Macleod Pinsent Care Limited

Gracelands

Inspection report

42-48 Richmond Avenue
Bognor Regis
PO21 2YEA
Tel: 01243 867707
Website: www.mpch.co.uk

Date of inspection visit: 11 November 2014
Date of publication: 11/03/2015

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 11 November and 2014 and was unannounced.

Gracelands provides accommodation and care for up to 31 older people living with dementia. People living at the home had a range of needs and required differing levels of care and support from staff related to their health and mobility. There were 27 residents' rooms in Gracelands, 24 of these were single rooms and 3 were double rooms. There were two lounges and a dining room which were located on the ground floor. Bathrooms, toilets and bedrooms were located on both floors of the building. There was a lift to access the first floor of the building.

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

At our previous inspection in February 2014 we asked the provider to take action to make improvements to premises, in assessing people's needs and planning their care, and how the quality of the service was monitored.

Summary of findings

The provider sent us an action plan to tell us the improvements they were going to make. At this inspection we saw that these actions had been completed.

People were cared for by kind and compassionate staff. There was a shared emphasis between staff and the management team of caring for people in a compassionate way. Staff took time to speak with the people they were supporting and staff and people chatted with each other in a relaxed and natural way. Interaction was often one to one and friendly and personal. When someone became upset staff responded quickly to reassure them and the person responded positively and quickly became calm.

People felt safe living at the service. The service had good systems and processes in place to keep people safe. Assessments of risk had been undertaken and there were clear instructions for staff on what action to take in order to mitigate them. Accidents and incidents were dealt with in timely manner and actions taken recorded. Staff knew what action to take if they suspected abuse and had received training in keeping people safe. Arrangements were in place to keep people safe in the event of an emergency. The service employed enough qualified and well trained staff and had safe recruitment practices. The provider had systems were in place to ensure staff were competent to be able to deliver the care people required. Staff felt supported and were positive about their roles. A plan of work had been undertaken to improve the environment of the home and premises to keep people safe. The home was clean and measures in place for the prevention and control of infection.

The provider had arrangements in place for the safe ordering, administration, storage and disposal of medicines. People were supported to get the medicine they needed when they needed it. Staff received training to meet the needs of the people living at the home. People were supported to maintain good health and had access to health care services when needed.

Staff followed the requirements of the Mental Capacity Act 2005 (MCA). People's capacity to make decisions in different areas of their life had been assessed. The registered manager had made applications to the Deprivation of Liberty Safeguards (DoLS) Team to ensure that people who could not make decisions in relation to where their care and treatment was provided had the appropriate safeguards in place. Staff observed the key principles of the MCA in their day to day work checking with people that they were happy for them to undertake care tasks before they proceeded.

People had sufficient to eat and drink throughout the day and had access to the healthcare services they required. Staff knew the people they were supporting well and the choices they made about their care and their lives. The needs and choices of people had been clearly documented in their care records. People were supported to maintain independence and control over their lives. Activities took place within the home and we saw that work was being undertaken to develop activities so that they reflected people's interests and experiences further.

The registered manager sought feedback on the care and support provided and took steps to ensure that care and treatment was provided in a safe and effective way and, where necessary improvements were made. Any complaints received were recorded along with actions taken in response. The registered manager was actively involved in the service and involved in the day to day monitoring of the standards of care and support that were provided.

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?

Good

The service was safe. People were supported by staff who understood their responsibilities in relation to safeguarding. The provider followed safe recruitment practices and there were sufficient staff to meet people's needs.

Potential risks were identified, assessed and planned for.

Medicines were managed, stored and administered safely. Premises were well maintained and equipment replaced when required. People were protected by the prevention of and control of infection.

Is the service effective?

Good

The service was effective. People were supported to have sufficient to eat and drink and maintain a healthy diet. They had access to healthcare professionals and were supported to maintain good health.

Staff had an understanding and acted in line with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This ensured people's rights were protected in relation to making decisions about their care and treatment.

Training was scheduled for staff throughout the year relevant to the needs of the people living at the home and was refreshed as needed. Staff had effective support through induction and regular one to one meetings.

Is the service caring?

Good

The service was caring. People were supported by kind and friendly staff who responded to their needs quickly.

