Four Seasons Homes No. 1 Limited

Redwell Hills Care Home

Inspection report

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05 June 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 30 and 31 May and 5 June 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Redwell Hills Care Home in July 2015, at which time the service was compliant with all regulatory standards and was rated Good. At this inspection the service remained Good.

Redwell Hills is a care home in Leadgate, Consett, providing accommodation and nursing care for up to 51 older people who require nursing and personal care. There were 35 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected against a range of risks by risk assessments and care plans that were regularly reviewed. Risks were considered with the input of external professionals where appropriate.

People we spoke with and relatives agreed staff faced a challenging workload, but there were sufficient numbers of staff on duty in order to meet people's needs and keep them safe.

Pre-employment checks ensured the service did not employ people who were unsuitable to work with potentially vulnerable people.

Staff were trained in areas such as dementia awareness, moving and handling, safeguarding, health and safety, infection control, mental capacity and food hygiene. Training needs were monitored and managed well at location and provider level.

Infection control procedures were in place and we found all aspects of the home to be clean and well maintained.

Staff received consistent support through supervision and appraisal meetings, as well as group supervisions and staff meetings.

The management, administration, storage and disposal of medicines was carried out in line with National Institute for Health and Care Excellence [NICE] guidelines.

People healthcare needs were well managed with the support of external healthcare professionals where necessary.

All people who used the service we spoke with, relatives and visiting healthcare professionals agreed staff were caring in their interactions with people and we saw evidence of this during our inspection.

The registered manager was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's nutritional and hydration needs were met by kitchen staff who had up to date information about their preferences and specialised diets. We observed calm and unhurried mealtimes, with people able to choose alternative options and staff attentive to their needs.

Care plans were sufficiently detailed and staff demonstrated a good knowledge of people's needs, likes and dislikes. The registered manager was in the process of introducing additional one-page profiles to ensure new staff had readily accessible person-centred information.

The service had an activities co-ordinator in place and there were a range of group activities on offer. At times the activities co-ordinator did not have sufficient time to ensure people who chose not to engage in group activities were able to engage in activities meaningful to them.

The service had a range of quality assurance and auditing processes in place to continually review service provisions. Relevant policies and procedures were in place and regularly reviewed.

People who used the service, relatives and staff were positive about the impact the registered manager had made and expressed confidence in their abilities. We found they had successfully developed a culture that was focussed on people feeling at home whilst receiving good standards of care.

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 remains Good.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service was caring.

Feedback from people who used the service and relatives was generally positive about how staff focussed on their needs rather than tasks.

We observed numerous positive interactions between staff and people who used the service and the atmosphere was vibrant and welcoming throughout the inspection.

The registered manager planned to introduce dementia and dignity champions.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Redwell Hills Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 30 and 31 May 2017 and the inspection was unannounced. This meant the provider or staff did not know about our inspection visit. We also returned to the service on 5 June 2017 to speak with the registered manager, who was on leave at the time of the inspection. The inspection team consisted of one Adult Social Care Inspector, one specialist advisor and one expert by experience. A specialist advisor is someone who has professional experience of this type of care service. An expert by experience is a person who has relevant experience of this type of care service. The expert and specialist advisor in this case had experience in caring for older people and people living with dementia.

During the inspection visit we looked at six people's care plans, risk assessments, staff training and recruitment records, a selection of the home's policies and procedures, meeting minutes and maintenance records. We saw the service's feedback, incident/accident reporting and quality assurance systems, which were IT-based.

We spent time observing people in the living rooms and dining areas of the home. We inspected the communal areas, kitchen, bathrooms, toilets and laundry.
Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with professionals in local authority commissioning and safeguarding teams, as well as Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

We spoke with eleven people who used the service and seven relatives. We spoke with sixteen members of staff: the area manager, the registered manager, the nurse in charge, an agency nurse, five care staff, the administration officer, two kitchen staff, the activities co-ordinator, one domestic assistant, the laundry assistant and the handyman.

