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Lobswood House

Inspection report

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Date of inspection visit:
08 November 2016
14 November 2016

Date of publication:
22 December 2016

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 8 and 14 November 2016 and was unannounced.

Lobswood House is a residential care home registered for up to 26 people living with dementia or mental health needs. At the time of our inspection, 24 people were living at the home. Lobswood House is situated in a residential area of Littlehampton. The majority of bedrooms are of single occupancy and some have en-suite facilities. Communal areas include a large sitting room, smaller sitting room, dining room and an outdoor patio area with tables and chairs.

A registered manager was in post. 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.

People were protected from avoidable abuse and harm by trained staff who knew what action to take in the event of suspected abuse. Risks to people were identified, assessed and managed safely. Staffing levels were sufficient to meet people's needs appropriately and staffing rotas confirmed this. New staff were recruited according to a robust recruitment process which the provider had in place. Medicines were managed safely.

Staff completed training in a range of areas and new staff followed the Care Certificate, a universally recognised qualification. Staff had regular supervision meetings and attended team meetings where items were discussed including staffing and residents' needs. Handover meetings enabled staff to discuss people's care and support needs and any issues that staff coming on shift should be aware of. Staff understood their responsibilities under the Mental Capacity Act (2005) and associated legislation, Deprivation of Liberty Safeguards, and put this into practice. People had sufficient to eat and drink and menus provided people with a choice of food. Healthcare professionals supported people to maintain good health and a range of services was available. Rooms generally were personalised and recent redecoration of parts of the home had been completed, with further planned improvements in the next 12 months.

Staff knew people well and positive, kind and caring relationships had been developed. People and their relatives spoke highly of the care and staff at Lobswood House. People were supported to express their views and in decision making about their care. Relatives were also involved in care planning. People were treated with dignity and respect and they were encouraged to maintain their independence.

Care plans were comprehensive and provided detailed information to staff about people's care needs and how they wished to be supported. A range of activities was planned to provide entertainment to people, some from external entertainers. Staff also supported people in activities such as arts and crafts and reminiscence. The provider had a complaints policy in place and no formal complaints had been received within the last year.

People were asked for their views about the home through conversations with the registered manager. Relatives gave their feedback through questionnaires and the results were positive. Staff felt the home was well managed and that the registered manager was accessible and approachable. A range of quality assurance systems was in place to measure and monitor the standard of care, including health and safety audits.

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.

Risks to people were identified, assessed and managed appropriately. Staff had been trained in safeguarding and knew how to protect people from the risk of harm, including what action they would take.

Staffing levels were sufficient and safe recruitment practices ensured that new staff had all necessary checks before commencing employment.

Medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

People were supported to have sufficient to eat and drink and to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services.

The majority of people's rooms were personalised and redecoration had been completed in some parts of the home, with further improvements planned.

Staff completed a range of training to ensure they had essential skills and knowledge. They received regular supervisions and attended team meetings.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well. They were treated with dignity and respect.

As much as they were able, people were supported to express

their views and to be involved in decisions relating to their care.

Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information, advice and guidance to staff and how people wished to be supported. Relatives were involved in reviewing care plans.

A programme of weekly activities was in place, including visits from external entertainers.

Complaints that were received were managed in line with the provider's policy. No formal complaints had been recorded within the last year.

Is the service well-led?

Good

The service was well led.

People were asked what they thought about living at the service through 1:1 conversations with the registered manager. Relatives were asked for their feedback via questionnaires and the results overall were positive.

Staff felt the registered manager was accessible and they enjoyed working at Lobswood House. Care delivered was of a high standard.

A range of audits was in place to measure and monitor the operation of the service and care overall.

Lobswood House

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.

The inspection took place on 8 and 14 November 2016 and was unannounced.

One inspector and an expert by experience 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. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. 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 service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with seven people living at the service and spoke with two relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy manager, the operations director, two care staff and the chef.

The service was last inspected in October 2013 and there were no concerns.

Good

Is the service safe?

