of the service took place to monitor quality.

Staff, people and their relatives felt supported by the registered manager.

The registered manager submitted notifications as required.

Westcott House Nursing 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 was 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 was an unannounced inspection that took place on the 10 January 2017. The inspection was carried out by two inspectors who had experience in adult social care, a dementia specialist 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 service. The expert had experience in caring for someone living with dementia and older people.

Prior to this inspection we reviewed all the information we held about the service, including information about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

We had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. There had been technical issues and the provider had not been able to submit this prior to the inspection. This has now been completed.

We spoke with eight people living at Westcott House Nursing Home and nine relatives. Some people were unable to communicate with us at length so instead we observed the care and support being provided by staff.

As part of the inspection we spoke with the provider and twelve members of staff. We also spoke with the

chef, the administrator and five health care professionals who visit the home. We looked at a range of records about people's care and how the home was managed. For example, we looked at care plans, medicine administration records, risk assessments, accident and incident records, complaints records and internal and external audits that had been completed. We also looked at four staff recruitment files.

We last inspected Westcott House Nursing Home was on 8 October 2015 where we found the service was in breach of three regulations. This inspection was to check to make sure that improvements had been made.

Good

Is the service safe?

Our findings

People felt safe living Westcott House. One relative said" Yes my husband is safe here, they are always checking on them to make sure they come to no harm." Another relative said "Most definitely Mum is safe. They are constantly looking in on her. If I was not happy she would not be here." One person said I am as safe as houses because they look out for me."

At the last inspection people were not always protected from harm because risks were not being managed. The provider sent us an action plan telling us how they were meeting this regulation.
People were kept safe from harm because the provider managed risks to people's safety. When hazards had been identified risk assessments were in place to manage them. These were detailed and contained information for staff to follow regarding what the risks were to people and the measures needed to be taken to reduce the risk of harm. For example when someone was at risk of developing a pressure ulcer the risk management plan provided guidance for staff on the frequency the person required to be repositioned and importance of maintaining records to indicate this was being done. It also gave staff specific information on a wound management plan and the type and frequency of dressings to be used. When people were at risk of choking an appropriate diet had been arranged and guidance and training put in place for staff to follow to minimise this risk. When people required assistance with their mobility their risk assessment included guidance on how to move them safely without compromising their independence. This included the number of staff needed to move a person and the equipment to use such as a hoist, a standing frame or walking frame. Staff were competent at undertaking these procedures and were seen to follow these guidelines to keep people safe when mobilising.

People were kept safe because staff understood their roles with regard to safeguarding people from abuse. Staff had a good understanding of what abuse meant and the correct procedures to follow should abuse be identified. All staff members had undertaken adult safeguarding training within the last year in line with the provider's policy and the local authority's procedures. One member of staff said "I would report anything I felt unhappy about to the manager." Another member of staff said "I know I would report abuse of any kind. I would tell the manager, or the nurse in charge or the police depending who was available. It is very important people are kept safe." Staff were confident talking about safeguarding and their responsibilities to the people they cared for. There was information in the main office and the nurse's office explaining the different types of abuse with contact details of the local authority should staff require this information. The provider was aware of their role and responsibility about informing the Care Quality Commission regarding any referrals made to the local authority under safeguarding.

People's medicines were managed and given safely. Medicines were safely stored in a dedicated medicine room that was kept locked. Medicines were administered safely in accordance with the home's medicine policies and procedures and in accordance with the Nursing and Midwifery Council's (NMC) Code of Professional Conduct. Staff that gave people their medicines received appropriate training which was regularly updated. The deputy manager undertook monthly audits of medicines to ensure they followed best practice to keep people safe. This was to ensure medicines were managed safely and to monitor medicine errors if applicable. The pharmacy also undertook safety monitoring audits and provided advice

as appropriate.

People received their medicines when they needed them and as prescribed. The medicines administration record (MAR) charts were completed properly, without gaps or errors which meant people had received their medicines when they needed them. Each MAR chart held a photograph of the person to ensure correct identification of individuals and there was information on any allergies and how people liked to take their medicines. People had their medicines given to them in an appropriate way by staff. For example with food or after food as directed. A number of senior care staff had undertaken training in medicine administration. This was so they could accompany qualified nurses during medicine rounds to give people their medicine. This was to reduce the time it took to undertake a medicine round and to ensure people got their medicines at the correct time.