Good

Is the service safe?

Our findings

Nobody who used the service raised concerns about their safety and we found a range of evidence demonstrating people were protected from various risks.

One person told us, "I'm very relaxed here – staff help me if I need it but I am fine." A number of people who used the service showed us where their emergency call bell was and confirmed staff responded to these when they used them. One person told us, "Staff are always there when you need them." Relatives we spoke with were consistent in their description of a service that protected people from harm and abuse.

Two relatives we spoke with felt the service would benefit from having more staff, although they did not think staffing levels presented a specific risk. A member of staff told us, "We could always do with more staff but we're doing okay," whilst the majority of staff confirmed they had sufficient time to complete their duties. We saw the registered manager used an established dependency planning tool to ensure there were sufficient staff on duty to meet people's needs. During our inspection we observed people were supported promptly and call bells were answered. We found, whilst staff were under pressure at times, there were sufficient staff on duty to meet people's needs and to keep them safe. People were not therefore put at risk due to understaffing.

Medicines were administered safely and in line with National Institute for Health and Care Excellence [NICE] guidelines. Medicines records were accurate whilst medicines were generally stored safely in line with good practice. We saw that the temperature in one treatment room had on occasion risen above the recommended higher limit of 25 degrees. The provider ensured this was remedied with a fan during our inspection.

We sampled a range of Medicine Administration Records (MARs) and found them to be error-free and in good order. MARs contained photographs and allergy information, whilst sample signatures of staff who administered medicines were in place, making auditing and error-identification more accountable. A We saw evidence to show controlled drugs were regularly checked by staff and stored in line with good practice. Controlled drugs are medicines liable to misuse.

We saw body maps were in place to ensure staff administering medicines in a cream format knew how and where to apply these medicines. Where people required medicines 'as and when' we saw there were protocol sheets in place giving staff a rationale for when they should be given and why. Staff demonstrated a good knowledge of people's medicinal needs and their competency was assessed annually. Daily audits of medicines and external annual audits by a pharmacist were also in place. This meant people were not placed at risk through the unsafe administration of medicines.

We observed nurses communicating effectively with people and seeking consent before administering medicines.

Nursing and care staff we spoke with were consistent in knowing what was expected of them should they witness anything of concern. Safeguarding and whistleblowing training had been delivered to staff. We found evidence that staff had previously appropriately raised concerns about practices they were concerned about, and that these concerns had been properly dealt with by senior leadership in the organisation.

Staff used a range of recognised risk assessment tools to help them ensure people were protected from harm. These included the Abbey Pain Scale and Waterlow assessments. The Abbey Pain Scale is a means of assessing pain in patients who are unable to verbally articulate their needs, for example by documenting facial expressions. Waterlow assessments are used to estimate the risk to a person of the development of a pressure sore. We saw these documents had been completed accurately and used to inform how staff kept people safe.

We saw people had other individualised risk assessments in their care plans to ensure staff were aware of the risks they faced, and how to reduce those risks. For example, where one person required the use of a slide sheet to reposition them whilst in bed. We saw instructions for staff were clearly detailed and, when we spoke with staff, they demonstrated a good understanding of how to keep the person safe from harm when supporting them to reposition. We observed safe moving and handling practices throughout our inspection.

Access to the home was through a locked door and visitors were asked to sign in, whilst the rear patio area was enclosed and secure.

Accidents and incidents were consistently documented on the service's electronic data management system. This automatically generated reports for the area manager and other senior managers in the organisation, dependent on the level of severity. We saw incidents were recorded and reported in a structured way, as well as being acted on and analysed to see if any patterns or trends emerged.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks had been made. Where a new member of staff had disclosed a previous conviction we saw this was fully risk assessed prior to employment. We also saw that the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

Maintenance records showed that hoists, lifting equipment, fire detection and firefighting equipment, call bells, gas and electrical equipment had been serviced. Window restrictors were in place and had been regularly checked. Staff used a maintenance book to log any remedial action required by the handyman, who also demonstrated a good understanding of the need to undertake intermittent checks, such as water temperatures and the flushing of little used outlets. This protected against the risk of, respectively, scalds and water borne viruses such as legionella. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

Personalised Emergency Evacuation Plans [PEEPS] were in place. They detailed people's mobility and communicative needs and were easily accessible in the event of an emergency.

