Roseberry Care Centres GB Limited

Valley View and The Lodge

Inspection report

Back Lane
Penshaw
Houghton le Spring
DH4 7ER

Tel: 01913857776

Date of inspection visit:
12 July 2017
13 July 2017

Date of publication:
24 August 2017

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 12 and 13 July 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

The service was last inspected in July 2016, at which time the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection of July 2016 we identified that the provider was unable to provide assurances, due to the electrical installation being deemed as unsatisfactory, that the premises were safe. We also found not all staff training was up to date. At this inspection we found the provider had ensured all necessary action had been taken to ensure the electrical installation was safe and fit for purpose. We also found staff training was up to date and well managed. At our inspection of July 2016 we rated the service as Requires Improvement. Following this inspection we rated the service as Good.

Valley View and The Lodge is a care home in Penshaw, providing accommodation and personal care for up to 38 people, including people living with dementia. There were 34 people using the service at the time of our inspection. The home is divided into two areas: one area for elderly people, including people living with dementia, and the other area for younger adults with learning and/or physical disabilities.

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 directors, 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.

All areas of the building were clean, with an infection control champion in place and another handyman recently hired.

The storage, administration and disposal of medicines were safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). Controlled drugs were safely stored and regularly audited.

Risks to people were managed through person-centred risk assessments and care plans. Both were reviewed regularly and had regard to relevant professional advice.

Staff were aware of their safeguarding responsibilities and knew what to do if they identified potential signs of abuse. People we spoke with and their relatives felt staff helped keep them safe.

Pre-employment checks of staff were in place, including Disclosure and Barring Service checks, references and identity checks.

Visiting professionals had confidence in staff, as did commissioning professionals we spoke with.

Staff completed a range of training relevant to people's needs and this training was regularly refreshed. Supervision and appraisal of staff was well organised and effective.

Staff interacted warmly with people who used the service and had built positive, friendly relationships with them.

People's choices at mealtimes were respected and their views listened to when planning menus. Kitchen staff demonstrated a good understanding of people's specialised needs.

The premises benefitted from some aspects of dementia-friendly design and the registered manager was keen for more areas of the building to benefit from such additions.

Staff displayed a good knowledge of people's needs and individualities, whilst care planning documentation was well organised and sufficiently detailed.

Individual and group activities were well planned, with people's involvement, and meant people enjoyed a range of outings. These were enabled by the use of the service's minibus.

The registered manager was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with 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.

The atmosphere at the home was relaxed, welcoming and at times vibrant. People who used the service, relatives and external stakeholders agreed. The culture was a caring, open one where people were encouraged and enabled to feel at home.

The registered manager had a good understanding of the area and local community and had formed strong community links.

Staff, relatives and external professionals we spoke with described the registered manager as proactive, professional. People who used the service knew them well and confirmed they took an active interest in their wellbeing.

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.

Servicing and remedial work had been carried out on the electrical installation of the home, meaning it was safe.

Medicines were safely managed and administered by staff who demonstrated a good knowledge of people's needs and good practice.

There were sufficient staff on duty to safely meet the needs of people who used the service.

Is the service effective?

Good

The service was effective.

A range of training was in place, with refresher training up to date and well managed through the use of a training matrix.

The premises were well suited to people's needs. The manager demonstrated a good understanding of the importance of dementia friendly environments and had ensured aspects of good practice were in place.

People's nutritional and hydration needs were well met by kitchen staff who had a comprehensive understanding of people's needs and preferences.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Valley View and The Lodge

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 12 and 13 July 2017 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one exert by experience. An expert by experience is a person who has relevant experience of this type of care service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

We reviewed all the information we held about the service. 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 teams, safeguarding teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

We spent time speaking with people who used the service and observing people and staff in the communal areas of the home, including lunchtime. We spoke with seven people who used the service and five relatives. We spoke with ten members of staff: the registered manager, the area manager, the administration officer, a senior carer, four carers, the cook and a domestic assistant. Following the inspection we spoke with two health and social care professionals.

