Mrs M Fuller

Kinloch Tay Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Kinloch Tay Residential Care Home is a privately run care home registered to provide accommodation for up to 21 people, including older people living with a cognitive impairment. At the time of our inspection there were 21 people living in the home.

The inspection was unannounced and was carried out on 29 July 2016 and 04 August 2016.

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, medicines were not always managed safely. The system for recording and storing medicines was not robust and led to inconsistencies which could lead to confusion as to whether a person had received their medicine or not. Staff did not have access to guidance to help them understand when 'as required' (PRN) medicine should be given. By the second day of our inspection the registered manager had taken action to resolve these concerns.

Staff sought verbal consent from people before providing care. However, the assessment of people and decisions made in their best interest were not always recorded to help staff understand the person's ability to make decisions for themselves or why a decision had been made. By the second day of our inspection the registered manager had taken action to resolve these concerns.

Legislation which allows people to be deprived of their liberty in their best interests was not followed and people were deprived of their liberty without it being legally authorised.

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.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

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. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand.

People were encouraged to maintain relationships that were important to them. The home was animal friendly and people were encouraged to being their pets with them when they moved in.

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.

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

There was an opportunity for people and their families to become involved in developing the service. They were encouraged to provide feedback on the service provided both informally and through 'resident meetings' and an annual questionnaire. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. The provider was fully engaged in running the home and provided regular support to the registered manager. 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 were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People's medicines were not always managed safely. The system for recording and storing medicines was not robust, which led to inconsistencies between the records and actual amount of medicine held. Staff did not have access to guidance to help them understand when 'as required' (PRN) medicine should be given.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed. However, not all checks were fully recorded.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

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

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought verbal consent from people before providing care. However, staff did not always follow 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, on-going training and support 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. The registered manager promoted an animal friendly culture.

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?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

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

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Kinloch Tay 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 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 July 2016 and 04 August 2016 by two inspectors. Before the inspection, we reviewed the 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 nine people using the service and with two visitors. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three members of the care staff, the chef, the deputy manager and the registered manager.

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

The home was last inspected in October 2013 when no issues were identified.

Requires Improvement

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said, "I feel very safe [here]. That's what I like. This is the second best thing to being at home". Other comments from people included "Physically I'm being looked after very well", "Couldn't be better really" and "I could leave if I wanted, but I don't want to". Family members told us they did not have any concerns regarding their relative's safety.

However, people's medicines were not always managed safely. The system in place to for managing the storage of medicines was not robust and led to discrepancies between recorded levels of medicines held and what was actually there. For example, a review of the pain relief medicine for one person identified a discrepancy of more than 26 tablets between the recorded expected quantity and the actual quantity. We raised this with the deputy manager who was unable to account for the difference. The temperature in the room where medicines were kept was not taken. Therefore, the registered manager was unable to assure themselves that the medicines were being stored in accordance with the manufacturer's instructions.

There was no guidance available to support staff in administering 'when required' (PRN) medicines. For example one person was prescribed PRN medicines to help them when they became anxious. The was no guidance available to assist staff in understanding when this medicine should be administered and what alternative strategies could be tried prior to it being administered. The National Institute for Health and Care Excellence (NICE) guidance Managing Medicines in Care Homes (2014) identifies the need for providers to record in the person's care plan any PRN medicines, when these should be given, the expected outcome and the action to take if that outcome was not achieved.

We pointed out our concerns to the registered manager and by the second day of our inspection a revised medicines stock management process was being introduced but had not had time to be embedded in practice. The registered manager had also created new PRN guidance for all 'when required' medicines.

Staff had received appropriate training and their competency to administer medicines had been assessed by the registered manager 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. 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.

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 they had any concerns, "I would speak to the manager and if they did nothing about it I would do something myself, like getting in contact with safeguarding".

Each person's care plan described measures staff should take to keep people safe. For example, how staff

should support a person who occasionally displayed behaviour that staff or other people using the service may find distressing. 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.

People were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person had a risk assessment regarding the use of their walking stick when mobilising. The person confirmed that they had been involved in this decision of how this risk should be managed and told us they now felt safe.

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. 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.