With regard to infection control, the service was clean throughout and we observed staff adhering to hand washing good practice during our inspection. We saw people's rooms were clean, whilst domestic staff confirmed they received the appropriate equipment and support to perform their duties. For example, we saw concerns had been raised about the level of odours in certain areas of the home recently, and that

domestic staff asked if anything more could be done. We saw they were provided with odour neutralizers and that this had had a positive impact. This meant the service actively managed and reduced the risk of acquired infections.

Good

Is the service effective?

Our findings

We found people who used the service were supported and cared for by staff who had the relevant skills and knowledge to meet their needs. Nursing and care staff consistently demonstrated a good knowledge of people's individual needs and how they helped them.

We saw that staff liaised regularly with external professionals such as district nurses, tissue viability nurses, dietitians and doctors. We saw advice from these professionals was incorporated into care planning documentation and adhered to. For example, advice regarding how to manage and maintain one person's skin integrity. We saw actions taken by staff were in line with the professional guidance given.

We saw staff had received training relevant to their roles, such as safeguarding, food hygiene, moving and handling, dementia awareness, fire safety, infection control and equality and diversity. The registered manager ensured staff training was up to date through regularly tracking the proportion of staff who had completed necessary training. The area manager also had access to this information and requested updates from the registered manager if staff training was not above the provider's targets. We found the system to be working effectively, whilst staff told us, "We have plenty of training," and, "I've signed up for the level 5 (management) qualification – they encourage us."

Staff were also supported through formal supervision meetings and annual appraisals. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. We saw these discussions were detailed and focussed on specific areas of practice improvement and knowledge. Appraisals are an annual review of staff performance. The registered manager also held group supervisions, where they felt it was important to update all staff on a particular issue. This meant staff received good levels of support to enable them to perform their roles well.

People who used the service were generally complimentary about the standard of meals available. Two relatives felt standards had recently declined although this view was not shared by the majority of people who used the service and relatives we spoke with. For example, people who used the service said, "The food is lovely," "I'm happy with the home and the food – it's good," and, "They know what I can have - I have porridge and I love the soup." One relative told us, "[Person] is eating much better now and has put on some weight, which is great. I think the meals are fine."

People confirmed they were given a choice of meals at each mealtime and that staff acted on their preferences. Where people required a specialised diet we saw this was catered for by kitchen staff who were kept aware of people's changing needs and acted on advice from, for example, the Speech and Language Therapy (SALT) team.

The majority of people ate downstairs in the larger dining area but some people chose to eat in the upstairs dining area or in their rooms. We observed mealtime experiences and found them to be calm and unhurried, with staff helping people to eat where required. We saw a recent internal audit had raised concerns about one dining experience appearing, "chaotic." We found there to be adequate staff to ensure

people could have a pleasant mealtime experience, whilst staff knowledge of people's preferences in this regard was good. One person for instance commented on how they appreciated staff remembering their favourite mug. This demonstrated that systems were in place to ensure people's mealtimes were suitably resourced.

We observed people being offered drinks and snacks such as yogurts and fresh fruit from a trolley throughout our inspection. This meant people were supported to maintain a healthy, balanced diet.

A GP had recommended that one person had thickeners added to their drinks, to decrease the risk of them choking. We saw the person, in discussion with their relative and their GP, decided not to have these thickeners added as they did not like the consistency. This demonstrated staff had regard to and respected the choices of people who used the service. We saw that care plans were altered accordingly, with additional close observations in place and further instructions for staff to ensure the person remained safe whilst drinking.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw appropriate applications had been made to the local authority and staff we spoke with demonstrated an understanding of the importance of DoLS.

