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Tudor Cottage

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on the 17 and 18 December 2015 and was unannounced. We previously inspected the service in January 2014 and found the service was compliant with the standards we looked at and there were no breaches of regulations.

Tudor Cottage is registered to provide accommodation with personal care for up to 19 older people, who have become frail, are living with dementia or who require respite or palliative care.

12 people lived there when we visited and we met all of them. It is also registered to provide personal care for people in their own homes but this service was dormant when the inspection took place. The provider had notified us about this.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are ‘registered persons’. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service, relatives and health and social care professionals gave us positive feedback about the service. People were treated with dignity and respect and staff were caring and compassionate towards them.

Staff knew each person as an individual and what mattered to them. The service was organised around people’s needs and wishes. Staff documented detailed life histories about each person, their life and family before they came to live at the home

People experienced care and support that promoted their health and wellbeing. They received effective care, based on evidence based practice, from staff that had the knowledge and skills needed to carry out their role. Health and social care professionals gave us positive feedback about the care and support provided for people.

Each person’s care needs were assessed and care records had information about how to meet those needs. Care was focused on people’s individual needs, wishes and preferences and people were supported to remain active and independent. People were supported to express their views and were involved in decision making about their care.

People were offered day to day choices. Staff sought people’s consent for care and treatment and ensured they were supported to make as many decisions as possible. Where people lacked capacity, staff confidently followed the Mental Capacity Act 2005 and its code of practice. People’s capacity to make day to day decisions was assessed. Where people lacked capacity relatives, friends and professionals were involved in best interest decision making.

People praised the quality of food and choices available at the home. Staff supported people with poor appetites who needed encouragement to eat and drink, to stay healthy and avoid malnutrition and dehydration.

People said they felt safe living at the home. Staff were aware of signs of abuse and knew how to report concerns; any concerns reported were investigated. A robust recruitment process was in place to make sure people were cared for by suitable staff. People knew how to raise concerns and were confident any concerns would be listened and responded to. The service had a written complaints process. Any concerns or complaints were investigated with actions identified to make improvements.

People, relatives and staff said the home was organised and well run. The culture was open and honest. Staff worked well as a team and felt supported and valued for their work. Senior staff acted as role models to support staff to achieve high standards of care.

The provider had a range of quality monitoring systems in place, which were well established. There was evidence of making continuous improvements in response to people’s feedback, the findings of audits, and of learning lessons following accidents and incidents.

The care environment was adapted to meet the needs of people living there. People were assisted to identify key areas such as toilets and bathrooms independently. This was because they were well signposted to help people find them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. People were protected because staff knew how to recognise signs of abuse and how to report suspected abuse. People's risks were assessed and actions taken to reduce them as much as possible. People receive care and support at a time convenient for them because staffing levels were sufficient. Staff had been recruited safely to meet people's needs. People received their medicines on time and in a safe way.	**Good**
Is the service effective? The service was effective. People were cared for by skilled and experienced staff. Staff had regular training and received support with practice through supervision and appraisals. Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People experienced a level of care and support that promoted their health and wellbeing. Staff recognised any deterioration in people's health. They sought professional advice appropriately and followed it.	**Good**
Is the service caring? The service was caring. Staff were kind and compassionate towards people, and had developed warm and caring relationships with them. Staff supported and involved people to express their views and make their own decisions, which staff acted on. The service was organised around people's needs.	**Good**
Is the service responsive? The service was responsive. People received personalised care from staff who knew each person, about their life and what mattered to them. People were encouraged to socialise and pursue their interests and hobbies. There was a varied programme of activities. People and their relatives felt confident to raise concerns. There was a complaints process which was on display in the home.	**Good**

Summary of findings

Is the service well-led? The service was well-led. There was a registered manager and the culture was open, friendly and welcoming. People, relatives and staff expressed confidence in the management and said the home was well organised and run. People, relatives and staff views were sought and taken into account in how the service was run and suggestions for improvement were implemented. The provider had a variety of systems in place to monitor the quality of care provided. They made changes and improvements in response to findings.	**Good**

Tudor Cottage

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 took place on 17 and 18 December 2015 and was unannounced. An adult social care inspector carried out this inspection. Prior to the inspection we reviewed all information we held about the service. This included reviewing the provider information return (PIR), our previous contacts with the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

We met all 12 people who were living at the service, spoke with two relatives and a friend. We spoke with nine staff, attended a staff handover meeting and looked at four staff records. We also looked at four people's care records, and at the provider's quality monitoring systems. This included systems for staff recruitment, training, supervision and appraisal. We also looked at audits of medicines, care records, health and safety, and at actions taken in response to feedback from people, relatives and staff. We sought feedback from health and social care professionals who regularly visited the home and received a response from four of them.