During the inspection visit we looked at four people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes, maintenance records, surveys and quality assurance documentation.

Good

Is the service safe?

Our findings

At the previous CQC inspection in July 2016 we identified concerns that the provider's electrical installation was deemed 'unsatisfactory' at a recent service by external contractors, and that sufficient steps had not been taken to ensure the electrical installation was made safe. At this inspection we found the provider had ensured the electrical system had been serviced and remedial action taken to ensure it was safe.

We saw other aspects of premises upkeep and management were in place. For example, portable appliance testing (PAT) had been completed, whilst fire alarms, firefighting equipment and emergency lighting had all been regularly tested. Gas boilers had been checked by accredited professionals. Hoists and slings had been tested and serviced in line with Lifting Operations and Lifting Equipment Regulations (LOLER), whilst water temperatures were regularly checked to prevent against the risk of scalding. Window restrictors were in place and regularly checked for faults. People were therefore not at risk through the lack of adequate testing of facilities.

The service had recently seen a handyman retire but had confirmed the recruitment of a replacement. In the meantime, the provider ensured other personnel from other services had helped with the upkeep of the premises, which we found to be in good order.

Emergency planning was good, with a business continuity plan in place for a range of interruptions to the service, such as gas leaks and electrical failures. Personalised Emergency Evacuation Plans (PEEPs) were easily accessible in an emergency box, which contained other essentials such as a torch, mobile phone and map of the building. This meant emergency service personnel would be better enabled to help people evacuate the premise in the event of an emergency.

We found examples of good medicines administration practice in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). For example, there were specific details in place for people who had medicines prescribed 'when required'. These additional protocols told staff when they might need to use the medicine and what effects they should see. Where people were unable to verbally communicate they were in pain and required medicines, these forms told staff what signs to look out for. For example, one person would grimace and scratch the area where they felt pain. We saw staff also used the Abbey Pain Scale to help determine whether people living with dementia may require pain relief. The Abbey Pain Scale is a tool designed to help staff identify when people who are unable to articulate their views may be in pain.

We saw medicines were stored securely and kept in a separate locked trolley, in a locked room where the temperature and fridge temperature were regularly checked to ensure they were within a safe range. People's medicines profiles contained a large recent photograph, allergy information, GP contact details and personal preferences regarding how the person liked to take their medicine. People we spoke with confirmed staff explained to them what their medicines were at each administration.

We reviewed a sample of people's medicines administration records (MARs) and found there to be no errors.

Likewise we stock checked a random sample of controlled drugs and found these to be accurate. Controlled drugs are medicines that are liable to misuse. The manager undertook weekly checks of these medicines and a monthly audit of medicines more generally.

With regard to topical medicines (creams) we found there were some inconsistencies in the systems used. For example, some people had accurate body maps in place, with shaded areas indicating where creams should be applied, whilst other people's care files contained descriptions of whereabouts on the body creams should be applied. When we reviewed people's topical medicines administration and spoke with staff, they demonstrated a good knowledge of people's skincare needs. The manager ensured all records had a consistent body map in place during our inspection.

People who used the service and their relatives told us they felt safe at Valley View and The Lodge. People told us, "I do feel safe living here because the staff are very helpful," "I have been living here for a good few years and feel very safe," and, "I feel safe because there are plenty of staff around." Relatives told us they had no concerns about people's safety and, when we spoke with external professionals, they felt staff were well equipped to keep people safe.

We saw there had been one recent instance where two members of staff had left a number of people who used the service unattended. We saw the manager had dealt with the matter promptly via the provider's disciplinary policy. This meant, where there was any risk to people's wellbeing, the manager acted accordingly to keep people safe.

