Lowmoor Nursing Home Limited

Lowmoor Carehome

Inspection report

Lowmoor Road
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 August 2016 and was unannounced.

Accommodation for up to 42 people is provided in the service over two floors in three separate units. The service is designed to meet the needs of older people living with or without dementia. There were 42 people using the service at the time of our inspection.

A registered manager was in post and she was available during the inspection. 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.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Risks were generally well managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were generally safely managed.

People's rights were not fully protected under the Mental Capacity Act 2005. Not all staff had received sufficient training to support people with behaviours that might challenge.

Staff received appropriate induction, training and supervision. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. The environment had been adapted to support people living with dementia.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though care plans could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that

appropriate action would be taken.

The provider and registered manager were generally meeting their regulatory responsibilities, however, they had not sent statutory notifications when DoLS had been authorised. There were effective systems in place to monitor and improve the quality of the service provided.

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.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Risks were generally well managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were generally safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005. Not all staff had received sufficient training to support people with behaviours that might challenge.

Staff received appropriate induction, training and supervision. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. The environment had been adapted to support people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though care plans could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident in raising any concerns with the registered manager and that appropriate action would be taken.

The provider and registered manager were generally meeting their regulatory responsibilities, however, they had not sent statutory notifications when DoLS had been authorised. There were effective systems in place to monitor and improve the quality of the service provided.

Lowmoor Carehome

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 2 and 3 August 2016 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor with experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with five people who used the service, five visiting relatives, the cook, a domestic staff member, a laundry staff member, an activities coordinator, three care staff, a nurse, the registered manager and a representative of the provider. We looked at the relevant parts of the care records of nine people who used the service, three staff files and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People we spoke with told us that they felt safe living in the home. A person said, "I feel safe now." Most visitors felt that their family member was safe. A visitor said, "Yes, I've got that peace of mind now with [my family member] being here." However, one visitor said, "I can't say [my family member]'s safe as it's such a strange environment for him. I didn't like the atmosphere upstairs." This visitor was referring to one of the units upstairs where people with the most challenging behaviours were living.

Staff were aware of safeguarding procedures and the signs of abuse. They said they would report concerns to the registered manager but they were also aware of the role of the local authority and that they could make a referral if necessary. We noted safeguarding phone numbers were displayed in the home.

A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety however it was not easily accessible. The management team agreed to add the information to the guide for people who used the service. Appropriate safeguarding records were kept by the service of any safeguarding referrals they made.

Risks were generally well managed so that people were protected from avoidable harm and not unnecessarily restricted.

Individual risk assessments had been completed to identify people's risk of falls, developing pressure ulcers, and nutritional risk using recognised risk tools, along with risk assessments for the use of transfer equipment, and behaviours which might challenge. Risk assessments had been reviewed monthly to ensure they remain an up to date assessment of risk.

When bedrails were in use to prevent people falling out of bed risk assessments had been completed to ensure they could be used safely. However, we saw that one bedrail risk assessment was not personalised to the person. It was not clear whether bedrail protectors should be in place. We saw that they were not in place and the person was rubbing their legs on the bedrails putting them at risk of skin damage. These protectors were put in place during our inspection.

A visitor said, "I have a nose at [my family member]'s turns chart and it's always up to date." There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers, they were functioning correctly and set appropriately for the people using them. People's repositioning charts had been completed to show that staff had supported people to change their position in line with the instructions in their care plan.

We saw that the premises were well maintained and checks of the equipment and premises were taking place, however, we found two sinks where water was of a high temperature. We also found two windows on the first floor that had not had their opening restricted. Action was taken to address these issues during our inspection. We saw that action was taken promptly when issues were identified from premises and

equipment checks.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals in order to minimise the risk of re-occurrence. The registered manager told us that falls were analysed to identify patterns and any actions that could be taken to prevent them happening.

At lunchtime, we saw that dining room tables did not have any place mats, cutlery or condiments on them. We raised this with the registered manager and they agreed to review this to ensure that access to these items was only restricted to people when they had been assessed as at risk. This would ensure that other people were not unnecessarily restricted.

People told us their belongings were safe. A visitor said, "100% safe here." Another visitor said, "All's been very safe so far."

People told us there were enough staff to meet their needs. A person said, "We've got plenty." A visitor said, "Oh yes, there's plenty of staff around." Another visitor told us, "There are plenty here and so much better than the other place [my family member] was in."