Good

Is the service safe?

Our findings

People said they felt safe and secure at the home. One relative said, "I know she is well looked after, it gives me peace of mind."

Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. All staff said they could report any concerns to the registered manager or deputy manager and were confident they would be dealt with. The provider had safeguarding and whistle blowing policies available so staff were clear how to report concerns. Any safeguarding concerns identified had been notified to the Care Quality Commission and the local authority safeguarding team. They had been investigated and actions taken to protect people and keep them safe.

People said staff met their needs at a time convenient to them. The atmosphere in the home was calm and organised, staff worked in an unhurried way and were able to spend time with people. Staff responded promptly to call bells. Each person who needed help to eat was supported to do so at lunchtime.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. During the day there were four staff on duty in the morning and three in the afternoon. At night , there was one waking member of night staff, with one sleeping night staff, available in case of emergencies. At night, hourly checks were made of each person's safety and wellbeing. The provider did not use agency staff, which meant people benefitted from continuity of care by staff who knew about their care needs and preferences. Mostly, any gaps in staffing were met by existing staff working extra shifts.

We followed up concerns raised with us about night staffing levels at the home in relation to providing end of life care. The provider and registered manager had met with a community nurse manager to discuss their practice in managing end of life care. The registered manager said where a person needed one to one support, this would be provided by staff from the home working extra shifts on a short term basis. Where previously one to one care was needed for longer periods, the provider had worked another service to ensure the person's needs were met. The registered manager regularly assessed dependency levels to identify workload based on individual people's needs. This included monitoring how often 'sleep in' staff were called at night, which was rarely.

People's care records included individual risk assessments and information about how to manage and reduce risks. For example, risks of falling and developing pressure sores from skin breakdown and reduced mobility. People's care plans showed actions being taken to these reduce risks as much as possible. Accidents and incidents reported were reviewed to identify ways to reduce risks for each person as much as possible.

People received their medicines safely and on time. An assessment was undertaken of whether the person could take their own medicines or needed staff assistance, but staff were supporting all of the people who lived there with medicines when we visited. The service used a monitored dosage system on a monthly cycle for each person. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge.

Medicines administered were well documented in people's Medicine Administration Records (MAR), as were records of prescribed creams applied. Where a person's dosage of medicines was altered in accordance with blood test results, there were systems in place to make sure the prescription was updated accordingly and the correct dosage obtained. Medicines were checked and medicine administration records were audited regularly and action taken to follow up any discrepancies or gaps in documentation. Following a medicines error in September 2015, the provider sent us information about their investigation and action plan. This included an outline of the circumstances of the error, contact with the GP for advice, and additional training and checks undertaken to ensure lessons were learned.

Environmental risk assessments were completed for each area room and showed measures taken to reduce risks. For example, hazard signage where the floor was sloping in lounge/dining area. At the time we visited, one bedroom was temporarily out of use following a leak, and the person moved to another bedroom whilst repairs were undertaken. We noticed hazard warning signage on display in some bathroom areas. However, when we followed this up by checking records of water temperatures, we found water temperatures were below the 44 degree maximum safe limit for vulnerable people set by Health and Safety

Good

Is the service safe?

Executive. We discussed this with the registered manager who said a new boiler had been fitted last year.
The provider may therefore wish to review the current hot water hazard signage in use.