There were sufficient staff on duty, day and night, to ensure people's needs could be met in a safe environment. The manager assessed people's needs and planned rotas accordingly. Staff we spoke with acknowledged there could be days when they were particularly busy but felt staffing was appropriate. People who used the service told us, "There seem to be enough staff around," and, "I use the buzzer if I'm not well and the staff arrive very quickly usually." Relatives shared these opinions about staffing levels. This meant people were not put at risk due to understaffing.

Staff we spoke with demonstrated a good knowledge of the risks people faced and how to minimise them. We saw risks were set out in people's care files and clear actions were described for staff to help keep people safe. Staff had been trained in safeguarding. They displayed a sound of their safeguarding responsibilities and a confidence in raising concerns if they needed to.

We saw incidents and accidents were consistently recorded, acted on and analysed by the registered manager to identify any common patterns or trends.

We reviewed a range of staff records. References, identity checks and enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. The provider also asked people at each supervision whether they had any relevant information to disclose regarding, for example, receiving a caution or a conviction. 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.

Good

Is the service effective?

Our findings

At the previous inspection in July 2016 we found that not all staff had received refresher training in the core areas of moving and handling and fire safety training. At this inspection we found the provider's training matrix to be working well and staff were up to date with the necessary training.

Staff told us they felt well supported and welcomed the prospects of more responsibility. For instance, one member of staff told us they were going on a one-year training course to improve their all-round health and social care knowledge. When we spoke with external professionals they confirmed that staff took an interest in developing their own knowledge and skills, and were also always able to give visiting professionals useful and accurate updates on people's needs.

Staff training included topics such as dementia awareness, safeguarding, infection control, moving and handling, equality and diversity, diabetes awareness, self-harm awareness, falls prevention and DoLS. We found staff were supported to complete a good array of training relevant to people's needs.

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 found staff had a good awareness of DoLS and the registered manager was in the process of updating care planning documentation so that each care plan would have a capacity assessment at the front. This demonstrated they were aware of the need for capacity to be assessed on a decision-specific basis rather than as a blanket decision. We found however some of the wording on these capacity assessments was unwieldy and confusing. The registered manager agreed to review the standard wording. We reviewed a sample of DoLS applications to the local authority and found these to be appropriately completed.

We reviewed a range of daily notes and handover information and found them to be accurate and sufficiently detailed to ensure people's needs could be met. The manager showed us new care plans they were due to implement. We saw these included the necessity of a sign-off by two people at the end of each day, whereas currently one senior carer would do this. This appeared to build in a significant amount of resource which may not be necessary given the auditing systems in place. The manager agreed they would trial the process and feedback to the provider if there were concerns.

Regular staff supervision and appraisal meetings had taken place. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. Appraisals are an annual review of staff performance. Staff we spoke with confirmed these conversations were useful and helped

them ensure their skills were up to date.

The environment was appropriate to the needs of people who used the service and the provider had made a range of improvements to ensure people living with dementia could orientate themselves. For example, people's doors were a different colour to the adjoining wall, whilst some doors had knockers on so they resembled a front door. A local artist had been commissioned to paint a mural the full length of one corridor, which depicted a scene from a mining community, whilst the dining room was well-signposted from a distance, with a sign ('Tea Room') that stood out perpendicular to the wall. The manager told us they planned to make further improvements regarding dementia friendly environment, including memory boxes, more murals and more signage in line with the dining room. The service had a spacious outdoor area at the back of the home with views over a valley, a washing line which one resident used to dry their clothes and a greenhouse in which residents grew tomatoes.

We saw Do No Attempt Cardiopulmonary Respiration (DNACPR) forms were in place, as were Emergency Health Care Plans (EHCPs). A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. An EHCP makes communication easier in the event of a healthcare emergency. This meant people's needs had been considered in the context of unforeseen circumstances and developments.

We saw advice from health and social care professionals had been incorporated into in people's care, for example from the Speech and Language Therapy Team (SALT). People were supported to access primary healthcare when needed.

