Homestead Homes Limited

The Homestead

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 16 February 2018. The inspection was unannounced which meant that the staff and provider did not know that we would be visiting.

At our last inspection in December 2015 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The Homestead is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Homestead is a large detached property situated in a residential area of Exmouth. The home is set over three floors with access via a passenger lift. The main communal spaces are situated on the ground floor. The service provides accommodation for up to 24 older people. There were 22 people living at the home at the time of our inspection. The provider also provided a day care provision during the week at the home. This was not inspected as it was not part of the provider's regulated activity.

Why the service is rated Good:

People told us they felt safe at the home and with the staff who supported them. Comments included, "I can't fault them. They are superb."

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

Staff had received safeguarding training and were aware how to raise concerns if they felt people were at risk of abuse or poor practice.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed.

People were supported by adequate staff levels to meet their needs. The staff had the required recruitment checks in place. Staff received an induction and had received training and developed skills and knowledge to meet people's needs.

People received person centred care. Staff knew people well, understood their needs and cared for them as individuals. They were familiar with people's history and backgrounds and supported them fairly and without bias.

People were treated with respect and compassion by staff. They were relaxed and comfortable with staff that supported them. Staff were discreet when supporting people with personal care, respected people's choices and acted in accordance with the person's wishes.

People's views and suggestions were taken into account to improve the service. Monthly residents meetings were carried out and an individual review with the registered manager each month.

People were referred promptly to health care services when required and received on-going healthcare support. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them. People knew how to make a complaint if necessary. There had been no complaints received at the service since our last inspection.

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 support this practice. Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments were completed and best interest decisions made in line with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager was aware of their responsibilities in relation to people being deprived of their liberty and the need to make an application to the local authority DoLS team if required.

People were supported to follow their interests and take part in social activities. A program of activities was available for people to attend as they chose.

People were supported to eat and drink enough and maintain a balanced diet. People were complimentary about the food at the service.

Not all information at the home had been provided to people in differing formats if they had a communication difficulty. We recommend the service consider how information could be made available to people to support assisted communication where they may benefit from this.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service.

The premises were well managed to keep people safe. The home was clean and homely with a welcoming homely atmosphere. Robust arrangements were in place to ensure the environment was kept clean and safe with audits being completed on all aspects of the building and equipment. There were emergency plans in place to protect people in the event of a fire or emergency.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

The Homestead

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 checked 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 comprehensive inspection took place on16 February 2018. The inspection was unannounced and was carried out by an adult social care inspector and an Expert by Experience. 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 on this inspection had experience of working with and supporting older people.

We reviewed the information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We met and observed the majority of the people who lived at the service and received feedback from seven people who lived at the service.

We spoke to eight staff, including the registered manager, deputy manager, care workers, the activity person and the cook.

We reviewed information about people's care and how the service was managed. These included three people's care records and five people's medicine records, along with other records relating to the management of the service. These included staff training, support and three employment records, quality assurance audits and minutes of residents and staff meetings. We also contacted four health and social care professionals and commissioners of the service for their views. We did not receive a response from any of the health and social care professional's contacted.

Good

Is the service safe?

Our findings

People felt safe living at the home. People were happy the service was safe. Comments included, "Jolly good, "I would not want to go anywhere else" and "I can't fault them. They are superb."

There were sufficient staff to meet people's needs. Staff said they had enough time to meet people's individual needs. Comments included, "We have enough staff, residents here are quite able handed, we don't need to rush them" and "I don't feel rushed when offering personal care. They understand it is their individual time." During our visits call bells were answered in a timely way. One person said, "It's a fantastically fast response. If they are with someone else the carers come and tell you they are busy with someone else."

The service followed safe recruitment practices. Staff files included application forms, interview notes, records of employment history and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had undertaken training in safeguarding vulnerable adults. They had a clear understanding of what abuse was and how to report any concerns both internally and externally to outside agencies. Staff were confident any concerns would be addressed by the registered manager. One staff member said, "I am confident it would be dealt with." The registered manager understood their responsibilities to inform the local authority safeguarding team and submit notifications to CQC in line with regulations. To keep people safe the provider had produced identity card for people to carry when they left the service to go into town or for a walk. This arrangement had been put into place with people's agreement and meant they could show people if they lost their way.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. In each person's folder there was a falls calendar that staff completed. It clearly showed how many falls people had had. Staff recorded accidents and incidents and the actions they had taken. The registered manager reviewed all accidents and incidents to ensure appropriate action had been taken.

People were protected because risks for each person were identified and managed. Risk assessments had been completed for mobility, skin integrity and nutritional status. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. Where one person had a high score on their skin integrity assessment measures had been taken to prevent skin breakdown. These included a pressure relieving cushion and mattress.

Room risk assessments were completed monthly to look at risks to people. These included looking at slips and trips, checking call bells were working, lights were safe, water temperature, beds and furniture were safe. A health and safety check was completed each month for each person. This includes their room,

mobility and walking, footwear and equipment in their rooms.