Our findings

People were protected from abuse and avoidable harm and told us they felt safe living at Lobswood House. One person said, "It is very secure here. They ask me if anything is wrong and I can talk to them". Another person told us, "I feel very safe, it's never been an issue. I can talk to the staff, they are lovely" and a third person stated, "There's always someone here for me". Staff had been trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place. One member of staff explained, "We'd be looking at all angles within the home between resident to resident and staff to resident. We have to keep a good eye on this, even including families visiting people in their rooms". Staff told us they would immediately report any concerns relating to safeguarding issues to the registered manager, the local safeguarding authority or to the Commission.

Overall, risks to people were identified, assessed and managed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments had been drawn up for people in a range of areas including skin integrity, mobility, nutrition, falls and moving and handling. One person had been assessed as being at risk of choking and a referral was made to a speech and language therapist (SALT) for advice and guidance. The SALT had made a number of recommendations that staff should follow, to prevent the risk of choking and a further risk of aspiration pneumonia. While information from the SALT was evident in this person's care records, the associated care plan and risk assessment related to eating and drinking had not been updated. We drew this to the attention of the registered manager who stated they would update the care plan and remind staff of the latest advice from the SALT in order to ensure the person received safe care and support. However, staff we spoke had a good understanding of how to support this person safely. Another person, who had recently been admitted to the home, had not been risk assessed against one specific issue and we discussed this with the registered manager, who stated they would ensure the associated risk assessment was completed.

Risk assessments were reviewed monthly or when needed, for example, if a person had sustained a fall. Where one person had sustained a number of falls, a referral had been made to the local authority's falls prevention team. Accidents and incidents were reported appropriately and managed safely. One staff member told us, "We make sure the environment is free from any trips and ensure that doors are closed. We regularly monitor people's whereabouts". Another member of staff told us they were always aware of changes to people's risks and would report any concerns they had to senior staff. People felt their risks were managed appropriately and they were involved in making decisions about risks. One person had been risk assessed and was deemed to be safe to access the community independently. They told us, "Basically they just leave me alone to my own devices, I can go out whenever I want, only recently I have started to go out with someone else, it depends on how I feel".

There were sufficient numbers of suitable staff to keep people safe and meet their needs. People told us that staff responded quickly when they rang their call bells or asked for help. One person said, "Oh yes, I don't have to wait often". Another person told us there were more than enough staff adding, "I've got a buzzer and they are up here in a few minutes and it's the same at weekends". We looked at the staffing rotas

over a four week period. These showed there were at least four care staff on duty during the day, with an additional member of care staff at busy times, for example, when people needed assistance to get up in the morning and in going to bed. At night, there were two waking staff on duty. During the week, the registered manager and deputy manager were also available to work on the floor if needed. The registered manager said that staffing levels could be increased if required, for example, when people's care and support needs increased as a result of advancing dementia. Recently, staffing levels had been temporarily increased to ensure people's safety whilst the home was being redecorated. The registered manager explained that additional staff were required, "To monitor people on the floor. If it's justifiable it will be agreed [by the provider]".

Safe recruitment practices were in place and staff files showed that appropriate checks had been completed. Two references had been obtained, employment histories checked, identity checks verified and applications made to the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and help prevent unsuitable staff from working with people.

People's medicines were managed so they received them safely and staff completed audits on the management of medicines. We asked people about their medicines. One person said, "The doctor says when I can take it and the staff dish it out". Another person confirmed they received their medicine as needed and added, "Staff explain it to me" and a third person said, "I get given it by the nurse [referring to care staff]". People also told us they were offered pain relief medicine if this was required. One person said, "They ask me what the pain is" and another person said, "If I ask for it [referring to medicine to be taken as needed] they will give it to me". We looked at the storage of medicines and medication administration records (MAR), to check these had been completed appropriately and that people had received their medicine as prescribed.

A comprehensive medication policy was in place which guided staff on the safe administration of medicines. We read, 'For medication with limited life after opening (e.g. creams, ointments, liquids, lotions and eyedrops, which must be used within 20 days), the first date of opening must be clearly written on the container. This date must be checked before administration as well as the overall expiry date'. Whilst the majority of these particular types of medicines did have a date of opening recorded, we found that two medicines did not have the date of opening recorded. We brought this to the attention of the registered manager who stated they would remind staff of the need to record dates of opening in line with the provider's policy. Only staff who had received specific training were permitted to administer medicines. The registered manager and deputy manager carried out competency checks to monitor staff administering medicines. We observed a staff member safely administering medicines to people at lunchtime.