People and their families told us there were sufficient staff to meet people's needs. One person, who liked to stay in their room said, "Yes there are plenty of staff here. They always pop in and ask if I'm happy and everything is okay". They added "If I need them I ring my bell and they come as quickly as they can". The registered manager told us that staffing levels were based on the needs of the people using the service. They said that the provider was happy to take a flexible approach to staffing, "For example I have the flexibility to increase cleaning hours if needed". A member of staff told us, "There is enough staff. We have an extra member of staff who comes in if someone needs to go to the hospital for an appointment".

The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. One member of staff told us, "I have a lot of time on a Sunday to spend time with people". Staff responded to people's needs promptly. 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 bank staff employed by the provider. The registered manager and the deputy manager were also available to provide extra support when appropriate.

The provider had a 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. However, the records did not always show where gaps in the employment history of potential new staff were fully explored. We raised this with the registered manager who took action to ensure this was correctly recorded in the future.

There were appropriate plans in case of an emergency occurring. There was a person centred approach to the action staff would take to support people in the case of a fire. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Requires Improvement

Is the service effective?

Our findings

People and their families told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "I feel well cared for, they will do anything you want". A family member told us, "Staff know [my relative] well and how to look after her. They are all very good; I have no complaints".

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 and procedures, however, the recording systems were not robust. The assessment of people and decisions made in their best interest were not always recorded to help staff understand the person's ability to make decisions for themselves or why a decision had been made. By the second day of our inspection the registered manager had taken action to ensure that where assessments were required these had been completed and fully recorded. There was also a process in place to record decisions made in people's best interest. However, these had not had time to be embedded in practice.

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 registered manager was not following the necessary requirements and had not submitted DoLS applications to the supervisory body with the relevant authority for those people using the service who were deprived of their liberty. By the second day of our inspection the registered manager had commenced the process of submitting DoLS applications to the appropriate authority. People's families and other representatives were being consulted as part of this process to ensure that this decision was made in the person's best interests and the least restrictive option.

The failure to ensure that a DoLS application had been made in respect of people who were deprived of their liberty is a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their families told us that staff asked for their consent when they were supporting them. One person said, "They [staff] ask you first and check everything is okay before they do anything". A family member told us, "[My relative] would let them know if she didn't want to do something. I have no doubt about that".

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 explain to people what I am doing. If they don't want to do

something I might offer an alternative or try again later but it is their choice really". 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. Since April 2015, 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.

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, managing challenging behaviour, dementia awareness, end of life care, mental capacity act, first aid and inhaler techniques. Staff were supported to undertake a vocational qualification in care. 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.

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. One member of staff said, "Yes we have supervisions. [The registered manager] sits down with us and we chat through things and then we sign and add any comments. We have them every two to three months. On top of that we have observations where [the registered manager] will watch us doing things and then she will tell us what she thinks".

People were supported to have enough to eat and drink. People told us they enjoyed their meals and there was enough to eat. One person said "They often do a roast; breakfast is at seven and lunch is at 12. I can rely on that". Another person told us, "I prefer being up here [in their bedroom], so they bring my meals up. If there is anything you don't like the chef will cook something else for you". They added "I have plenty of drinks. When I want them I just ring the bell and they get another jug or a cup of tea, whichever I want". A third person said, "I find out what is for lunch when they put it on the table, but if I don't like it they will get something else".

The chef was aware of people's preferences and dietary needs. They told us that where people had dietary needs linked to medical conditions, such as diabetes, they adapted their food so they had similar to everyone else. For example, using sweetener in their rice pudding rather than sugar. People were also able to chose the size of meal they preferred, small medium or large.

Meals were appropriately spaced and flexible to meet people's needs and when they wanted to eat. People were able to choose where they ate their meals. Some were happy to eat in the dining area, others in their bedroom and some in front of the television. 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. For example, two people were reluctant to eat their meal. Staff identified their reluctance and supported them with patience in a friendly calm manner, giving them the space and time to enjoy their meal.

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. One person told us, "If I am not feeling well they will call the doctor and he comes here to see me".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person said, "I've been to a lot of care homes and this is the best. The difference is that staff actually care". Another person told us "The staff are excellent. I am quite content to be here. It is very comfortable". They added "I would prefer to be in my own home but I am surprised I settled in so quickly. That's down to the staff". Family members told us they did not have any concerns how their relatives were cared for. One family member said, "They take good care of her".