Medicines given on an as needed basis (PRN) and homely remedies (medicines which can be bought over the counter without a prescription) were managed in a safe and effective way according to protocols in place. Staff understood why they gave this medicine.

People were safe because there were enough staff to meet people's needs. People's care needs had been assessed and a staffing level to meet those needs had been set by the provider. We looked at the staff duty rota for the previous four weeks and we saw there were sufficient staff provided to meet people's needs. There were three registered nurses allocated throughout the day and two registered nurses allocated to work during the night. They were supported by 14 care staff during the morning shift, 13 care staff allocated for the afternoon shift and 7 care staff to work the night shift. Duty rotas could be flexible depending on situations within the home. For example an extra care staff had been deployed to work the morning of our inspection to accompany a person to a hospital appointment that took five hours.
Staff supported people throughout the day and there was a continued staff presence in the lounge areas where people sat and interacted with staff. People did not have to wait for assistance when they required this. A relative told us "There are plenty of staff employed that's one thing for sure." Another relative said "Mum and residents are safe because there is always staff in the back lounge to attend to their needs."

The staff recruitment procedure was safe. The provider carried out appropriate checks to help ensure they only employed suitable people to work at the home. Staff files included information that showed checks had been completed such as a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services. There were also systems in place to check qualified nurses Personal Identification Numbers (PIN). This is a legal requirement and qualified nurses must be registered with the NMC professional body before they can practice in the UK.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager to look for patterns or triggers that may suggest a person's support needs had changed. Action taken and measures put in place to help prevent reoccurrence had been recorded. For example when a person was unsteady or had fallen the provider was proactive and looked at the causes of this. They may take a urine sample to send for analysis to rule out a UTI and alert the GP before referring to the falls team for additional support and intervention.

People would continue to receive appropriate care in the event of an emergency. There was information and guidance for staff in relation to contingency planning and we read each individual had their own personal evacuation plan (PEEP). The provider had made arrangements with the local authority if the home had to be evacuated for any length of time. A recent fire risk assessment had been carried out on the building and fire

drills were undertaken routinely both for day staff and during the night. Training records showed staff were up to date with fire training which meant they would know what to do should the need arise.

Good

Is the service effective?

Our findings

A relative told us "Staff have the experience and skills they are excellent at what they do." Another relative told us their family member was "Well cared for by staff who knew what they were doing."

At our last inspection we made a requirement around the effectiveness of staff training. The provider sent us an action plan telling us how they were going to meet that requirement.

People were supported by well trained staff that had sufficient knowledge and skills to enable them to meet people identified needs. The induction process for new staff ensured they learnt the skills required to support people effectively. This included shadowing more experienced staff to get to know more about the people they cared for. We saw this in practice during our visit.

People benefitted from staff who were well supervised. Staff had the appropriate knowledge to undertake their roles. Mandatory training was undertaken regularly. This included safeguarding adults, fire safety, dementia awareness, health and safety, first aid, infection control, pressure area care, record keeping and food hygiene. One staff member said, "I have done my manual handling training. This included using a host and sliding mats to move people in bed. I am confident in what I do."

Qualified staff were provided with the opportunity to update their professional skills and training. We saw evidence to support they had attended coursed on catheter care, medicine update and awareness, and venepuncture (taking blood). They told us they were supported by the provider in preperation for revalidation which is a requirement of the NMC part of their updating skills.

Staff were able to meet with their line manager on a one to one basis, for supervision and appraisal. Records showed that staff were up to date with both of these. Supervision gives a manager the opportunity to check staff were transferring knowledge from their training into the way they worked. An appraisal is an opportunity for staff to discuss with their line manager their work progress, any additional training they required or concerns they had. Both of these are important to help ensure staff are working competently and appropriately and providing the best care possible for the people they support.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were implemented appropriately. 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. Mental capacity assessments had been carried out for individual decisions. People's capacity was recorded on their care plans. It included areas such as people being able to retain information, and around specific decisions like living in a care home. The registered manager told us if someone was unable to give consent then a best interest meeting would take place. For example if a person was not able to consent to having bed rails in place to keep them safe. We saw a best

interest meeting had been undertaken for this person.

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). Staff understood the legal framework regarding the MCA and DoLS. DoLS. Applications were made and authorised where necessary. For example, in relation to people not being able to go out alone, requiring the door to have a key pad, or when someone required additional support to manage their financial affairs.