Most staff thought they had enough staff. Staff on one of the units told us there were generally enough staff on duty to provide the care people needed. However, they commented on the fluctuations in support required by some people depending on their mood and behaviour. They said they sometimes had to wait for staff to be available to enable them to provide personal care due to the requirements for the monitoring of people and their support needs. Domestic, laundry and kitchen staff felt that they had sufficient time to complete their work effectively.

During the inspection we observed staff attending to people's needs. During our observation in communal areas, we found that there was always a minimum of one staff member in each lounge area and another staff member observing the corridor on one unit, in addition to staff members providing one to one support.

Systems were in place to identify the levels of staff required to meet people's needs safely. A staffing tool was not used to calculate staffing levels. However, the registered manager explained that they considered people's dependencies when setting staffing levels and monitored them closely to ensure that staffing levels remained at the correct level.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People had no concerns with how their medicines were managed. A person said, "I'm on oxygen and they look after it all." A visitor told us, "It's very good here the way they do it." Another visitor said, "They know exactly what they're doing."

We observed the administration of medicine; staff checked against the medicines administration record (MAR) for each person and generally stayed with the person until they had taken their medicines. However, we observed that one staff member left a tablet with one person to take later and did not check that they had taken it. We observed that the person did take the medicine. MARs contained a photograph of the person to aid identification, a record of any allergies but did not include their preferences for taking their medicines. MARs confirmed people received their medicines as prescribed.

Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability.

We saw there was a record of the use of medicines which had been prescribed to be given only as required. However, protocols were not always in place to provide staff with additional information on when to give this medicines and how to use them safely. Liquid medicines were not always labelled with their date of opening although the creams we checked had been labelled.

Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. However, we found the room temperature in two of the three treatment rooms had been above the recommended maximum temperature for over a week at a time. No action had been taken to obtain advice from pharmacy on the possible deterioration of the medicines as a result of the increased temperatures. Management agreed to take immediate action.

Staff administering medicines told us and we saw documentation indicating they had received competency checks for medicines administration. They told us they had completed training in medicines administration and records confirmed this.

Requires Improvement

Is the service effective?

Our findings

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 DoLS. We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were not being followed consistently. We found mental capacity assessments had been completed for some people for all or some decisions about their care and best interest decisions recorded. However, this was not consistent and there were gaps for one person where capacity assessments had been completed for some decisions but not others such as the use of bedrails and the insertion of a urinary catheter. Mental capacity assessments had not been completed for another person although a DoLS application had been made.

When people were being restricted, DoLS applications had been made. Staff had a good knowledge of MCA and DoLS and the staff member we asked was able to tell us which people were subject to a DoLS authorisation in the unit they worked in.

Staff were able to explain how they supported people with behaviours that might challenge others. Staff were always professional in their interactions with people showing patience and empathy. When people presented with behaviours which challenged and which might cause injury to others, staff responded calmly and professionally, and supported each other to de-escalate the situation.

We observed staff supporting a person with behaviours which challenged. They reacted calmly and professionally and used the minimum amount of restraint to maintain the safety of staff and people using the service. We checked later in the day and found the incident had been documented and an incident form completed. Staff we talked with said they documented all incidents on the person's behaviour chart and where necessary filled out an incident form. They said incidents occurred frequently and they filled in charts, "All the time." However, we saw the person unexpectedly punch a member of staff in the middle of their back and this incident was not documented when we checked.

We observed the behaviour of a small number of people on one of the units upstairs who were very loud and this appeared to have an impact on the experience of others. In particular, we observed the behaviour of one person whose behaviour was difficult for staff to manage, in that they physically abused staff and shouted loudly for prolonged periods throughout the day. We saw some other people who used the service move away and a person who we were sat close to in another room, sighed and said, "He never talks quietly does he." There were daily incidents relating to the person's behaviour and we noted a safeguarding referral

had been made in relation to another incident where the person had been hit by another person using the service. When we discussed it with a member of staff, they said this was possibly a response to the person's ongoing behaviour. We also saw examples of incidents where the person had had to be stopped from going into other people's bedrooms. We discussed this person with management who told us they had been closely monitoring the situation and would be contacting commissioners in order to obtain further support for the person.

We saw that some people's care records referred to staff sometimes holding people's arms when they were providing personal care. Appropriate assessments of capacity and DoLS applications had been made but not all staff had received up to date training in order to hold people safely. The management team agreed to arrange this immediately.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had mostly been fully completed, however, staff agreed to contact the GP to review two DNACPR forms that were not properly completed.