The registered manager recognised the importance of people's relationships with their pets and promoted an animal friendly culture. They told us, "Being able to keep their pet with them when the move in helps to give them a sense of home". One person had brought their dog with them and there was also a cat residing at home. The person with the dog told us, that having his dog was "a real comfort". He also said it meant he went out with the dog and a member of staff for walks. Other people in the home engaged with both the cat and the dog. One person had previously owned a dog that had subsequently passed away. She often confused the other person's dog with hers. The owner of the dog and staff encouraged her to interact with his dog. Staff said that they did this as it gave them comfort and reassurance knowing they had a dog around.

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. One person was sat doing a jigsaw puzzle in the lounge area. As different staff passed through the room they stopped and asked her how she was getting on. When she indicated that she was struggling to find pieces they asked if she would like assistance and then sat at the table and with her supporting her to do a bit more of the jigsaw. We saw from their expression and comments that the person enjoyed having the staff there to support her. Staff were attentive to people and checked whether they required any support. For example one person, had fallen asleep in the chair and slumped over to one side. The registered manager gently woke the person and supported them to reposition themselves so they were more comfortable. She then offered to get the person a pillow to prop herself up on to, which was accepted.

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. One member of staff told us they gave people a choice and added, "For someone who lacks capacity [to make a decision]. I would pick two blouses and ask them which one they would like". Where people declined to take part in an activity or wanted an alternative this was respected.

We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. Some of the rooms were double occupancy and screens were available to allow staff to support people discretely. A member of staff told us that when supporting people, "I make sure the doors and curtains are shut and place a towel over them. We have screens but in a shared room I try and

do it when only they are in the room". We spoke to the registered manager about people sharing rooms who told us people were offered a choice when they first come into the home. They added the pairing of people was carefully considered to ensure they were well suited. This was demonstrated by the matching of one service user who is bed bound with another service user who chooses not to spend much time in her room. Checking care plans and daily logs confirmed this pattern of behaviour and that there had been no incidents in relation to them sharing a room together. We spoke with people sharing rooms and they confirmed they were happy with the arrangement. One person who shared a room with a relative told us, "I like sharing with my niece. I like to keep an eye on her. She goes down for entertainment if there is any on. I am not interested so I get time on my own".

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 detailed 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. When asked staff were able to give detailed information about people and their individual likes, dislikes and life history.

People were encouraged to be as independent as possible. One person told us staff, "Encourage you to do things for yourself if you can but they are there to help if you need them to". A member of staff said, "Most clients are able to wash themselves. So I try and encourage them to keep doing things". Another member of staff told us, "I always try and promote residents to do things for themselves if they can".

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. People and their families confirmed that the registered manager and staff supported their relatives to maintain their relationships. One person told us, "They encourage visitors. The first thing they ask them is would you like a cup of tea. When they [visitors] are here they [staff] respect our privacy so we can talk in private". One person had a visit from a older person who had had a fall on their way to the home resulting in a grazed arm. Staff saw there was a problem with the person and enquired what had happened then provided first aid, support and reassurance. People's bedrooms were individualised and reflected people's interests and preferences.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and 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, "They will do anything for you. They will get your Christmas cards if you can't get them yourself".

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 received care and treatment that was personalised and met their needs. People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of individually focused care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. For example, one person's care plan detailed that although they were forgetful; they had expressed a preference to keep their beard and would like staff to support him to maintain this in his personal care routine. Their care plans also included specific individual information to ensure medical needs were responded to in a timely way. Care plans and related risk assessments were reviewed monthly to ensure they reflected people's changing needs.

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. This corresponded to information within the person's care plan. Handover meetings were held at the start of every shift and 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. One member of staff told us, "When things change you would be told at handover. If I've been away I would look at the care plan to see what has changed".