People were protected against hazards such as falls, slips and trips. A falls assessment had been completed for each person and action taken to minimise potential incidents. This included ensuring people's environments were free from clutter and safe footwear was being used.

Peoples' medicines were managed and administered safely. All staff administering medicines had received medicine training. Staff recorded medicines they administered, including topical creams they had applied, on people's medicine administration records (MARs).

People's MAR's were accurately completed and there was a current photograph of the person and information about any known adverse reactions to medicines. Regular medicine audits were completed and action taken if required.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service. This showed the home had plans and procedures in place to safely deal with emergencies. The PEEP's were held in people's individual care folders. There was a quick reference sheet of people's needs in the main fire file for use in the case of an emergency

The environment was safe and secure for people who used the service and staff. As part of the admission process for new people coming into the home a checklist was completed by staff to ensure electrical equipment being brought into the home was tested to ensure it was safe. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout without any odours present and had a pleasant homely atmosphere. There were effective infection control measures in place. The provider had an infection control policy to guide staff and undertook regular infection control audits. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. The laundry was in a room separate from the house. There was a clear separation between soiled and clean laundry. Soiled laundry was placed in red soluble bags and laundered separately at high temperatures in accordance with the Department of Health guidance.

Good

Is the service effective?

Our findings

People's needs were consistently met by staff who had the right competencies, knowledge and qualifications. Staff had received appropriate training and had the experience, skills and attitudes to support the complexities of people living at the service.

Staff had completed the provider's required training which included food hygiene, infection control, moving and handling, safeguarding of vulnerable adults, fire safety, Mental Capacity Act (MCA), Deprivation of Liberties Safeguards (DoLS), first aid, health and safety and COSHH (Control of Substances Hazardous to Health). As well as the provider's mandatory training, staff had received other training to help them perform their roles. This included training in: tissue viability, nutrition, hydration, prevention of pressure sores, end of life, diabetes and dementia awareness. The registered manager said staff were aware of their equality and diversity obligations and were also completing equality and diversity training. One staff member said, "Training is good… all up to date." Nine care staff out of 20 employed at the service had a higher qualification in health and social care with two others being put forward for training courses.

Staff underwent an induction which gave them the skills to carry out their roles and responsibilities effectively. New staff completed an induction program and shadow shifts working alongside experienced staff as part of their induction. This enabled them to familiarise themselves with the homes routines and people's needs. One staff member said, "I did two shadow shifts and followed (experienced staff member). We went through the checklist, what to do in an emergency and fire. I was asked if I felt ready to do a shift. I wasn't allowed to do any manual handling until I had completed my training." Another said, "I did two shadow shifts which was enough. It can be more, it depends on your previous experience." The registered manager said they had approached three care workers who had undertaken the provider's induction to ascertain how effective they felt it had been. They wanted to know whether information had been introduced at appropriate times during their induction or could some things have been delayed. The outcome was discussed with the provider and changes had been made to the induction program.

New care workers who had no care qualifications were supported by the registered manager to complete the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice.

People were supported by staff who had supervisions and appraisals (one to one meetings). The registered manager said appraisals were completed every six months and supervisions were completed as required. They explained that new staff had supervision weekly until they were confident in their roles. The registered manager said they had an open door policy and that they were available at any time. Staff confirmed this was the case. One said, "One hundred percent I feel supported. I can go to (registered manager) anytime. I went with personal issues, so easy to talk to."

The registered manager ensured that each member of staff was treated as an individual and they recognised their individual cultural needs. The registered manager said, "All staff are given a form to complete if they choose, about their gender, beliefs and support required." This would help them support the staff member.

A care worker gave an example of a staff member whose first language was not English. They said the person had required additional support when becoming competent with administering medicines. This had been provided until they felt confident about administering medicines.

The registered manager had reflective discussions and learning sessions with staff. These included discussing the MCA, safeguarding, prevention and management of pressure sores. Staff were also asked to record their reflections following training. For example staff had been trained to use an elk (an emergency lifting device designed to lift people from the floor in a safe and dignified manner). One staff member recorded in their reflection how it had made them feel very unsteady using the elk. The registered manager had also undertaken practical sessions with staff for them to experience how people felt using a wheelchair, a bath hoist or having their face washed. They asked staff afterwards to reflect on how it made them feel and how they would improve their practice following the experience.

The 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. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

The Care Quality Commission (CQC) monitors the operation of DoLS and we found the home was meeting these requirements. The registered manager was aware of their responsibilities in relation to DoLS and was aware of how to make an application if they needed to restrict a person's liberties. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions. One staff member said, "(The registered manager) quizzes us weekly about MCA." When we asked what it meant to the staff member they said, "Ensuring residents agree to personal care and consent to it. Can they make an informed choice?"

People's rooms were personalised with their possessions, photographs and furniture. The home had two lounges the Edwardian and Orchard lounge, a small private seating area and a dining room. Most people used the Edwardian lounge because it was centrally located.