All repairs and maintenance were regularly undertaken. Equipment was regularly serviced and tested as were gas, electrical and fire equipment. Regular checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. In the Provider Information Return (PIR), the provider commissioned an external fire risk assessment report and installed nine fire doors. This was to improve safety and efficiency of fire exits for people and staff. Each person had a personal emergency evacuation plan showing what support they needed to safely evacuate the building in the event of a fire.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had access to hand washing facilities and used gloves and aprons appropriately. Housekeeping staff had suitable cleaning materials and equipment. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance. In one bathroom area, some tiles had come off the wall and there were a few rust patches on the foot of a bath hoist. This would make it more difficult to clean equipment properly to prevent cross infection. We followed this up with the registered manager who had already made a request for the repairs to be undertaken.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Staff had police and disclosure and barring checks (DBS), checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Good

Is the service effective?

Our findings

People felt well supported by staff who were appropriately trained and knew how to care for them. When staff first came to work at the home, they undertook a period of induction. This included working alongside the registered manager and experienced staff to get to know people and about their care and support needs. New staff were undertaking the national care certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life.

Most staff had qualifications in care or were undertaking them. Staff undertook regular update training such as safeguarding adults, health and safety, and infection control. The registered manager had undertaken a 'train the trainer' course on moving and handling. This meant they could train other staff, monitor practice and assist with updating people's moving and handling care plans as their needs changed.

Staff felt well supported to do their job. One staff member said, "Training is fun, it's not boring, we all take part." They had lots of training and updating opportunities relevant to the needs of people they cared for. For example, training on the Mental Capacity Act and Deprivation of Liberty safeguards (DoLs), living with dementia, tissue viability and end of life care. Staff received support through regular one to one supervision. This included one to one discussions and observing staff practice around the home, such as moving and handling and providing constructive feedback. Staff had an annual appraisal where they had an opportunity to discuss their practice and identify any further training and support needs.

Before each person came to live at the home, a detailed assessment of their needs was undertaken. This included a careful assessment of people's mobility needs. The building was very old, so was not ideally suited to people with reduced mobility. However, reasonable adjustments had been made to improve the environment for people who lived there. For example, both staircases had stair lifts fitted to assist people to go upstairs and handrails were fitted in bathroom and corridor areas to assist people to move around independently. All toilet and bathroom areas had clear signage to enable people to identify and locate them. Since we last visited, a 'wet room' shower was fitted upstairs at the home, which improved disabled access for people. Following feedback from people and staff about dim lighting in the lounge, the provider was arranging for an electrician to install new lighting to improve this area.

The service used evidence based tools to assess if people were at risk of developing pressure sores, and of falling, malnutrition and dehydration. Where a person was at risk of developing pressure sores, care plans provided staff with detailed instructions about the care. We looked at the care of two people at high risk of developing pressure sores and saw they had the appropriate moving and handling aids and pressure relieving equipment in use. They received regular skin care, and were repositioned at regular intervals in accordance with the detailed instructions in their care plan. All equipment needed such as electric beds, pressure relieving mattresses and moving and handling equipment were available at short notice from within the provider group.

People were supported to access healthcare services such as attending regular appointments with their dentist, optician and any hospital appointments. People were regularly visited at the home by their GPs, district nursing team and by the community mental health team. Health professionals confirmed staff contacted them appropriately for advice and carried out that advice.

Mealtimes were a very sociable occasion, most people ate lunch in the dining room where they chatted and socialised with other people. People gave us very positive feedback about the food choices at the home. At lunchtime, people had a choice of three meals accompanied by freshly prepared vegetables. One person who didn't fancy any of those and asked for a cheese omelette instead which was made available. Another person liked their lunch later, as they didn't get up earlier, and their preference was accommodated. Staff supported people who needed help to eat and drink.

Where people had any food likes/dislikes, these were known by kitchen staff. Reduced sugar alternatives and sweeteners were available for people with diabetes. Some people who lived at the service were at increased risk of malnutrition or dehydration. For those people, care plans instructed staff to monitor the person's food and drink intake, as well as checking their weight regularly. Where people had a poor appetite or were unwell, staff tried a variety of ways to tempt them to eat. For example, one person sometimes refused their meal but would accept a

Is the service effective?

bowl of cornflakes as a snack. People were offered drinks and snacks regularly throughout the day. Weight charts showed staff were managing people's weight well, and we saw no significant weight loss. One person was experiencing some difficulties with eating and swallowing, although was not thought to have a choking risk. Staff were working with the person's GP and with a speech and language therapist (SALT) to try foods of different consistencies to encourage this person to eat.