One person received their medicine covertly, that is, without their knowledge. Care staff explained they would always give this person an opportunity to take their medicines in the normal way, but if this was refused, then it would be given covertly. A member of staff said, "We ask him first and show him the medicine". The person's care plan stated, 'He is unable to self-medicate and needs the assistance of trained staff to administer his medications at the right time with the right dose. He can be non-compliant and has been known to refuse'. This person's capacity had been assessed in relation to their understanding of taking their medicines. As a result, an application for medicines to be administered covertly had been made to the GP, who agreed this as an appropriate form of action, on the occasions when the person refused to take their medicine.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills they needed to carry out their roles and responsibilities and people confirmed this to us. One person said, "Yes, I think they are skilled" and another person told us, "I think so, there have been no problems so far". We looked at the staff training plan which showed that staff had completed training in dementia awareness, equality and diversity, fire safety, first aid, food safety, health and safety, nutrition and diet, medication, mental capacity, moving and handling, end of life, infection control, control and restraint, positive behaviour support/challenging behaviour and safeguarding. In addition, some staff had completed training in care planning, falls prevention and tissue viability and wound care. Staff had face to face training either at Lobswood House or at one of the provider's other care homes which was close by. Training dates for 2016/2017 were set by the training provider and enabled staff to book on to the relevant training sessions. Staff we spoke with confirmed they had completed all the necessary training to enable them to care for and support people effectively.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. One new member of staff confirmed they had completed, "Lots of training. I'm working on the Care Certificate right now and I've just had my initial introduction to NVQ2". Staff were encouraged to study for qualifications, such as National Vocational Qualifications (NVQ) in health and social care.

Staff received supervisions every three months or as needed and staff files held completed records of staff supervision meetings. The registered manager told us that supervision meetings were often held in a room at a nearby church. This enabled staff to speak freely and confidentially, without interruption and without being overheard. One staff member told us about their supervision meetings and said, "Any concerns I have I can talk about, how I'm getting on with my work and any support the management can offer". In addition to 1:1 supervision meetings, staff attended team meetings and records confirmed that staff meetings had taken place in January, March, July and September this year. Items discussed included staffing, staff support and supervision, working guidelines, residents' social activities, training and vacancies. Staff on duty also attended handover meetings which took place between shifts. We observed a lunchtime handover meeting on the first day of our inspection. Staff discussed people's care and support needs and any issues that staff coming on shift should be made aware of. This ensured that people's most up-to-date needs were known and met.

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 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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, five authorisations had been granted by the authority. A further 22 applications had yet to be processed by the authority. DoLS applications had been completed appropriately, as well as capacity assessments, and documented in people's care records.

We asked people whether their consent was sought with regard to their care and treatment and in day-to-day decision making. One person said, "They [referring to staff] will ask if I want to have a shower". A second person told us, "Yes, I can choose what to wear or what I want to eat". A third person said, "When I moved in I was in a smaller room and I asked to move. They did it". We asked staff about their understanding of mental capacity and DoLS. One staff member said, "We assume that they all have capacity to decide on what they want to do. Some people don't have capacity, so we have a best interests meeting". Another staff member explained mental capacity as, "The ability for someone to make a decision and thinking how it would be assessed" and referred to the five key principles under the MCA. They went on to talk about DoLS and the fact that the front door was locked saying, "You can go out, but would need to go out with staff", although one person had been assessed as being safe to go out independently.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. People's weights were monitored regularly and their risk of malnutrition had been assessed. We asked people what they thought about the food on offer, menu choices and any special dietary needs. One person felt the food was, "Good. A very good chef. In the summer I like salads. They do it all. I'm a diabetic. I can have as much fruit and vegetables as I want". Another person stated simply, "Well it's all right. I just don't have an appetite at the moment". A third person said, "I like it [referring to the food]. I can pick from two or three things and there is always enough food for me". The menu for the day was on display in the dining room and showed pictures of the meal choices available to people. The main meal was served at lunchtime. On the first day of our inspection, people could choose either pasta or jacket potato for lunch, followed by apple tart or yogurt. A relative told us, "She likes it here, especially the food. They are very patient with her as she needs help eating. Someone will always sit down and help her. I also get a meal when I'm here or a cup of tea, cake or a biscuit. They never have the same food in a four week period. The girls are very friendly".