Where people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place, we saw they, their relatives and clinicians had been involved in the decision. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant people's needs had been reviewed appropriately with those who know them best.

We also saw people had Emergency Health Care Plans (EHCPs). An EHCP is completed by an external healthcare professionals and makes communication easier in the event of a healthcare emergency. For example, one person's EHCP set out seven different health scenarios and how professionals should respond to those scenarios. This demonstrated staff worked well with external professionals to ensure people's preferences regarding how and where they would like to be treated could be acted upon.

The premises were suitable and appropriate for the needs of people who used the service, with well-lit corridors, ample bathing and toileting facilities, multiple lounge areas and an enclosed rear yard with plants and raised beds. We saw people enjoying this space throughout the inspection, although noted that the service was dependent on relatives for the upkeep of the planted borders, and did not allocate any resource to this area.

Good

Is the service caring?

Our findings

People who used the service were consistently positive about staff who cared for them, describing them as, "Caring," and, "Kind." One person who used the service told us, "I love everyone here, it is so friendly," whilst another said, "It's very nice – they look after me."

One relative told us, "It's definitely not outstanding – it's attention to detail they need to tighten up on." Another told us, "There are quite a lot of new, young staff and they need to know how to care, not just do the tasks." Two relatives we spoke with therefore felt there was sometimes an emphasis by some staff on completing tasks rather than getting to know people who used the service. We found however a strong consensus of opinion that staff did take the time to know people's individualities and that there was a focus on ensuring people were treated in an unhurried manner.

When we spoke with staff they confirmed they received sufficient support shadowing experienced members of staff, who were responsible for ensuring new staff behaved in a caring manner in their interactions, as well as completing tasks. We spoke with the registered manager about this and one way they planned to ensure the culture retained this balance was by introducing a dignity champion and dementia champion. These would be good practice and help ensure people were treated with dignity, particularly where they were unable to verbally make their views known.

During our observations we saw evidence of staff interacting with people who used the service in ways that demonstrated genuine care and compassion. For example, during the bingo activity, staff who were not taking part took the time to come over and interact with people, whilst when an entertainer was performing staff danced with people. We also observed staff sharing jokes with people who used the service and vice versa, demonstrating that there were mutually friendly relationships established.

We observed people who used the service interacting warmly with others, for example one person helping another to complete their bingo card, and there was a welcoming, relaxed atmosphere to the home on the three days we visited. We observed people who used the service being supported in a dignified fashion. For example, by staff knocking on doors and waiting for an answer before opening, and explaining aspects of care to the people they were supporting, such as when helping people mobilise around the home.

Further contributing to the relaxed atmosphere were the personalised rooms, with people's furniture, photographs and mementos. The majority of people who used the service congregated in the downstairs living rooms and there was a vibrant atmosphere, with visitors encouraged to bring their pets.

In terms of communication, we observed staff interacting well with people, tailoring their style to make sure people knew what they were asking. For example, bending down and making eye contact with one person who was sat down, rather than talking down to them. This level of detail was included in people's care plans, meaning that before staff had built up a rapport with people who used the service, they had sufficient detail to enable them to interact with people in line with people's wishes.

The file containing previous thank-you cards was archived at the time of inspection due to redecoration but we noted two recent cards had been received. They read, "Thank you for all your care and support," and, "The 'heart' [a design on the card] signifies all the love and care you have given."

We saw information regarding advocacy services was readily available in the Service User Guide, a copy of which was available in people's rooms. At the time of our inspection no one who used the service had an advocate but we saw evidence of how the registered manager ensured those who knew people best were involved in helping them to make decisions.

We saw people were asked about their religious beliefs at the assessment stage and that these preferences were met via a regular church service. Where people were not of that denomination the church provided a general service. This meant people's right to religious beliefs were respected. End of Life care plans were in place, meaning that people's preferences regarding how they should be looked after if their health deteriorated, and where they felt most comfortable, could be respected.