Staff were knowledgeable about the care people required. Staff presented people with choices and gave people the time to express their wishes and respected the decisions they made

People's privacy and dignity were respected and their independence promoted.

Is the service responsive?

Good

The service was responsive. People's needs and preferences were clearly documented in care records. People were involved in activities according to their interests and choices.

People were supported to maintain relationships important to them.

People and their relatives knew how to raise complaints if they were unhappy with the service and action was taken to resolve them.

Is the service well-led?

Good

The service was well-led. Staff were supported by the manager and senior staff and felt able to raise any concerns they had.

There was a shared culture of caring for people with compassion.

Summary of findings

There were systems in place to measure and evaluate the quality of the service provided. Improvements had been made to the service in line with the provider's action plan.

Gracelands

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.

This inspection took place on the 11 November 2014 and was unannounced.

Two inspectors and an expert by experience with an understanding of the care of older people and nursing undertook this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and support in communal areas; spoke to people in private, with relatives, with staff and the registered manager and with health professionals visiting the service during our inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people. We spent time looking at records including care records of five people, the records of four staff and other records relating to the management of the home.

On the day of our inspection, we met with 12 people living at the home, two relatives and a health professional. We spoke with the registered manager, the head of care and three care staff.

Good

Is the service safe?

Our findings

On our last visit of 18 February 2014 we found improvements were needed as people were not protected against the risks of unsafe or unsuitable premises. We judged this had a moderate impact on people and set a compliance action. We found that the provider had taken sufficient action in this area and the compliance action was met.

At this inspection, we revisited the areas for improvement outlined in the provider's environmental plan. There were nine areas for improvement identified in the plan. These were: fire safety, bathroom and toilet improvements, laundry room, wiring in the home, kitchen flooring, work to the lift, general paintwork, bedroom improvements and rubbish removal. We walked around the home, spoke with the registered manager and examined documentation that related to these issues. We found all areas of concern had been addressed in a timely and satisfactory manner. We also noted work was underway to update the lounge areas, one of which was being converted to a sensory room. The lounges had been decorated in colours designed to support people with dementia. We saw that legal requirements such as Portable Appliance Tests (PAT) and gas and fire safety checks were up to date. The registered manager had a plan of ongoing improvement for the premises and that general maintenance tasks were undertaken as required.

People told us they felt safe at the home. One person said, "Definitely" and another, Oh yes". We observed that people were cared for in a safe way. People appeared settled and contented and there was at least one member of staff in each room giving assistance and socialising with people. Whenever people wished to walk somewhere they were supported to do so using equipment such as walking frames if required. One staff member told us, "We are all aware that the people living here are at extra risk and we try to manage that".

People were protected by the prevention and control of infection. The home was clean and staff used personal protective equipment (PPE) such as disposable aprons when serving food or cleaning. Aprons were colour coded to avoid cross contamination and were disposed of in the appropriate containers. Sanitary hand gels were available and information provided for staff in key areas with instructions related to cleanliness and infection control.

Records showed staff received training in cleanliness and infection control. Any issues identified in this area were raised at meetings of senior care staff to ensure they would be addressed. Staff were provided with information related to infection control at team meetings. Procedures related to cleanliness and infection control were outlined in the home's policy document. We observed that staff used and disposed of PPE in the correct bags in line with the policy document.

Staff were aware of their responsibilities in relation to keeping people safe. They told us the different types of abuse that people might be at risk of and the signs that might indicate that abuse was taking place. Staff told us that they had undertaken safeguarding training in the last year and this was confirmed in records. Staff were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency such as the local Adult Services Safeguarding Team should be made. Staff told us the manager had an open door policy and they felt able to share any concerns they had in confidence. One staff member told us, "I would definitely let my Manager know if I suspected abuse was going on here. Failing that I would contact the CQC (Care Quality Commission)". Another member of staff told us, "I have had training in whistleblowing and I know who to contact". The provider completed the required notifications to the CQC and informed the local authority of any concerns or incidents that related to keeping people safe.