People told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "They're thorough, very good." A visitor told us, "They've got some extremely good senior ones and some fantastic younger ones too." Another visitor said, "They're really good here, top notch." We observed that staff competently supported people.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. A staff member said, "If we ever want any training we let the [registered] manager know and they will put us on it."

Staff told us they received regular supervision. Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training.

We saw staff asked permission before assisting people and gave them choices. We observed two staff assisting a person to move from an armchair to a wheelchair. One staff member said to the person, "OK [person's name], are you ready? Ready, steady, stand. That's good, now a few steps forward. That's perfect. Sit yourself down. Jolly good. Right, off we go." Where people expressed a preference staff respected them. A visitor said, "[Staff] do ask as I hear them and they ask very kindly."

People spoke positively about the food choices available and told us that they received meals that met their needs. One person said, "It's nice and we get a choice of things." Another person told us, "I like the food. I have a cooked breakfast and it's lovely." A visitor said, "[My family member] seems to be fine. [They are] a fussy eater but the kitchen know [them] well and will do specials for [them] no problem."

A staff member said, "One chap loves his cooked breakfast every day and so looks forward to it. Another person loves cornflakes with honey and he'll have two big bowlfuls for breakfast, ladling on the honey. And if they don't fancy the lunch or tea, they can have anything – we get asked for a jam sandwich, cheese on toast, bedtime cereal and all sorts. They can choose anything they fancy."

People told us that they had sufficient to eat and drink. A person said, "We get a good plateful." Another person told us, "I never get thirsty." A visitor said, "I've no worries at all about [my family member]'s fluids." We saw that people were offered drinks throughout the inspection.

We observed the lunchtime meal in all three areas of the home. People received their meals promptly and staff supported people if they needed assistance when eating their meal. A person who had one to one support was waiting for their meal and showed signs of becoming restless, the member of staff providing support initially offered the person a drink and then asked the staff serving the meal if they could serve the person next and the meal was provided promptly, maximising the person's chance of eating their meal.

Nutritional risk assessments had been completed and care plans were in place to provide information on people's dietary and support needs. People were weighed monthly and the records we reviewed showed people were maintaining or gaining weight. Food and fluid charts were in place for people and fluid charts had a fluid target to guide staff on people's fluid intake requirements. People's total fluid intake was totalled daily in such a way as to enable ease of monitoring and trends to be identified. We saw people had an adequate or good fluid intake.

People told us they were supported with their health care needs. A person said, "The optician comes to see me. I have the chiropodist quite often and they do my hair here." A visitor said, "[My family member] has all the people coming in for [them] – teeth, feet and hair."

Care records contained records of the involvement of other professionals in the person's care, including the GP, dementia outreach team, speech and language therapist, dietician, optician and chiropodist.

Adaptations had been made to the design of the home to support people living with dementia. Bedrooms, bathrooms, toilets and communal areas were clearly identified. Toilet seats and handrails in bathrooms were differently coloured to their surroundings so that people with visual difficulties could distinguish them, however, handrails in corridors were the same colour as the surrounding walls and would be more difficult to see.

Some people's bedrooms were very bare on one of the units. We discussed this with the management team and they agreed to consider how they could make some of the bedrooms more homely without putting those people at risk.

Good

Is the service caring?

Our findings

People told us that staff were kind, caring and considerate. A person said, "They help me and they're nice and gentle." Another person told us, "They're kind to me." A visitor said, "I listen to [staff] talking with the other residents when they don't know I'm here. They really care, so I feel at ease." Another visitor said, "[Staff] really care and are definitely in the right job. Such dedicated folk."

Staff impressed us with their knowledge of the people they cared for and their individual preferences. A person said, "They know me well, I'd say." A visitor told us, "They know [my family member] so well, which is important to me."

We saw very good interactions between staff and the people they cared for. These interactions indicated empathy for people and a caring approach by staff. We saw a staff member was sitting on a lounge sofa writing up notes. A person came into the room and sat on the sofa. The staff member sitting on the sofa put down her file, put her arm around the person's shoulder and let her nestle up against her as she was tired. The person had just had paracetamol for a headache and the staff member joked with her about having a handsome doctor come to check on her if she did not feel better.

We observed staff sitting beside people who used the service in the lounge and chatting when not required for tasks elsewhere. A staff member said, "I like it when we have these spells of quiet so we can sit down and chat and relax with them."