People had enough to eat and drink to keep them healthy. They were happy with the quality, quantity and choice of food and drinks available to them. One person said "The food is home cooked and very tasty. " Another person said "The food is very good. I do like my meals very much." A relative said "The food they have is very good especially the meat. Such good quality."

Menus were seasonal and were reviewed regularly. Menus were displayed in the dining room which showed people what was on the menu that day. There was a choice of roast turkey or minced cobbler, choice of potatoes and vegetables, followed by apple crumble and custard.

Lunch was served in several areas of the home. Some people had their meal in the main dining room, some ate in the dining room in the annex, some had their meal in the day centre and some people chose to eat in their rooms. There was a good staff presence throughout lunch and people had support to eat if they required this. One person had a poor appetite and did not want to eat. Staff supported them to eat and provided alternative choices of food to encourage them to eat something. However people who required a soft diet were not offered a choice and had the mince cobbler. We spoke with the chef regarding the possibility of introducing a second choice for people and they were going to implement this to ensure people had an alternative choice.

People had a nutritional care plan and specific dietary needs were addressed in these plans. The registered manager told us if someone had specific dietary requirements they would be referred for the appropriate professional guidance. There was also guidance for staff to follow if people required specific support when eating and drinking. For example if people needed their food to be cut up or required soft food. Other people required their drinks thickened as they had swallowing difficulties. Staff were also aware of people who were at risk of choking and had undertaken first aid training regarding this. Fluid charts were used to monitor fluid intake for people who may be at risk of dehydration.

Monthly weight checks were in place which enabled staff to assess and monitor if people were eating and drinking enough to stay healthy. There was guidance for staff should people's weight reduce and staff had followed this when required.

People were supported by staff to maintain good health. Care records showed people's health care needs were monitored and action taken to ensure these were addressed by appropriate health care professionals. People were registered with a local GP who visited the home weekly or more frequently when required to do so. People were also visited by a dentist, optician, dietician, and other health care professionals on a regular basis. During our visit a person had a care review undertaken by the local authority, and people were visited by their GP. The registered manager is also a qualified nurse and had a good understanding of the health care needs of the people in her care. They were proactive in recognising when a person became unwell and acted immediately by getting the relevant support. For example a person developed a temperature and the registered manage was able to listen to the person's chest to suggest a chest infection. They were then referred to the GP at their visit. Specialist input from the tissue viability nurse (TVN) was sought if someone

required their input for the treatment and prevention of pressure ulcers. Community psychiatric nurses (CPN) and continence advisors were also available to support people by referral. We noted advice and guidance given by these professionals was followed.
Individual hospital passports were in place which explained people's needs and preferences for continuity of care and treatment should they be admitted to hospital.
Care plans documented when people's care needs had changed. When people's health needs had changed appropriate referrals were made to specialists for support. For example a person had been referred to the occupational therapist following moving and handling assessment for advice and guidance on equipment to be used. A health care professional told us the service was extremely good at working with them to achieve the most effective outcomes for people.

Good

Is the service caring?

Our findings

Staff were caring, attentive and interacted well with people. People were positive about the caring nature of the staff. One person said "I am well looked after and want for nothing." Another person said "The staff are good to me they are very caring people." One relative said "The staff here treat residents like they would want their relatives to be treated." Another relative said "I would have no hesitation in recommending this home to anyone. It is very good."

Staff demonstrated warmth, concern and appeared knowledgeable about individual's backgrounds. Their interactions were well paced and responsive to needs using humour as appropriate. Staff smiled, were friendly, acknowledged each person by their name and used appropriate touch.

Prior to lunch a person had been given their medicine whish left some residue around their mouth. The nurse in charge spotted this and asked for their face to be wiped. A staff member reappeared almost immediately with a flannel and towel and cleaned their face. This was done in a sensitive way, explaining what she was going to do, apologising "Sorry about this" and reassuring them.

People were well dressed with clean clothes and either shoes or slippers. Their hair was neat and tidy and they had access to a hairdresser who visited the home regularly. Male service users clean shaved and some female service users were supported to wear makeup if they chose to do so. A member of staff was undertaking a hand massage and the person was enjoying this and responded to this through smiling.