People's confidential information, such as medical information and care records, were securely stored in the nurses and senior carer's offices.

Good

Is the service responsive?

Our findings

People's changing needs were supported through detailed preadmission information and regular review. There was a preadmission assessment in every care file we reviewed, documenting people's medical, dietary, religious, mobility and other needs. We saw each care plan contained a good level of information about people's needs, an up to date photograph and a 'My Choices' booklet. This contained additional information about people's likes, dislikes, personal history and other information, for example their favourite music or films. We also saw the registered manager was in the process of introducing additional one-page profiles for each person, meaning new staff would have a readily accessible document that gave them person-centred information about people.

Care records and associated documents we reviewed, including daily notes, were generally comprehensive and easy to follow. People's personal preferences were taken into account, for example one person's shaving plan specified they preferred a wet shave once a week and an electric shaver on other days. We found one instance of bathing/showering information being recorded in a separate book, rather than the relevant daily recording sheet. This was rectified during our inspection.

When we spoke with care staff they demonstrated a good knowledge of people's backgrounds and preferences, as did the activities co-ordinator. Group activities included bingo, armchair exercises and coffee mornings. We observed these activities and found them to be well attended and well received. The activities co-ordinator worked five days a week but we found they sometimes did not have sufficient time to ensure people who used the service, particularly those who did not partake in group activities, were sufficiently able to take part in activities meaningful to them.

One relative felt this to be the case, although acknowledged the activities co-ordinator would be doing a calligraphy activity with their relative, as they would like to do that rather than take part in things like bingo. Similarly, one relative told us during the inspection they thought the service should use a dog-patting service. The activities co-ordinator was able to show us they had already arranged this. This demonstrated that the activities co-ordinator was able to support people on a one-to-one basis when they had the time, as well as plan activities beneficial for the wellbeing of groups of people. They were passionate in their role and had recently introduced a newsletter, which gave people who used the service and relatives information about upcoming events and, for example, birthdays. One person celebrated their birthday during the inspection and we saw the activities co-ordinator had arrange entertainment for them. The activities co-ordinator acknowledged, "There isn't always the time for everyone and sometimes I have to help with the care side." They told us they did not get to take people on outings as often as they would like, but had access to a minibus once a week. We reviewed outings activities and saw some outings had constituted, for example, a trip to the hospital for one person, and a funeral for another. The registered manager agreed to review the time and resources allocated to the activities co-ordinator.

We saw that care plans were reviewed monthly and changes were made where necessary. Where people's needs changed this was identified by staff and either care plans were updated or external support was sought. For example, we saw specific information relevant to people's needs had been incorporated into

care file documentation, for example from vascular and orthopaedic services. This meant people's changing health needs were consistently met through regular review.

The registered manager had recently introduced a keyworker system, although this had yet to bring beneficial impacts for people who used the service. We saw there was a keyworker list in the nurse's office, but people who used the service were unaware of their keyworker, whilst staff confirmed they had yet to be assigned specific keyworker activities. The registered manager agreed to review the keyworker system. Notwithstanding this, people received care and support from staff who knew them well and were able to support their needs.

With regard to other means of ongoing review, the service used an iPad in the entrance foyer, which enabled relatives and other visitors to provide feedback about the service. Staff were also encouraged to use the pad to gather feedback from people who used the service on a regular basis. We saw feedback was wholly positive. We also saw there were residents and relatives meetings. This meant the registered manager routinely involved people who used the service and their relatives in the ongoing review of service provision.

We saw the registered manager had acted in line with the complaints policy when they had been raised. Complaints were regularly analysed to determine any trends or patterns. A significant majority of people who used the service and relatives we spoke with were confident in how to make a complaint should they need to and we saw this information was in the service user guide. One relative told us, "We did complain, through the right channels, and it is sorted now. Things have changed." One relative told us, "I never know who to ask," and stated that they had previously felt their concern had not been managed as promptly as possible. They did go on to state, "They have put in place an extra bit of support now. It does seem calmer." This meant people could raise concerns and that these concerns or complaints would be dealt with.