People we spoke with were unaware of the contents of their care plans. Visitors told us they had been involved in discussions about their family member's care. A visitor said, "They let me know everything. I'm 100% updated." Another visitor told us, "I'm the contact. I feel involved." We saw that care records contained information which showed that people and their relatives had been involved in their care planning. Care plans contained information regarding people's life history and their preferences and we saw that a person had signed some of their care plans to confirm that they agreed with them.

Advocacy information was available for people if they required support or advice from an independent person; however it was not easily accessible. The management team agreed to add the information to the guide for people who used the service.

Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us. We saw staff communicating with people in a very positive way. They reminded them of expected visits from relatives and gave reassurance when people asked about their relatives. Staff provided people with choices and when people found it difficult to make a choice, they simplified the choices and gave them time, to encourage their participation.

People felt that their privacy and dignity were respected. A person said, "Oh yes, they're very polite." Another person told us, "They close everything when they wash and dry me." A visitor said, "They're very respectful here." Another visitor said, "I leave the room [when staff provide personal care] – they do it as it should be

done." We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. The home had a number of areas where people could have privacy if they wanted it.

Staff were able to describe the actions they took when providing care to protect people's privacy and dignity. We observed staff maintaining people's dignity. One person was raising their jumper above their waist a number of times while sitting. A staff member came to sit with them and quietly said "Can I just pull your jumper down please [person's name] so you don't get a cold tummy?" On another occasion, a staff member came to kneel beside a person in the lounge and quietly asked if they would like to go to the toilet, so that they could not be easily overheard.

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner. Some staff had been identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

We observed that people were supported to eat their meals independently where appropriate. Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence. A visitor said, "[My family member] likes to feel a bit useful and help the others if [they] can. [Staff] let [them] push the tea trolley in."

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service. A person said, "They can see me often, any time." A visitor told us, "I can come anytime and usually drop in unannounced anyway." Another visitor said, "We can come whenever."

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs. A person said, "I can choose when to go to bed and I pick out my clothes." A visitor told us, "I know she can choose her bedtime if she's been watching TV."

People's views were positive about the activities that were provided. A person said, "I like the art. Sometimes we get music coming in and a little dog to visit. I can go out and about if someone comes with me." Another person told us, "I like to join in. There's always something on."

A visitor said, "They'll take [my family member] down for singalongs or anything that involves listening or watching, as that's all she can do. She's been out in the garden a few times too, in her sunhat." Another visitor said, "He loves anything musical and plays his vinyls in his room – and sometimes they'll let him play them in the lounge like a disco and get people to name the song. They'll persuade him to join in anything else too. The fete at the weekend was really good. The displays they do in the rooms here are always light and bright." A third visitor said, "I've seen a singsong but I don't think she gets involved – she likes watching. The activity girls are fantastic and take her for a trip into town and she's going to Skegness soon."

The activity team comprised two full time staff. The staff worked together on activities to ensure sufficient support was provided for people who used the service. We were told that they used the downstairs dining room for a lot of the activities, with people from the first floor units being brought down to join in too, if they wished.

The activity staff told us that they planned three months ahead and worked off a weekly planner allowing activities to be adaptable to reflect the weather, transport availability, staffing, unforeseen events or opportunities. They usually included musical acts/singers, visiting pets and animals and musical movement each month.

An activities coordinator said, "We try and include the [staff] as much as possible too – and they will do activities when we're not here. We have a competition for the carers like the best Easter bonnet worn, Halloween hat or best costume if it's an event like the royal birthday. So they get to join in. We also do a lot of idea sharing with them." They also said, "Our theme at the moment in the dining room and lounges is 'Under the Sea', hence all the ceiling decorations. We've got a Skegness trip in a few weeks – we hire a minibus and don't have a shortage of staff volunteering to come and help. We'll take about seven residents with seven staff, so it's always one to one. Our fundraising helps with the cost of everything but we get good support from management, they don't let us struggle."

We observed staff interacting for short periods of time with people on one of the units on a one to one basis. For example, a member of staff gave a person a squidgy ball to hold and feel and although the person was unable to engage verbally, the staff spoke encouragingly to the person and the person smiled and laughed, clearly enjoying the interaction.

We saw staff playing a balloon game with people in the lounge and several of the people, participated.

Some people went down to the ground floor to join a paper aeroplane making activity. We saw other craft activities taking place during our inspection. On the second day of inspection we saw that staff supported two people to go to the nearest town to go shopping and visit a café.

Pre-admission and admission assessments had been undertaken and care plans were in place for people's care and support needs. Care plans had been reviewed monthly and were generally reflective of people's current needs. Some people had an "All about me" document or a life history in their care record.