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

People were offered day to day choices such as what time they wanted to get up and go to bed and about how they spent their day. People's consent for day to day care and treatment was sought. Staff had demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

Mental capacity assessments were completed for each person including their decision to live at the home. Where a person was assessed as not having the capacity to make a decision, people who knew the person well and other professionals, were consulted and involved in making a decisions in the person's 'best interest'. For example, one person was regularly refusing their medicines and lacked capacity to understand the risks versus benefits of taking them. Staff had discussed this with the persons GP. They had authorised staff to give the person their medicine disguised in food or drink (covertly) in their 'best interest', when needed. However, staff said this had not yet been necessary.

Another person had nominated a relative as a Lasting Power of Attorney (LPA) to make decisions about their care and treatment, and staff involved them appropriately in decision making. LPA is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if either they are unable to or no longer wish to.

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).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. One person living at the home had a Deprivation of Liberty authorisation in place, which staff were acting in accordance with. Applications had been made to the local authority DoLs team for five other people living at the home, who were awaiting assessment. These applications were made as a result of the Supreme Court judgement on 19 March 2014 which widened and clarified the definition of deprivation of liberty. It confirmed that if a person lacking capacity to consent to arrangements is subject to continuous supervision and control and not free to leave, they are deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

People's liberty was restricted as little as possible for their safety and well-being. Although there was a locked front door with a key code, the code was available to people who could safely use it. Where people needed to be accompanied for their safety, staff help was provided. A careful assessment was undertaken whenever the use of bedrails or a pressure mat was considered for a person's safety. One person was sometimes verbally and physically aggressive, showing behaviours which challenged the service, particularly in relation to accepting help with personal care. The person's care plan had detailed step by step instructions, including the need to seek additional help, when the person's aggression was increasing. Staff described how they used distraction techniques and one or two staff to help the person, depending on their mood. The techniques described were those outlined in the person's care plan, and no restraint was used.

Good

Is the service caring?

Our findings

One person said, “Staff are lovely, they couldn’t do enough for you, they care for you, I couldn’t wish for better.” A relative said, “Staff are dedicated, they treat people like family, lots of care and love, and that means more than anything.” Another relative said, “The care is brilliant, staff are absolutely wonderful.” A professional who visited regularly said, “They listen to people, ask them what they would like and do it, people love it here. “One staff member said, “People have still got a good quality of life here, it’s their home.”

Staff had positive caring and compassionate relationships with people. They knew people well, and spoke about them with respect and affection. Staff treated each person as an individual and they was lots of joking and laughter and gestures of care and affection. Staff demonstrated empathy in their conversations with us about people. Staff were visible round the home, spent time with people and were interested in what people had to say. They organised themselves flexibly around people’s needs and wishes. Before lunch a staff member was leading a word quiz with people in the lounge. They were encouraging each person to join in and praising their suggestions and contributions.

Families were welcomed, and chatted easily to staff. Staff kept in contact with relatives and updated them about how the person was doing. Some visitors visited regularly and appreciated being offered refreshments. When we visited, people and families had just enjoyed the Christmas party. Several people had party photographs on display showing the person enjoying time with family members, which they talked to us about. One relative said they particularly appreciated how staff encouraged one person to get out of bed and attend the party, and they enjoyed spending time with their family member.. Staff had collected and transported some relatives to the home to make sure they could attend. One person and their key worker told us how they had made contact with relatives in Australia. The staff member had set up an e mail account for the person, and was helping them keep in contact via regular e mails and Skype, which was giving them great pleasure.

In the Provider Information Return PIR, the provider outlined how each person who came to live at the home was given a welcome card and flowers and each person’s birthday was celebrated. Each person had a keyworker who ensured people had everything they needed such as helping people to buy clothes and toiletries.