People received good care from a staff team some of whom had worked in the home for a long time. This built a trusting relationship between people and staff. A relative told us "This home has given me my confidence back. I tried to manage at home but since my relative came here they have changed for the better." Another relative said "If there were more care homes like this the world would be a better place." People looked relaxed and there was a caring and confident atmosphere in the home. For example when someone needed some reassurance staff held their hand and spoke gently to them and sat with them until they were settled. There was a good staff presence throughout the day and there was constant chatter between people and staff each time staff passed by.

Staff communicated effectively with people and listened to what they said. A member of staff spoke to a person by kneeling down and making eye contact with them. They continued their conversation by telling the person who we were and why we were visiting the service. They supported one person who was in bed to talk with us by speaking gently in their ear and providing their feedback to us. For example how they were feeling, if they were comfortable and happy.

People were supported to be involved in their care as much as possible. They had been consulted about how they liked their care undertaken and what mattered to them. People told us they were always consulted before any decisions were made about them. A relative told us they had been involved in their relatives care as due to capacity their relative was unable to make some choices for themselves. They said "I

am involved totally and they always ask my opinion. That makes me feel that I can still be part of their life in a good way."

People's rooms were personalised with photographs, ornaments and furniture which reflected their interests and hobbies. A relative said "When my family member first came they were encouraged to bring their personal possessions to make it feel like their home."

People's dignity and privacy were respected. Staff knocked on people's doors before they entered. Personal care was undertaken in private and bathrooms and toilets had doors that locked. People could have a key for their room if they wanted this. There were screens and curtains provided in shared bedroom to maintain the privacy and dignity of the people who shared these rooms.
Staff addressed people appropriately and called them by their preferred name. When staff discussed a person's needs or any personal information this was done in the office or a private area so that other people could not over hear what was being said.
However during lunch some people wore clothing protectors which were old and frayed and did not promote their dignity. We spoke with staff about this and how they could offer an alternative to people to maintain people's dignity. They said they would make a point in future of offering people the choice.

Relatives told us they were able to visit when they wanted and were made to feel welcome. One relative said "The staff are amazing, caring and kind." Another relative said "This home is very caring; I am very happy with everything and made to feel included."

Requires Improvement

Is the service responsive?

Our findings

Before people moved into the home pre admission needs assessments were undertaken. This was to ensure people's health and social care needs could be met and the provider had the resources in place to meet these needs. One person told us that someone came to visit them in hospital to meet them and asked them questions about what they liked and did not like. Relatives told us they had also been included to the pre admission assessment process in order to 'get things right' before people moved into the home. A relative said they had been encouraged by the provider to visit the home on several occasions before they made a decision on behalf of their family member to move into Westcott House. They said "We have no regrets as this place is the best and everything we wanted."

People had been involved in their care planning whenever possible. A person said their care had been discussed with them and they were asked to sign their care plan. One person told us their relatives had been involved with their care plan and said "It was too much for me to deal with and I trust my family to do things like that." Relatives told us they were consulted at each stage of the care planning process to ensure their family member's care was individual and personal to them. One relative said "They are excellent at keeping me informed of any changes and no matter what time of day they will ring me to let me know." Care plans had been signed by the person to show they had been involved. When people were unable to sign their care plan relatives or advocates had been involved in this process.

Care plans were written on information gathered from the needs assessments, and input from people whenever possible. They provided an account of people's likes, dislikes, how personal care would be delivered, communication skills, medicine plan, nutrition plan, emotional wellbeing plan, and mobility needs. Care was provided according to people's care plans and their needs. Care plans were regularly reviewed with people and updated appropriately when needs changed to ensure the most up to date information was available for staff to follow. They also identified objectives for people and the action required by staff to meet these. Care plans were hand written and some were not particularly easy to follow in places. However when we spoke with staff they were aware of people's individual needs. For example why a person required a pressure cushion because they were at risk of becoming sore, or what intervention was required by a person who had increased falls. Relatives told us they were invited to meet with the registered manager and staff to talk about care plans when this was appropriate.

We recommended that care plans should be written in a format to make them easy for staff to follow.

People in the front lounge were asked what they wanted to watch on television before it was tuned on and at one stage this was turned off as people were listening to music. One person was reading the paper and another person was enjoying a visit from their dog. People chose to please themselves. One person chose to stay in their room for part of the day as they liked to read the daily paper and had a selection of books which they also enjoyed. They told us they participated in activities when the felt like doing so. External entertainment was arranged as part of the activity programme.