The cook and kitchen assistant demonstrated a good knowledge of people's likes, dislikes and any special dietary requirements, such as soft diets. Where people had diabetes the cook and staff encouraged healthier options but respected people's choices. Choice was supported through the use of picture menus and also making people alternative meals should they decide not to have the chosen option. We found information in one person's care plan pertaining to their diabetes could have more useful detail for staff and the provider ensured this was updated on the day of the inspection.

People were regularly weighed and staff used the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. Records we reviewed demonstrated people were not at risk of malnutrition. Throughout our inspection we saw people being offered drinks and snacks.

We found lunchtimes to be calm and relaxed. There were sufficient staff to help people who needed support and people we spoke with clearly enjoyed the meals. One person said, "The food is usually good," whilst another told us, "I go to the dining room for my meals or sometimes have them in my room. I enjoy the food."

Good

Is the service caring?

Our findings

People who used the service and their relatives consistently told us they found staff to be respectful and caring towards them. One person who used the service told us, "They are really friendly towards me and very respectful," whilst another person said, "Nothing seems to be a problem with the staff, you only have to ask." Relatives told us, "Everyone seems to do the job with a smile on their face," and, "They are very friendly and caring."

We saw numerous thank-you cards in the foyer and found these contained positive feedback about the attitudes of staff. For example, "Thank you for all the care and love," and, "Thank you for the unbelievable kindness and support."

We asked people specifically about how staff helped to maintain their dignity and people told us, for example, "If I'm struggling walking a bit they always help me," and, "If I want any privacy I close the door and the staff respect this." We saw the manager had made dignity a key theme to focus on and had begun implementing aspects of best practice. For example, they had plans to have a dignity champion in place, who would be the long-term lead in this area, undertaking their own observations and feeding back to staff meetings. The manager had also recently introduced 'critical friend' audits whereby relatives were invited to undertake observations of how dignity was maintained and feed these observations back to the manager.

We also saw the manager had implemented the 'Dignity Challenge'. This was a system whereby, each month, the manager would have a new topic around the theme of dignity and would encourage staff to refresh their knowledge in this area by discussing it at supervisions and team meetings. When we spoke with staff they were aware of this month's dignity challenge (in this case, maintaining dignity when someone had experienced a fall). They were able to tell us what steps they would take to ensure the person's dignity was maintained. We observed dignified interactions between staff and people who used the service throughout the inspection. Staff ensured they spoke with people in line with how their care plans set out their communicative preferences. This demonstrated the provider valued the importance of prioritising and maintain people's dignity.

We asked people whether they felt at home and there was a broad, positive consensus. We one saw one person had pet fish in the foyer, as well as a budgie, whilst people's rooms were personalised. The entrance area provided a welcoming area for people to congregate and chat and we found the provider had ensured the service had a homely feel by ensuring people were included in the running of the home. For instance, one person's favourite radio station was 'Smooth FM' and we noted this was regularly played in the foyer, where they liked to sit. Similarly, two people who used the service had recently been asked to help interview a prospective member of staff, whilst other people who used the service were also on the 'Links committee', a group that met 6-weekly to discuss the home and any changes or suggestions they had.

People who used the service were encouraged to maintain and build on their independence, for example through looking after a pet or spending time in the community. One person told us, "I help run the activity sessions and I run the tuck shop as well." This demonstrated people were encouraged to play a meaningful

and inclusive role in the running of the service.

People were encouraged to make their own choices, for example with regard to what meals and activities they preferred, and how their rooms should be decorated. We saw rooms were well personalised.

The manager told us staff turnover was low and that they did not use agency staff. We saw the majority of staff had been at the service for a number of years and had a comprehensive understanding of people's needs and preferences. This meant that people who used the service received a good level of continuity of care and were comfortable in the presence of staff they knew well. Relatives confirmed with us that they could visit the service at any time, meaning people who used the service could feel more at home.

People had end of life care plans in place which detailed, for example, whether they wanted to move to hospital at the end of their lives, or to stay in the service. We saw these documents had been written in consultation with family members.