We observed some people having their lunchtime meal in the dining room. Other people chose to eat their lunch in the sitting room on overlap tables. People were offered a choice of cold drinks prior to being served with their meal. We observed staff handing out meals to people, however, one person did not want the pasta that was offered to them. The staff member then asked whether they would prefer to have a jacket potato or a sandwich, but the person appeared confused by the question. Another person, when offered a choice of apple tart or yogurt for dessert said, "They're about the same aren't they?". We discussed this with the registered manager as staff should have shown people the food on offer which would have acted as a visual prompt and supported them to make an informed choice. The registered manager was surprised at our findings and told us that staff were aware of the need to show people the food on offer. They told us they would remind staff of the need to do this.

We talked with the chef about menu choices and special diets for people. The chef told us they were in the process of changing from a summer to a winter menu. Menus were planned over a four weekly cycle. People liked to have a roast lunch on Sundays and fish on Fridays. The chef said that they regularly spoke with people to find out whether they enjoyed the food on offer and whether they had any particular requests or food preferences. The chef said, "They do like their vegetables. I come and talk to people. I keep an eye and see how things are doing. If anyone wants a sandwich, there's always ham and cheese available or toast". They added, "I take a pride in what I do and it's important that people enjoy their food. I've got high

standards and that's the way I was trained". The chef told us that some people had dietary needs and these were catered for, for example, people living with diabetes or a pureed diet for people who had swallowing difficulties (dysphagia).

People told us that drinks were always available. One person said, "When the weather is hot I like soft drinks and when it is cold I like tea and coffee". Another person told us, "Whatever I need, someone will get it for me. I have a jug here as well" and a third person said, "Yes, I can get a tea when I want".

People were supported to maintain good health and had access to healthcare professionals and support. One person confirmed they saw a GP and said, "Yes, whenever I need to I see one". Another person told us, "Yes, I saw him yesterday [referring to their GP]. They came pretty quick. I've got an optician appointment soon. I haven't seen a dentist, but I've had an oral hygienist appointment". A relative referred to their family member and said, "He had some broken teeth and they got the dentist to come in and got him a whole new set of dentures put in. The manager went out of her way to help". Care plans recorded when people saw healthcare professionals and any follow-up action that staff needed to take. One staff member said they would notice if a person became unwell and added, "I would immediately report to a senior who would call the surgery". Another member of staff told us, "We do inform relatives if people are not well and tell them what's happening". On the first day of our inspection, a district nurse visited the home to change one person's dressings.

The majority of people's rooms were decorated in similar neutral colours as were the communal areas around the home. However, some people were involved in choosing the decorations and had brought items of furniture with them when they moved to the home. We asked the registered manager about people's rooms and whether they were involved in choosing colour schemes. The registered manager said that people were encouraged to personalise their rooms and to keep items of importance to them. We saw that some people's rooms were homely and contained photos and pictures, whilst other people's rooms contained basic items of furniture and little in the way of personal memorabilia. The registered manager told us that they were often reliant on family members to be involved in personalising people's rooms. After the first day of our inspection, the registered manager contacted people's families to ask whether they were happy with their family member's rooms; the majority of families confirmed they were.

A noticeboard in the hall area showed pictures of staff who worked at the home, so people could easily identify a member of staff and know their name. Similarly, the menu that was on display in the dining room was accessible and provided pictorial references of the food on offer. However, a large whiteboard on the wall in the large sitting room did not provide information in a way that could have been easily interpreted by some people living with dementia. The whiteboard recorded the day's menu and the staff on duty that day, but there were no visual aids to assist people in their understanding of this information. We discussed this with the registered manager who concurred with our findings and concluded that, since the information relating to menus and staff was also on display in other parts of the home, there was no need for the whiteboard.