Systems were in place to identify risks and protect people from harm. Assessments of risk had been undertaken and there were clear instructions for staff on what action to take in order to mitigate them. These covered risks from walking indoors and bathing independently to moving around the home at night. For each activity there was a description of the potential hazard and control measure in place. For example, some people were at risk of falls when walking. Equipment required to mitigate the risk was identified such as walking frames along with how many staff were required to support the person. During our visit we observed staff provided equipment required for people to walk safely. Staff positioned themselves alongside or behind the person so they could offer assistance to the person to prevent them from falling. Staff were discreet when offering support and people able to move around the home as they wished.

Good

Is the service safe?

There were sufficient staff to meet people's needs and keep them safe. The provider used a dependency scale in order to assess the level of staff required. We observed that people got the support they needed and were responded to quickly when they asked for assistance. Staff told us that there were enough staff to carry out their roles safely and effectively. Staff told us they had time to talk with people. One told us, "I wouldn't stay if I couldn't spend time with people". We saw that on occasion the provider used additional staff from a care agency to cover staff sickness or annual leave. Staff told us that they requested the same person from the agency as it was important to have consistency when working with people living with dementia.

Safe recruitment practices were followed when the provider employed new staff. Staff records held the required documentation including two references and proof of identity. The required checks had been carried out to ensure that new staff had no record of offences that could affect their suitability to deliver care. The provider had policies and procedures in place to manage any unsafe practice they identified. They took action in line with the policies and procedures when necessary. The provider ensured that people were cared for by staff who were fit to do so.

People's medicines were managed so that they received them safely. Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicine. We reviewed Medication Administration (MAR) charts and saw these were completed correctly; where someone had refused medicine this was recorded. There were systems in place for reviewing the charts and any issues identified, such as records not being completed, were raised at the senior care staff meeting for action. Staff had training in safe handling in administration of medicines and we observed medicine being given in line with policy and procedures. Care records identified if people were able to administer their own medicine and any risks associated with this. We saw that controlled drugs were recorded and stored appropriately. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs.

Contingency plans were in place to respond to emergencies and ensure the safety and well-being of people in the event of unforeseen circumstances. For example, staff had received fire safety training and knew the evacuation arrangements in the event of an emergency.

Good

Is the service effective?

Our findings

People were positive about the support they received. One person told us, "It's very good here. Everybody's nice and friendly and the food is good".

People were supported to have sufficient to eat and drink and maintain a balanced diet. We observed lunch and saw that food looked fresh, hot and smelt good. Portions were of a good size and looked attractive. Food was served at the table in the dining room or, if people preferred, on tables in the lounge. Lunch consisted of three courses and people looked as if they were enjoying them, with most people eating the majority of three courses. Staff were aware of people with issues relating to nutrition and those who required specialist diets for example, if they were diabetic. People who required support to eat received it promptly after the food was served. This ensured the food was still hot. Hot and cold drinks were available throughout the day and some people chose to have an alcoholic beverage with their meal.

Care records contained nutrition care plans with detailed information for staff on people's needs related to nutrition and hydration. For example we saw one person had `difficulty chewing and swallowing foods'. Records informed staff that the person required a `soft diet due to dysphagia and thickening powder'. How the person made choices was also recorded and advised that the person, `will turn her head away if she does not like food or has had enough'. We observed that the person's food was prepared in this way and that she was supported by staff in line with what he had seen in the care plan. Another person's nutrition care plan advised, `Assistance is required at all times to ensure (the person) has enough to eat and drink. (The person) is unable to communicate her needs therefore is to be offered drinks and snacks throughout the day and at night if she is awake'. We observed people were offered snacks and drinks throughout our visit. People's dietary preferences were recorded. Food monitoring was in place where people were at risk to ensure they ate sufficient amounts for their needs. The provider used the 'Malnutrition Universal Screening Tool' (MUST) to identify people who were at risk of poor nutrition or hydration. This was supported by a computer system that highlighted when people were at risk. We saw that referrals were made to health professionals when people's body mass index score reduced and they were identified at risk.

Staff told us they felt supported in their roles and had the skills and knowledge to provide the support people needed. We saw staff completed an induction that included how to support people in choosing what to wear, cleanliness and infection control and maintaining privacy and dignity. Senior staff recorded and signed when new staff had completed their induction.