Good

Is the service responsive?

Our findings

The service had a full time activities co-ordinator and they planned and delivered a range of individual and group, in-house and external activities. These included bingo, arts and crafts, armchair exercises and games, dog-petting visits, quizzes and outings. Virtual Reality headsets had also been trialled recently.

The service had use of a minibus and people therefore regularly went on outings, for example on shopping trips, to museums, to the coast, and to the Salvation Army, where people could watch a film in the afternoon and receive baked goods from a local bakery, who sponsored the afternoons. The bus proved popular with people who used the service, relatives and staff, who all agreed outings had a beneficial impact on people's wellbeing. One person told us, "I go to the Galleries at Washington in the minibus because I love shopping," whilst another said, "I like to play bingo and I go out in the minibus now and again to Seaburn and Roker." This demonstrated people were able to enjoy a range of meaningful activities.

The manager had recently introduced a "2o'clock stop", whereby all staff would stop what they were doing at 2pm and join in whatever activities were ongoing. We saw staff and people who used the service engaging in a range of activities and enjoying them together, for example taking part in a session with ipads provided by Age UK. This meant the registered manager had successfully ensured the culture around activities was an inclusive one across all staff and people who used the service, rather than seen solely as the role or task for the activities co-ordinator. This led to there being a particularly vibrant atmosphere in some communal areas.

The focus on socialisation was a key theme throughout the inspection and we saw evidence of one person who had previously been at significant risk of self-neglect was now engaging well with other people and taking an interest in their surroundings.

We found, whilst the service was split between the larger section of the building for older people, and a specific unit for younger adults with learning and/or physical disabilities, there was a good amount of interaction between people who used the service. One person told us, "We all mix in together in the communal area for bingo and things," whilst another said, "Yes, everyone mixes together for activities and when we go out in the minibus for day trips."

We found staff understood the importance of people's individual preferences and that care planning reflected people's individualities. The manager showed us new care planning documentation they were planning to implement, and also told us about the one page profiles they intended to introduce. Current files we reviewed contained comprehensive information about people's backgrounds, life history and the things important to them. Care planning was person-centred and contained information specific to how each individual preferred to be helped with certain tasks. For example, where one person was particularly anxious when being helped to bathe, we saw there were clear instructions for staff to help ease their anxieties.

The service used a combination of its in-house documentation as well as documents like the Alzheimer

Society's 'This is Me' document to record people's likes, dislikes and histories.

The manager had a good understanding of the need to make person-centred information as accessible as possible and the one page profiles would help enable this.

We saw people's needs were assessed prior to them using the service. One person was in the process of moving to the service from Portsmouth and we saw the registered manager had liaised with the local social worker and other relevant professionals via multi-disciplinary meetings held over the telephone. The manager had also taken photographs of the local area, for example Penshaw monument, to share with the person so they would have a sense of the environment before moving.

People's ongoing needs were assessed via reviews of their medical, mobility, nutritional and other needs. Relatives we spoke with confirmed they were regularly involved in the review of people's care needs and the registered manager ensured there were multiple forums for people to raise any issues. For example, the 'Links Committee' met 6-weekly to discuss concerns, compliments or changes people wanted to discuss. Whilst we saw current attendance was low, these meetings are good practice. Likewise, where people had raised a concern or complaint, we saw the manager had dealt with these comprehensively and in line with the provider's complaints policy. All people we spoke with were confident the manager and other staff would deal with any concerns they might raise.

In addition to the 'Links Committee' we saw there were regular meetings with people who used the service and family members to plan activities and to raise any concerns they had. For example, it was noted at one meeting that the service did not have access to a vicar. At the time of our inspection we saw this had been resolved. This meant the meetings were meaningful forums for people to share their opinions and that staff listened to the suggestions made.

Where people's needs changed we saw staff had responded and sought external professional advice where appropriate. People told us, for example, "The doctor comes here to see me if I need one. I've just seen the chiropodist this morning." We saw evidence of prompt liaison and effective communication with external healthcare professionals by staff.