People said staff always treated them with dignity and respect. For example, a staff member discreetly prompted and helped a person to go to the bathroom. In the (PIR), the provider described how they had introduced ‘Do not disturb’ signs to display of external doors. This protected people’s privacy and dignity, as staff were alerted when a person was receiving assistance with personal care.

People were supported to dress how they wished, a hairdresser visited regularly and people were offered nail care. People were wearing their glasses or they were at hand, and staff ensured people’s hearing aids were checked and maintained in good working order. Care records included detailed information about any communication aids.

People were consulted and involved in decisions about their care and treatment and in developing their care plans. Where appropriate, relatives were also invited to participate in regular reviews of people’s care. One person, who had no close relatives, had an independent advocate they met with regularly who could represent their views, if needed.

People’s religious and cultural needs were supported. One person attended services regularly in their local church and was looking forward to the ‘Carols by candlelight’. The registered manager also made adjustments for a staff member so they could have breaks during the day at set times for prayers. People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, such as the person’s views about resuscitation in the event of unexpected collapse. The provider offered end of life care, although no one needed this when we visited.

People and staff were involved in fundraising. They had chosen the ‘Poppy Appeal’, the Macmillan Cancer charity and a charity helping people in the Philippines, following a natural disaster.

Good

Is the service responsive?

Our findings

People received care that was personalised and responded to individual needs. Staff knew people well, understood their needs and cared for them as individuals. Care plans were easy to navigate and provided detailed instructions for staff about how each person wished to receive their care, support and treatment. Regular reviews of care plans were undertaken with the person and friends/relatives. This ensured the care planned and delivered was still suitable for the individual.

Each person's care records had detailed information about each person, their life before they came to live at the home and about their family. People's care records were reviewed and evaluated regularly as their needs changed. Daily records provided information about the care provided, people's physical and psychological wellbeing, their eating and drinking and how they spent their day. Several people had 'Mood boards' so staff knew about each person and their preferences. For example, their favourite foods, beloved pets, favourite music and films.

People were able to pursue their interests and hobbies and to try new things. Several people enjoyed a daily paper and reading books. Where people chose to remain in their rooms, they said staff popped in regularly to chat to people and keep them company. For example, staff helped one person to pursue their enjoyment of reading by providing a selection of newspapers, and magazines and reading their letters with them. An external activities co-ordinator visited the home twice a week and did a variety of activities with people. This included offering people hand massage using scented oils. A musician provided musical entertainment once a month. Staff were encouraged to do individual and group activities with people. The registered manager was working on ideas and resources for staff which included quizzes, word searches, board games, and dominoes and some staff liked singing with people. There were lots of photos of what people had enjoyed such as salt dough making, floor word puzzles and movie evenings.

The home was in the centre of Axminster and several people liked to pop into town. One person liked to visit the local shops, another regularly visited the local coffee shop, and a third person went to their local church regularly. When the weather was warmer, people enjoyed trips out in a minibus, which they shared with another home within the group.

Each person was encouraged to personalise their room with things that were meaningful for them. For example, photographs of family members, treasured pictures of army service days and favourite ornaments or pieces of furniture.

In the Provider Information Return (PIR), the provider outlined how staff were focusing on exploring ways to help orientate people to the current season. When we visited, people had made a window winter display of snowmen made from old white socks. They had also decorated the home for Christmas, including make a Christmas tree from tinsel, which featured each person's photograph. The registered manager described how people and staff had a craft day at the end of November, where they had enjoyed making all these creations together.

People were involved in decisions made about the home. In the PIR, people were consulted about what they wanted to buy, following a donation of some money. They chose to buy a fish tank, and were enjoying taking turns to feed the fish when we visited. They also arranged for a theatre group to visit, as some people could not access the theatre because of their reduced mobility. They also decided to try out and then purchase an iPad and an iPod, so people could have music in their rooms. The registered manager said the service was still working on making maximum use of the iPad and iPod and were getting help from family members to make sure information, pictures and music suitable for people was downloaded for their use.

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the manager or any staff and were confident it would be dealt with straightaway. The provider had a written complaints policy and procedure. Written information was given to people and was on display in the home about how to raise a complaint. One visiting professional said they would feel happy to raise concerns and were confident it would be sorted. They recalled seeing a soiled chair one day when they visited, and said it was sorted straightaway.