Staff had regular one to one meetings with the manager and were able to discuss matters of concern or interest to them on these occasions. One staff member told us, "I do get supervisions (one to one meetings) but I can also talk to a senior staff member when I want. It's very good here like that". Staff told us that training was offered to staff relevant to the care needs of the people they looked after. One staff member told us, "I have had training in dementia care which has really helped me". Another told us, "It's not just the training we learn a lot from each other". There was a programme of training that included moving & handling, fire training and infection control and dementia awareness. The registered manager discussed any areas for development with staff. For example, we saw in records of one to one meetings staff were asked, `Was there a time you did not know what to do? How did you deal with this?' We saw that a new member of staff stated that they had always been able to ask colleagues or the senior in charge and received support if they did not know how to do something.

The home caters for people living with dementia, some of whom may present with behaviours which may challenge others. One staff member told us, "We've never had to use restraint as none of the people living here are physically aggressive but they do get upset and can be verbally aggressive sometimes but we know how to manage that". The staff member described de-escalation techniques used to defuse difficult situations such as listening and distraction. We observed staff appeared confident and comfortable in delivering the care and support people required. A staff member supported a person when they became upset. The staff member responded promptly offering reassurance and the person quickly became

Good

Is the service effective?

settled. The staff member knew how to identify that the person required support and how to provide this in a way that was respectful and effective in promoting their well-being.

We discussed the Mental Capacity Act 2005 (MCA) with the registered manager. They were knowledgeable about how to ensure that the rights of people, who were not able to make or communicate their own decisions, were protected. Care records showed that the principles of the Mental Capacity Act 2005 Code of Practice had been used when assessing an individual's ability to make a particular decision. Care records contained a best interest checklist and evidenced that people and their relatives had been consulted about decisions and practices. The checklist identified areas where a person had the capacity to make decisions and where they did not. For example, one person was not able to make decisions related to their finances but were able to make everyday decisions in relation to daily routines. The registered manager had made applications to the Deprivation of Liberty Safeguards (DoLS) Team to ensure that people who could not make decisions in relation to where their care and treatment was provided had the appropriate safeguards in place. At the time of our visit one person was subject to DoLS. We observed staff applied the principles of the MCA when they delivered care. Staff consistently took care to ask permission before supporting people and spoke to people at eye level, sitting near them and checking to ensure people understood what they had said.

We saw that people were supported to maintain good health and had access to health professionals. Care records demonstrated that staff used the Waterlow pressure ulcer risk assessment/prevention policy tool to identify if someone was at risk of developing a pressure ulcer. Where someone had been identified as at risk the district nurse had been involved and advised staff on how to manage breakdown of the skin. Health professionals told us that staff were good at following advice given on how to manage pressure ulcers.

A paramedic practitioner from the local surgery visited the home on a regular basis. This was to undertake non-emergency tasks such as assessing any minor illnesses or receiving feedback on how people were responding to medicines prescribed. They were positive about the working relationship with staff at the home. They told us staff were good at involving health professionals for people, for example making referrals to Speech and Language Therapy as required and in a timely way.

Care records contained clear information for staff on people's health needs and actions to take. For example, one person was at risk of poor health due to diabetes. There were instructions for staff on what signs to look out for that might indicate the person was not well and what action to take. Daily living records contained comprehensive updates on people's health and any action taken. When a person's health had deteriorated, action was taken including which health professionals were contacted and when the person became well again.

Good

Is the service caring?

Our findings

One person told us, “It’s very nice here; friendly and a nice atmosphere”. A health professional told us about their positive experience of how the home cared for people at the end of their lives and described their approach as “gentle”.

People were treated with respect and in a kind and caring way. Staff were attentive, smiling and kind when supporting people. People appeared relaxed when being supported by or talking with staff. We observed staff supported someone to walk. Staff explained clearly where they were going, what they were doing and offered reassurance. Staff noticed and responded quickly when someone became upset, offering reassurance to them.

Care records contained information for staff on how to involve people in decisions about their care to ensure people could make choices. For example, Records stated staff to, ’encourage discussion about the clothing to be worn for the day, is it suitable for the weather? For the occasion? Is it a favourite?’ One person’s care records stated that they could not, ‘verbally choose her own clothes but will smile if it something that she likes to wear’.