We saw the provider published a quarterly newsletter, which celebrated developments such as the new murals, as well informing people about staffing changes, previous and forthcoming events.

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. They had a strong understanding of people's needs, relevant experience in health and social care and took a hands-on interest in the day-to-day running of the service.

We found they had made the necessary improvements to the service since the last inspection, namely ensuring electrical works had been completed and staff training was well managed and monitored. The manager and regional manager also demonstrated clear goals to make ongoing improvements to the service, which would have an impact on people's lives. For example, the area manager planned to trial 'rummage aprons' and the registered manager was able to clearly describe their plans to continue the areas of good practice already started with regard to ensuring the environment was dementia friendly. Rummage aprons can be worn by people and objects of interest kept in them, for example photographs and items relevant to their individual history.

The manager also planned to introduce dementia and dignity champions, whilst an infection control champion and a mental capacity champion were already in place. The manager told us they were also planning to introduce 'daily huddles', to ensure all staff on duty were given verbal updates and support. This demonstrated the manager was keen to ensure the service built on its good reputation and practices by trying ways to ensure people received a high quality of care on an ongoing basis.

The manager currently held a range of meetings, for example with senior staff, domestic and kitchen staff as well as specific health and safety meetings. We reviewed minutes of these meetings and found they contained important updates from the manager about, for example, training and activities.

The manager had in place a range of audits and undertook daily observations of the home. Audits included care files, complaints, mealtime audits, financial, staff files and medicines. We reviewed these audits and found the manager had identified areas for service improvement. For example, they had identified where people's photographs in records were over six months old, and that there were inadequate diabetes and epilepsy protocols in place for one person. We saw action had been taken to address these issues, demonstrating the audits were having a positive impact on service provision and, ultimately, the care people received.

We saw there was strong corporate oversight in place, with the area manager accountable for checking the manager's work. The manager had an ongoing service action plan in place, informed by the area manager's monthly visits.

We observed the manager interacting in a friendly, relaxed fashion with people who used the service throughout the inspection and saw this was reciprocated. One person who used the service told us, "The manager is called [name]. They are very friendly and we speak regularly." One person who had previously used the service provided written feedback which read, "Would just like to take a minute to praise your

fantastic manager. I loved every staff member and all the residents." This demonstrated that the manager, who had worked at the service for a number of years, took a lead role in behaving in the caring, interested manner they wanted their staff to. This meant the culture at the service was a caring and compassionate one.

Relatives and external professionals we spoke with were complimentary about the registered manager and expressed confidence in their abilities. One told us, "The manager is keen and driven, and they're well supported."

The culture was open and accountable. All people we spoke with confirmed they could approach the manager at any time, stating, for example, "The manager's door is always open always," and, "There's never a shut door in here."

The registered manager had attended 'My Home Life', a training course which aimed to give managers the skills to discuss difficult situations with staff and relatives in a balanced manner. The registered manager told us they found the course beneficial, as well as the opportunity to meet with other registered managers.

We saw the registered manager knew the local area well and had formed strong community links, for example with the Salvation Army, Age UK and FANS (a Friends and Neighbours Support group). These links contributed to people who used the service having the opportunity to remain part of their wider community.

The registered manager had recently used an external provider to conduct a quality inspection, whereby they spoke with six people who used the service. We saw the results of these conversations were uniformly positive. The registered manager also gave their own surveys to people who used the service and relatives. Results were pending at the time of inspection but we noted the results went to the provider's head office rather than directly to the manager. This meant, if people did want to raise feedback about the registered manager, it would go to a member of staff accountable for their performance, rather than directly to them. The manager also used regular meetings with relatives and people who used the service to gauge their opinions on a range of topics.

We found the office and administration of the service to be well organised and, when we asked for various documents to assist our inspection, these were easily accessible, up to date and accurate.