Good

Is the service well-led?

Our findings

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care. They had been at the service for one year and had a good knowledge of the day-to-day workings of the service in terms of policies and procedures, as well as people's needs, likes and dislikes.

The registered manager was on annual leave for the first two days of our inspection but we found they were ably supported by a team of staff who knew their roles well. The administration officer, nurse in charge and others were able to provide the necessary information. We also saw the registered manager had left clear instructions in place for the tasks that needed to be completed in their absence, and by whom. The area manager was also on site during our inspection to provide additional support to staff. When, for example, an agency nurse was required to help meet people's needs on the second day of the inspection, we saw this was well managed and did not have any detrimental impact on people who used the service.

During the inspection we asked for a variety of documents to be made available to us. These were well maintained and easily accessible. Records were clear, up to date and contemporaneous. Policies and procedures were regularly reviewed and we saw the previous CQC report displayed in a communal area, as well as clear information on how to make complaints and how to report safeguarding concerns. We also saw that appropriate notifications had been made securely to CQC in a timely fashion. This meant people could be assured their confidential information was treated carefully and in line with the Data Protection Act.

When we spoke with relatives there was general agreement that the registered manager had made positive changes since taking over the role and that they had brought a degree of stability to the service. One relative stated, "Care staff get stuff done immediately but I sometimes worry things aren't always followed up," but they did qualify this by saying they felt, overall, the registered manager had made a positive impact. Another relative said, "We've seen massive changes since the new manager arrived – good changes."

Nursing, domestic and care staff also told us they felt the registered manager was approachable and that they listened to suggestions or concerns. One told us, "The manager is good – whatever we need to do the job right, we get, and we have the support to do the job."

The registered manager had successfully instilled a caring culture that upheld good standards of care for people who used the service. They used staff meetings to instil a focus on meeting people's needs and ensuring staff were suitably skilled. For example, at a recent meeting they reminded staff about the need to attend mandatory training and the appropriate completion of senior carer and nurse audits. In another meeting, they made their expectations of staff clear: "Zero tolerance to bad practice and…not looking for a perfect team but common sense and good care delivery." We found through a range of conversations and the evidence we gathered that the registered manager had achieved this.

Auditing and quality assurance measures were comprehensive, with the registered manager and others

completing daily visual checks of various aspects of the service, such as infection control standards, dining room experiences, maintenance and health and safety. The registered manager oversaw the entirety of auditing at the service and put corrective actions in place where required. For example, when a dining room experience audit was not completed, the registered manager ensured this was done. Similarly, when medicines were found to be not properly signed for the registered manager addressed this. The service had a quality assurance system in place whereby certain criteria would automatically be escalated to the registered manager, for example where satisfaction survey results dipped below 75%. Likewise, the area manager scrutinised the performance of the registered manager and fed back to them and staff where there needed to be improvements. This meant quality assurance processes were robust and helped to identify where practice could be improved or where minor issues could be stopped recurring before turning into more serious issues.

Both the registered manager and area manager agreed that there was scope to complement the current iPad means of gathering ongoing feedback with observations undertaken by staff, whether that be by a level of management or through the planned dignity and dementia champions. This would ensure the service had ongoing feedback regarding the experiences of people who were not able to verbally communicate their views.

We saw evidence in care documentation of effective communication with professionals such as the Community Mental Health Team (CMHT) and Speech and Language Therapy (SALT) team.

The registered manager had maintained positive community links, for example with the adjacent church and school. They had also enquired about the possibility of a visit from a local dance troupe and we found their outlook to be one of community inclusion.

We found the culture the registered manager had fostered at the home to be in line with the provider's stated goals and that staff were consistent in their ability to deliver good levels of care to people who used the service.