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room. One member of staff told us, "It is nice being a keyworker because you build us a good relationship [with the person]. I check their nails and cut them if needed, soak their feet once a week and tidy their wardrobe".
Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People had access to activities that were important to them. These included going out shopping and trips out to visit family. People were also encouraged to take part in group activities within the home such as, quizzes, puzzles and balloon games. We observed eight residents in the lounge engaged in one of these sessions. The registered manager had also arranged for external entertainers to come to the home, once or twice a week and visits for the local church to support people's pastoral needs. Where people did not want to engage in group activities staff interacted with them on a one to one basis. There were other activities available for people in the home, such as doing jigsaws, reading, knitting, watching television and

listening to music.

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. The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. They also held regular 'residents meetings' which were held every three to four months. We looked at the minutes of the last meeting in April 2016 which included discussions on the colour of staff uniform, menu choice and pets.

The registered manager also sought formal feedback through the use of quality assurance survey questionnaires sent to people, their families, health professionals and staff. We looked at the feedback from the latest survey, from November 2015, which was all positive in respect of the care people received. Comments included 'Well run', 'Happy here', 'I have to say I think the staff are first class, always happy and jolly and willing to go the extra mile' and 'they are not just staff and residents. It is a home and they are all family'. Where concerns were raised action was taken. One person had requested a lock on their bedroom door, which was done. Another example was, people had raised an issue of the state of the downstairs bathroom. The registered manager told us she had now got approval to convert it into a wet room.

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 Care Quality Commission and the Local Government Ombudsman. One person told us they had made a formal complaint to the registered manager about a staff member. There is a record of this compliant and the person told us they felt that the issue was dealt with appropriately. They said, "The manager seems compassionate and seemed to listen to my concerns". The registered manager told they recorded all concerns as a complaint no matter how minor. For example one complaint related to a person raising a complaint about the number of people walking pass their bedroom door, which they like to leave open. The registered manager had spoken with the person about their concerns and explained it was a busy corridor and suggested they may prefer to close their door. The registered manager told us that people's keyworkers would support them to raise any complaints initially and people also had access to independent advocacy services if they needed them.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. One person said, "Yes I would definitely recommend the home to others. There is no place like [your own] home but if you can't be there here is the best place to be".

There was a clear management structure, which consisted of the provider, the registered manager, and the deputy manager. Staff understood the role each person played within this structure. 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 "Some of the senior staff have other duties. [Named member of staff] does the birthdays. She gets cards and gifts for people".

The provider were fully engaged in running the service and their vision and values were built around creating an environment that made people's lives as homely as possible. The registered manager told us "We are an animal friendly home, so people can bring their pets with them to give them a sense of home". They were also in the process of arranging a regular visit by an ice-cream van to the home. They hope this would enable people to enjoy memories from their past listening to the Ice-cream van's music and enjoying an ice-cream. Care staff were aware of the provider's vision and values and how they related to their work. One member of staff told us they felt lucky because the provider lived near-by and added, "She pops over quite a bit. If she find things she tells us, it's her baby. She is very approachable; I really get on well with her".

Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. They had also provided a suggestion box so staff could raise things anonymously if they did not feel confident to raise it at the meeting. One member of staff said, "Sometimes people don't want to speak up [at the meetings] so we have a suggestion box we can use. It seems to work quite well". 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, "I feel I can come up with an idea and they [the registered manager] will listen. They are happy to listen to any suggestions and if they can do it they will". Another member of staff said the registered manager was, "very approachable. If I have any concerns I will just raise them with her".

People and family members told us they were given the opportunity to provide feedback about the culture and development of the home and all said they were happy with the service provided. The provider had suitable arrangements in place to support the registered manager, for example regular informal meetings, which also formed part of their quality assurance process. The registered manager confirmed that support was available to them from the provider. They said, "I see [the provider] several times a week. She does night spot checks. She is my 24/7 support. She keeps hands on, if needed she comes in and sits with someone who is poorly".

There were systems in place to monitor the quality and safety of the service provided and to manage the

maintenance of the buildings and equipment. The registered manager carried out regular audits which included infection control, the cleanliness of the home, people's bedrooms, 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 and managed through the regular meeting processes. The registered manager acknowledged that their quality assurance system had not been robust enough to identify the areas where we had raised concerns. By the second day of our inspection they had updated and augmented their auditing systems to ensure the quality and safety of 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 provider and 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 the provider's registration. The home has not previously been rated.