In the Provider Information Return (PIR), the registered manager stated that improvements were planned within the next 12 months including: redecoration of communal areas, new furnishings and relevant equipment as required, widening of the front lounge entrance for easier access, additional plants and garden furniture and improvements to the entrance, dining room and communal toilets.

Good

Is the service caring?

Our findings

In a written statement, the registered manager recorded, 'Dementia care is not only about providing personal care, but also honouring and recognising how unique all our residents are. The care we provide is always guided by our residents' preferences, experiences and their respective abilities'. People told us that staff were caring, they felt they were listened to and staff knew them well, including their likes and dislikes. One person referred to staff and said, "Yes, they are caring, they are all very nice". Another person said, "There's never been any problems with the staff. They are always nice to me". A third person said, "Staff always listen to me" adding, "If I want to be left alone, they will do that".

We observed that staff were kind and caring with people and treated them with warmth and sensitivity. One person was visibly distressed and confused and asked to go to hospital, although staff knew that the person was well and did not need to seek medical advice. This person stated this several times during the two days of our inspection. Staff were patient and reassuring with them and one staff member said, "Yes, I'll take you later" and offered a cup of tea to the person, then sat with them. This calmed and comforted the person and they went with the staff member. Staff knew people well and one staff member referred to a resident saying, "She always likes white toast and marmalade for breakfast". Another person liked fried egg for supper. We asked staff how they developed relationships with people when they came to live at Lobswood House. One staff member explained, "We would go through people's histories and get information from Social Services. We build up some kind of picture of how the person has been. They could have been in hospital".

As much as they were able, people were supported to express their views and to be involved in making decisions about their care treatment and support. One staff member said, "We ask them what they want. Sometimes they can't hear, so we write it down or show them" giving an example of showing people their clothes so they could select what to wear that day. Another staff member told us one person's care plan was discussed with them on admission and that relatives were involved in planning their family member's care. The registered manager explained that people's families were involved prior to people being admitted and that they would provide input to the care plan. The registered manager added, "When I finalise the care plan, I ask the family to comment". Records confirmed that relatives were involved in care planning and plans were signed by them.

People's privacy and dignity were respected and promoted. One person said, "Staff are good. They shut the door when I'm getting changed". Another person told us, "It was not a problem" when we asked them whether staff treated them with dignity and respect. We asked staff how they were respectful of people. One staff member said, "Make sure before you enter the bedroom, you always knock. Cover the area when changing clothes and always explain what you're about to do". A second staff member told us, "I continually make sure they're okay. Always with privacy and dignity and respecting that person's decision really". We asked people whether their independence was promoted. One person said, "I do things for myself anyway" and a second person told us, "I think so".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. A member of staff explained, "[Named person] is able to tell us what he likes and wants and what he has done in the past". Care plans provided detailed information about people and the support they needed from staff. For example, one person's care plan described their 'daily living activities' which included a summary: 'Ability to eat, drink, move around (needs two staff for support), use both hands, communicate, use toilet (two staff as doubly incontinent), settle at night, participate in social activities, dress and self-medicate'. Further advice and guidance was provided to staff on personal care, dressing, continence, safety, skin integrity, behaviour and a specific medical condition. Care plans included a 'Next of kin communication page' which confirmed that relatives had been involved in reviewing care plans. Care plans were reviewed monthly and records confirmed this. A relative told us, "I think it is really good and I'm here a lot. There is a noticeboard in his bedroom that reminds him what is going on. While he doesn't have dementia, he does forget a lot of things after his stroke".

We asked staff whether they read people's care plans. One staff member said, "I've had brief looks at care plans, the front sheets and the bullet points. I would ask the seniors and other work colleagues and they explain things to me". They went on to explain how they would deal with people who had behaviour of a challenging nature saying, "Remain calm and polite at all times. Make sure people are safe. I would ask, 'What do you need from me?' and respect their wish to express themselves really". Care was delivered in line with people's care plans.