The service had an activity centre for people who lived at Westcott House. This was situated between the main house and the annex. This provided a stimulating environment employing many of the design approaches considered appropriate for people living with dementia. For example reminiscence pictures, photos of activities that people had engaged in, access to food and drink for people and relatives, craft items within reach around the room, chairs positioned in the round to enable good communication and reduce isolation, other seating areas for one to one conversation and an activity coordinator who engaged all those present in a stimulating activity. We observed people who used the lounge in the annex and the staff who supported them had great potential to become more engaged in activity. Although people appeared to be sleeping they were easily awakened once spoken to and engaged in activity such as a gentle ball game.

We recommended if the approach used in the day centre (both in terms of décor and an activity coordinator) could be replicated in the lounge and dining area in the annex and people engaged in person centred dementia type activities their emotional and psychological needs could be greatly improved. We also recommended existing staff would benefit from training in activity provision.

People's spiritual needs were respected. There was a service of worship organised monthly for people who wished to attend and the provider arranged visits from clergy on request.

People were supported by staff who listened to them and responded to any problems they may have. People and relatives knew how to raise any concerns or make a complaint. One person said "I have not had to make a complaint and if I had any issues I would talk to the manager who would solve the problem immediately.

People were provided with a complaints procedure when they were first came to live in the home and there was a copy of this displayed in the reception area. The complaints policy included clear guidance on how to make a complaint and by when issues should be resolved. It also contained the contact details of relevant external organisations such as the Care Quality Commission and the local authority. There had been two formal complaints received in the past twelve months. We saw these had been resolved in a timely way using the home's complaints process. The registered manager told us they were in the home every day and if anyone had an issue it would be resolved immediately.
Relatives were reassured that if they had to make a complaint that their concern would be acted upon. One relative said "I had a few minor niggles but these were sorted immediately." Another relative said "I have never made a formal complaint as the manager and staff go that extra mile to please everyone."

Good

Is the service well-led?

Our findings

There was an open culture in the home where people, staff and relatives were able to express their views and were listened to. People were very positive about the home and the way the home was managed. One person said "Everything about this home is good." Relatives were reassured by the open and transparent approach of the provider. One relative said "Not only is the manager in charge she is also a good listener." Another relative said "I have every confidence in the home and the way people are cared for." Another relative said "We are almost like a family here and the manager consults us about everything."

Staff were confident in their roles and felt they had the management support to be able to undertake their roles efficiently. Staff worked together as a team and there was good communication between them and the provider. Staff were aware of the organisation's vision and values. They said their priority was to encourage people to do as much as possible for themselves and to keep people comfortable, safe and happy. This was seen throughout the day and supported people with a smile and kind words.

We found at the last inspection whilst the provider had systems in place to monitor the quality of the service these were not always effective. At this visit the registered manager undertook monthly audits of medicine records, care plans, risk assessments nutritional plans and staff duty rotas to monitor the service people received. These records were dated and signed to indicate that they had been reviewed and changes were recorded and updated as appropriate.

External care reviews were undertaken by the local authority which contributed to the quality auditing process. External medicine monitoring was also in place to drive improvement.

The registered manager also undertook health and safety audits and infection control audits to ensure the safety and wellbeing of the people living in the home, people visiting the home and to promote a safe working environment.

Service user satisfaction surveys were undertaken to gain feedback on the quality of service provision and where improvement was required. Comments from the most recent survey completed in November 2016 included "Very happy with everything," "Extremely happy with the care provided," "Staff are very kind which is so important," and "This is a lovely place very impressed." The provider told us that they were in regular contact with relatives who give feedback and comments about the home and the care provided. Relatives were able to attend meetings and events such as garden and Christmas parties and were kept up to date on issues affecting the care of their family member or the running of the home.

Staff were involved in how the home was run. Staff had the opportunity to meet daily at handover as a team to discuss general information and any issues or concerns that occurred during the shift. They told us the registered manager would use the staff handovers to inform them of information change either to people of the management of the home. Formal staff meetings also took place. The last meeting was in September 2016 when qualified staff were offered support with revalidation to retain their registration. The handover we observed was positive and informative and provided staff with the necessary information for continuity of

care.

The registered manager operated an open door policy and we saw several examples of this throughout the day when staff, relatives and people who used the service sought their support and advice.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was displayed in the home so they would know how to respond if they had concerns they could not raise directly with the registered manager.