In the PIR, the provider said there had been three complaints in the past year. We looked at the complaints log when we visited. We saw each concern raised had been investigated and positive actions taken in response to address. This included a written response offering apologies where needed and explanations for any concerns raised. Concerns raised were discussed with the staff team, so lessons could be learned and care improved.

Good

Is the service responsive?

The service had also received lots of cards and letters of compliments about the service. This included a thank you card and praise for staff for the love and care shown to their relative which said, “Really wonderful and devoted care.” Another relative said, “You made her last year’s pleasant and happy.” A third family member said, “Thank you for the party you put on for mums 100th birthday.”

Good

Is the service well-led?

Our findings

People, relatives and staff were positive about the provider and spoke about the culture of the home as being friendly and open. When we asked people and relatives what was the best thing about the home, one relative said, "The manager is amazing, she looks after the staff and it's the nicest home, I'd give it ten out of ten." Staff described a "Really homely atmosphere."

In the Provider Information Return (PIR) , the culture of the home was described as being fair, open, honest and transparent. The registered manager provided visible leadership and role modelled the values and behaviours expected. Staff described them as supportive and willing to "sort out any concerns." One staff member said, "It's one of the best homes I've ever worked in, staff work as a team, its friendly, we have a laugh, there is no bullying." Speaking about the registered manager, they said, "I can talk to her about anything."

Staff worked well as a team, most had worked at the home for a long time and there was a very low turnover of staff. Staff had delegated roles and responsibilities, for example, senior staff were "Keyholders", which meant they took responsibility for holding the keys and doing the medicines and for liaising with health professionals. Staff were keyworkers for named people and were responsible for reviewing and updating care plans with each person. The registered manager and deputy manager carried about a number of audits and identified any areas for improvement.

Staff felt well supported, were consulted and involved in the running of the home through regular staff meetings and staff supervision. Staff meetings minutes showed findings of a medicine audit was discussed and improvement were agreed. Other issues discussed included laundry issues, communication, the use of social media and a discussion about end of life care. Staff felt valued and were praised for their work. When we visited, the registered manager had written to all staff thanking them for organising the party for people and families. Where staff were working a 12 hour day, a hot meal was provided for staff, which they appreciated.

There were good systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through daily handover meetings. A communication book was used to remind staff about people's appointments, changes in medicines and other messages.

The provider visited the home each week and spoke with people and staff. They monitored accident and incidents to identify any trends or individuals at increased risk. They checked that actions were taken to reduce risks. The registered manager said the provider gave them "Excellent support."

The registered manager was up to date with recent regulatory changes. They had notified the Care Quality Commission about all important events they were required to tell us about. They were a member of the Devon outstanding manager network, a network group for managers of social care provision. They described this as a network to share good practice ideas, discuss relevant topics and raise standards. They also worked closely with other registered managers in the provider group for mutual support.

The registered manager was trained to deliver fire training and moving and handling courses and did informal training sessions for staff on Mental Capacity act and Deprivation of Liberty safeguards. They were also very knowledgeable about managing challenging behaviour and shared their knowledge with other staff. They were hoping to undertake a teaching qualification so they can deliver more in-house training to staff.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. These included monitoring cleanliness, checking of equipment such as hoists, hoist slings and wheelchairs. The registered manager undertook regular audits of medicines management, and record keeping. In several people's care records, the registered manager had given staff detailed feedback from audits of care plans. This included highlighting any gaps, and constructive advice about how to further improve the person's care plans.

A maintenance book was used to report any repairs or maintenance needed, which was signed off to confirm when it was completed. A training matrix system was used to monitor staff attended all the required training and updating provided.

The provider conducted an annual satisfaction survey to seek feedback from people and families but said only a few

Good

Is the service well-led?

questionnaires had been returned. To encourage feedback, the provider was thinking about inviting families to a cheese and wine party to seek further feedback. Regular residents meetings were held through which issues were discussed and feedback was received from; any suggestions for improvements were acted on. Out of hours, on call support and advice was provided for staff, together with a contingency plan for emergencies.