A programme of activities was organised on a weekly basis and this included external entertainers who visited the home. For example singers, musicians and one person who played music and encouraged people with gentle exercises. On the days when no external entertainers came to the home, staff organised activities such as arts and crafts, reminiscing, massage, shooting hoops, singalongs, reading, balloon and ball passing and bowling. The registered manager told us that a drama company visited four times a year and put on a show for people. A range of newspapers, books and magazines were on hand for people to look at. The registered manager told us, "Music is always very popular" and that whilst no group community outings were organised, people did enjoy going out on a 1:1 basis with staff or were taken out by relatives. A relative said, "[Named family member] does not take part in any of the activities and she doesn't talk much anymore. The girls try and help her and ask her to point to things she wants. I get full updates to what is going on. They always write to me and tell me about the things that happen, like when she has to see a doctor or if she had a fall".

We asked people how they would make a complaint and who they would speak to. One person said they had never had to make a complaint and another person told us, "No I've never needed to". A relative told us, "They work with us to help him, which is lovely. They seem to really care. I've never had any problems or complaints, but we can talk to them about anything if we needed to". No formal complaints had been received within the past year. The registered manager told us that any informal complaints were dealt with straight away and gave an example of one person's clean laundry being put in another person's room. We looked at the provider's complaints policy which stated that all complaints would be investigated within 28

days. Contact details were also given for the local government ombudsman and the Care Quality Commission.

Good

Is the service well-led?

Our findings

People were involved in developing the service and their views were obtained on a 1:1 basis. The registered manager told us that residents' meetings had not worked in the past and that she would talk with people individually. She said she asked people whether they were happy and about the food on offer and told us, "It's usually a pep talk after lunch". No formal record was made to confirm these meetings had taken place and the registered manager told us she would do this in future so that any concerns raised could be formally documented and actions taken could be confirmed. The registered manager told us that there were few concerns and where issues were raised, these were dealt with straight away.

Relatives were asked for their feedback through formal questionnaires. Five responses were received to a questionnaire sent out in March 2016. Relatives were asked about the standard of care, bedrooms and communal areas, bathrooms, cleanliness, outside areas, food/meals and activities. They were also asked if they were kept informed of any changes to their family member's care, whether they were invited to reviews, the location of the home, accommodation and staff. In answer to a question, 'Would you recommend this home?', one relative stated, 'Quality of staff beyond reproach, driven by an excellent manager' and 'I would like to say that the support, not only to [named family member] but myself, is excellent'. Another relative had sent a card in October 2016 which read, '[Named family member] is safe and well looked after. The staff are kind and friendly. She is happy and settled in Lobswood'. An external healthcare professional had written, 'It's a lovely home and the residents seem very happy'.

We asked the registered manager about the culture of the home and she said, "It's a place for the elderly and some with mental health issues, to be looked after and cared for and supported. We're able to meet their health and wellbeing needs". The provider's mission statement recorded, 'Our aim is to provide a high standard of care inside a happy, homely environment. We aim to maintain dignity, privacy, choice, respect and courtesy at all times and to maximise independence and understanding, recognising the individual needs and rights of each resident'. From our observations, the staff were fulfilling the requirements of the mission statement.

Staff knew and understood what was expected of them. The provider had a whistleblowing policy in place which advised staff on action they should take if they observed any bad practice or had cause for concern. Staff felt the service was managed well and that the registered manager was approachable. One member of staff said, "I'm quite happy to work here, everyone helps each other". Another member of staff told us, "It's the working relationship we have with staff and everybody". A third member explained, "I feel I could talk to [named registered manager] about anything. She's very warm and open and always welcoming". The registered manager told us they had regular contact with the providers who visited a couple of times a year. The operations director supported the registered manager on a day-to-day basis.

High quality care was delivered and a member of staff told us, "We have tried hard; we have difficult clients who come in and we try and help them". Another staff member said, "It's good working with people, I absolutely love it". The registered manager stated, "It's more homely. When you enter a care home, you will feel if it's homely or not and whether staff support each other or not. If we're not working together as a

team, you will know".

A range of quality assurance and audit systems was in place to measure the quality of care delivered and to drive continuous improvement. Accidents and incidents were analysed and we checked records between March and October 2016 which recorded the professionals that had been contacted and actions taken to keep people safe. Senior staff were given responsibilities to audit specific areas such as health and safety, cleanliness, staffing rotas, care plans reviews, medicines, monthly weighing of people, premises and equipment checks. Any actions required were recorded and steps taken to address these.