However, there was a lack of personalisation in the care plans and a tendency to use generalised statements such as "monitor for triggers and eliminate triggers" (when the person had been living there for some time and any triggers should have been identified and documented), "employ distraction techniques" (with no information about things personal to them which might distract them). However, we did review one care plan for a person with behaviours which challenged which contained some additional detail such as ensuring they were sat out of arms reach of other people at the dining table. Two care plans for people with diabetes did not provide any information on the signs of hypoglycaemia or hyperglycaemia to enable care staff to recognise those signs. However, a care plan for another person did contain this information. The management team agreed to review these care plans to add further detail.

Care records contained information regarding people's diverse needs, including expressing their sexuality, and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences.

People told us that they would be comfortable raising any concerns with management. A visitor said, "I've not had to complain about one thing, which is not usually like me." Another visitor said, "We did complain last time we were here. He was asleep in a chair on a hot day – no shoes and his feet were really swollen hard. The nurse said they'd had to sedate him as he'd got angry. But they should have had his feet up. They moved him then."

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed throughout the home. There was a clear procedure for staff to follow should a concern be raised.

Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint. Staff said that if a person wanted to make a complaint to them they would write down the details, apologise to the person and see if they could rectify the issue and report it to the registered manager.

Good

Is the service well-led?

Our findings

People and visitors had opportunities to comment on the running of the service. A visitor said, "They redecorated [my family member]'s room for her and asked if she liked it, or if not, they'd change it. But it's so perfect and just her taste."

We saw that meetings for people who used the service and visitors took place where comments and suggestions on the quality of the service were made. A visitor said, "There's periodically a meeting for relatives so we can ask questions. They do act on things afterwards." Another visitor said, "I've been to one. They fill us in after and seem to do what they say."

We saw surveys had been completed by relatives and visitors. Actions had been taken where appropriate. A visitor said, "The few things I've mentioned, like her wardrobe door or the window being stuck, have all been fixed straight away. I was impressed." Another visitor said, "They accept anything we say or ask about." No surveys had been sent to people who used the service and management agreed to consider an accessible survey to gather people's views on the quality of the service.

A whistleblowing policy was in place and contained appropriate details and referred to the CQC but did not provide contact details for the organisation. Staff told us they would be prepared to raise issues using the processes set out in this policy.

The provider's values and philosophy of care were in the guide provided for people who used the service. Staff were observed to act in line with them during our inspection.

People felt that the home had a good atmosphere. A person said, "It's a good place. I'm happy." Another person said, "I really like it here. It's good." A visitor said, "It's very friendly and welcoming. The receptionist is a delight." Another visitor said, "It's very happy and feels under control, not rushed." A third visitor said, "Basically it's relaxed and happy."

Staff were positive about their work and told us they worked well as a team. A staff member said, "I love working here. I get on with anyone, it's a good atmosphere." Another staff member said, "Everyone's friendly. It's a nice place to work." An agency staff member said, "I'm so impressed with it here. I've worked in care for 15 years all over and think this is one of the best places, given the level of help the residents need. They're so good at paperwork here too – we record every little thing in behaviour, food, drink and anything different. I've let it be known that I'm available to come here again. I like it a lot. Very impressed."

Visitors were positive about the registered manager and the management team. A visitor said, "I can always find a manager and they're all approachable." Another visitor said, "I often see her [the registered manager] and it's easy to chat." A third visitor said, "They're all brilliant. If I need to say anything, I can do."

Staff told us they felt the leadership of the home was good. A staff member said, "It's a well-run place. If I have a problem I can go to any of the management team." Staff were positive about the registered manager.

Staff told us the registered manager was supportive and they could discuss issues openly with her. They said she took any concerns they raised seriously and acted to address them. Staff told us staff meetings were held regularly and they were encouraged to raise issues at the meetings. We saw that staff meetings took place and the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post and she was available during the inspection. We saw that all conditions of registration with the CQC were being met and most statutory notifications had been sent to the CQC when required, however, notifications had not been sent to the CQC when DoLS authorisations had been received for people who used the service.

The provider had a system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager. Audits were carried out in a range of areas including infection control, medicines, health and safety and care records. Actions had been taken where issues had been identified by audits.

A representative of the provider visited the service a number of times each month. They told us they spoke with staff, visitors and people who used the service. The documentation they completed for each visit did not provide this level of detail. They agreed to review this documentation to better reflect their visits.