Staff spoke positively about their role with an emphasis on having a caring approach to their work. One member of staff told us, “I think human contact is very important. Holding someone’s hand can speak a thousand words”. Another member of staff told us, “I think what makes the job worthwhile for me is when I can connect with people living here and see what happiness it can bring. For example, we had a lady who was visiting her husband here for the first time in a while as he had been in hospital. It was so lovely to see them with each other and to give them the time and space to be together”.

Staff were knowledgeable about the care people required. We saw staff in the home were able to communicate with the people who lived there. Staff assumed people had the ability to make their own decisions about their daily lives and presented people with choices in a way they could understand. Staff gave people the time to express their wishes and respected the decisions they made. We saw that care records contained people’s preferences in relation to clothing and that these were respected. People were supported to make sure they were appropriately dressed and their clothing was arranged to promote their dignity. People were supported to be as independent as possible. Staff encouraged people to do as much for themselves as they were able to. Some people used items of equipment to maintain their independence. Staff knew which people needed pieces of equipment to support their independence and ensured this was provided when they needed it. Care records gave information for staff on how to relieve people’s distress or anxiety. For example one person could become anxious about their finances and staff were to, `reassure him that his family care for his needs`. We saw examples of staff offering reassurance to people throughout our visit.

People were treated with dignity and their privacy respected. Staff offered care discreetly. People were able to meet with health professionals in privacy. The health professional told us that if people didn’t want to go their rooms for care that staff would use screens to maintain their privacy and dignity. They told us staff were respectful and treated people with compassion. That staff treated, “People like people and not just tasks”.

Good

Is the service responsive?

Our findings

As a result of our inspection in February 2014, we asked the provider to take action to make improvements in assessing people's needs and planning their care. At this inspection, we found that sufficient steps had been taken to improve and care was planned in such a way to meet people's individual needs.

People told us they were satisfied with the care provided. One person told us, "I'm quite content". Care records were personalised and contained information about the background and preferences of people. Each person's record contained a profile entitled, 'What people like and admire about me'. We saw for one person it was, `Having a strong character and a determination to survive'. There was information about people's history and life experience; for example one person was interested in the Royal British Legion, enjoyed opera and reading newspapers. We observed this person reading the newspaper on our arrival. There was evidence that people and/or their relatives were involved in care decisions and that these were reviewed on a regular basis. Care records indicated arrangements people had made in the event of their death.

People were supported to follow their interests and take part in social activities. There was information about the activities people enjoyed and information for staff on how to involve them. For example one person liked to listen to and be involved in music. The information recorded that the person found it difficult to participate fully but liked to sit where they could listen easily. Care records for another person stated, 'may not be able to fully participate in activities but staff should ensure she is supported to manage as much as she is able to. She needs staff to sit with her and talk to her so that she remains stimulated.' We observed people were supported to take part in activities of their choosing and staff regularly spoke with people and not just when undertaking care tasks.

Some activities were provided within the home. Staff told us they held regular events like barbeques and birthday parties that residents and relatives came to, using the garden when weather allowed. We saw pictures of these events. Newspapers and magazines were delivered to the home on a daily basis and people were reading these. Regular activities were provided such as music and informative talks. One person received a weekly communion provided by clergy from the local church.

Staff told us they entertained residents and took them out on a one to one basis when possible. We observed a number of social activities taking place. One staff member said, "We don't have an activities co coordinator at the moment but there are plenty of things for people to do." We saw items such as feather boas, brightly coloured fans and other items used for an afternoon of music in which most people appeared to take part and enjoy. We spoke with the manager about activities within the home. The manager advised it was an area they were developing. We were shown cards that had been made to provide information about people's background and interests for staff to have personalised one to one sessions with people. A card we looked advised staff, `To sit close, gently stroke arm. Work with sensory objects, Listen to Scottish country dancing music. Talk about son'.

We observed that staff responded quickly to people's requests and people received care when they needed it. Staff supported people when they wanted to walk to another part of the home, join others in the lounge or go to their room. People told us they always chose where they wanted to sit and who they wanted to sit with.

We asked staff how they found out about people's preferences, particularly those unable to communicate verbally. One staff member told us, "There are people here who struggle to tell us what they want. But they tend to come to live here at a time when we could find out about their likes and dislikes so we know a lot about them already. We use a lot of non-verbal communication and we know them really well so that helps a lot". Another staff member said, "We have training. We learn how to communicate with people living with dementia". Staff demonstrated a good knowledge and understanding of personalised care. One told us, "We really make an effort to make our care person-centred. If someone wants to do something, we will always try our best to help them".

Staff knew people's preferences for example, when people liked to get up and what clothes they liked to wear. They told us one person liked comfortable clothes such as jogging bottoms and did not like shirts and ties although sometimes wore a shirt. This was in line with what we had seen in the person's care records and observed.

Staff delivered care in line with people's care records. Records stated if the person became anxious or upset that staff should talk calmly and offer reassurance: 'Staff to explain slowly what is happening by using facial

Good

Is the service responsive?

expressions and indicating with hands'. We observed throughout the day staff used these methods to communicate and told us of their importance when speaking with people living with dementia.

We looked at how people's concerns and complaints were encouraged and responded to.

In one to one meetings, staff were encouraged to raise any concerns. Staff were aware of the process for managing both informal and formal complaints. One told us they were often available to respond to anything raised immediately. They said, "It's rare that it gets to a formal complaint as people and relatives can just talk to us". We spoke with one relative who told us when they raised a concern it had been addressed and dealt with swiftly. We looked at the records of any complaints. We saw that where a complaint had been raised this had been clearly recorded, including a synopsis of the complaint, details of action taken and the resolution. A copy of the response to the complainant was also kept.

Good

Is the service well-led?

Our findings

At our previous inspection we found that the provider could not demonstrate that they had a mechanism to regularly seek the views of people or persons acting on their behalf in relation to the standard of care and treatment provided. On this occasion we revisited the areas for improvement outlined in the provider's plan. We saw that improvements had been made and areas of concern were addressed. The views of people had been sought and action taken in response to feedback.

A survey was carried out of two residents and two relatives each month on an ongoing basis. We saw that people were asked about the quality of care provided, friendliness and helpfulness of staff, cleanliness and infection control, quality of meals and the general maintenance of the home. We looked at two recent responses and the feedback provided. The feedback was positive about the home. The provider had also carried out an annual survey of residents and relatives to gain feedback on the service provided. We saw that most of the comments in completed surveys were positive and that actions had been taken in response to feedback provided. For example, in the survey relating to satisfaction with food provided someone had asked for more jacket potatoes. The provider had added these to the menu on a more regular basis. Responses to questions about the home décor and furnishings were fair. We saw that new chairs had been provided in the lounge and that decoration of the bedrooms and home had taken place along with other improvements. Information in the survey invited people to raise any concerns they had with the manager directly if they wished.

At our previous inspection in February 2014 we asked the provider to make improvements to premises, assessment and planning of people's needs and monitoring the quality of care delivered. The provider sent us an action plan to tell us the improvements they were going to make. During this inspection we saw that improvements had been made in all of these areas in line with the provider's action plan. Legal requirements and regulations associated with the Health and Social Care Act 2008 were met.

The registered manager completed a weekly return to the provider which identified any issues including maintenance, staff training needs and updates in respect of people's care and treatment. We saw that accidents or incidents were recorded, actions taken and a summary sent to the provider. There were also audits completed such as health and safety. Issues were identified along with action taken and date completed. This meant the provider had information in order to monitor the quality of the service as well as the registered manager.

There was a shared emphasis on a caring approach between staff and management. The atmosphere was open and inclusive. Staff were observant and quick to respond to anyone who needed their support either on a physical or emotional level. People responded to staff and there was engagement on a personal level. People required different levels of support and staff ensured that those with additional needs such as support with eating were not disadvantaged. Staff were cheerful and kind. They were relaxed in their roles and comfortable supporting people with dementia. When we asked a staff member about the culture of the home they responded, "We always try to remember that this is people's home".

Staff were well informed of issues and challenges of the home and action taken to improve them. We asked one staff remember what could be improved. They told us, "Sometimes, I think we could provide more in the way of activities but I know that there are plans to sort that out". This was in line with what the manager had told us and the plans we had seen to improve activities offered.

We asked the registered manager about the home and the service provided. She told us, "We are here to support people and ensure that staff are trained to meet residents' needs appropriately and sensitively. I want people to be cared for as I would want for my mother and father".