The staff were all aware of people's dietary needs and preferences. The new cook said they were advised of people's likes and dislikes. They had a sheet which was regularly updated identifying people's dietary needs, for example diabetic or pureed diet. There were two main meal choices each lunch time with alternatives available if people wanted. The registered manager said people were asked twice a week for their meal choices and therefore ordered their meals three or four days in advance. People were happy about the food. Comments included, "Very nice. We have a new cook and she is marvellous", "They come every so often and give you the menu for next week. You order a week in advance. You can have whatever you order." Staff were also positive about the food at the service, comments included, "Since the new cook, really really good" and "The food is really good, the residents love it, everything is hand made."

People were involved in developing the menu at the home. The registered manager said, "People are asked

twice a year for their views on the menu and any suggestions they would like added to the menu." They confirmed suggestions made were sent to the provider who trialled the dishes to ensure they were feasible and new menus were generated. One person said, "When there's a new dish on the menu we have little tasters, and they take residents' views. If we have suggested anything it's always been looked at as feasible."

We observed a lunchtime meal in the dining room. There were 19 people in the dining room enjoying their lunch with refreshments of their choosing which included wine. Tables had table cloths, and cloth napkins with comfortable, cushioned dining chairs with arms. Music was playing quietly in the background. Care staff were very attentive; making sure everyone had the sauces and condiments they wanted. People said they enjoyed their meal.

To help improve people's dietary intake a new activity had been introduced called, 'Tasty Tuesday and Fun Friday'. Each afternoon snacks were prepared for people. These included, mini pizza's with different toppings, apples and bananas' in batter, spring rolls and dipping sauces and banana and strawberry smoothies. The registered manager recorded on their reflection of the trial, "Tasty Tuesday and Fun Friday has been a big hit and is going down really well. The residents have been enjoying trying different dishes that some have never had before…We found the communication with the residents has improved on these days as they are getting involved in talking about the different dishes." A person using the service had been asked to be a 'resident ambassador' to ask people their views on the food at these events and inform the staff of the successes and failures.

People said they had access to health and social care professionals. Comments included, "The optician comes here and we have our own chiropodist. We go to the dentist", "They get the GP. I haven't seen the optician. I see a chiropodist. I haven't seen the dentist" and "They will call (GP's name) if necessary… If we need a dentist the home calls them. The optician comes, and the chiropodist every month. We just go down and see (deputy manager) and she deals with it straight away." A health professional confirmed they were contacted promptly if required and their advice was followed.
This was confirmed in people's records which demonstrated people had access to a GP, dentist and an optician and could attend appointments when required. When staff undertook their monthly reviews they had to record when people had last seen their optician, dentist, podiatrist and audiologist. This enabled staff to identify if people required a check-up.

Staff were prompt to refer people to their GP or other health care professionals if required. For example, one person with a terminal illness was having their weight closely monitored by staff. The person's GP had prescribed additional supplements. The staff knew the persons likes and dislikes and they were eating well. Another person was very anxious. Staff had talked to the person's family to ascertain patterns and history and consulted the person's GP who had arranged for a community psychiatric nurse (CPN) to support the person.

We identified there was very little signage around the home to guide people and only small number plagues on people's bedroom doors. We discussed with the registered manager that there were several people at the home with eyesight impairment. The registered manager said they would review the signage at the home to see if it could be improved and look at guidance by the Royal National Institute of Blind People for other improvements they could make.

Good

Is the service caring?

Our findings

People and relatives were very positive about the quality of care at the home and the caring attitude of the staff. Comments included, "It's all very nice here, I like it very much. They are all very kind and helpful and put themselves out for me", "Excellent. It's a joy to be here. Very high quality. They do it so willingly. To me, it could not be improved" and "Nothing we would want to change."

Staff treated people with dignity and respect when helping them with daily living tasks. We observed care workers supporting people throughout our visit. They were very kind in their approach did not rush the people and throughout reassured them.

People's privacy and dignity were maintained. People confirmed this was usually the case and comments included, "Yes, they always knock on the door" and "Most of them do. Some don't, but not very often…They bring me towels." Staff said they maintained people's privacy and dignity when assisting with personal care. One said, "It is very important to keep them covered up, I wouldn't want to be left uncovered."

Staff treated people with kindness and compassion in everything they did. They were familiar with people's history and backgrounds and supported them fairly and without bias. Throughout our visits staff were smiling, patient and respectful in their manner. If people asked a question or required assistance this was carried out without any fuss. We observed when a care worker was helping a person to go from the sitting room to the dining room. The care worker quietly and gently reminded the person how to walk with their frame. They gave quiet encouragement as they supervised the person to the dining table.

The atmosphere at the home was very calm and homely. This was demonstrated by a sign in the main entrance which said, "Our residents do not live in our workplace, we work in their home." One staff member said, "It feels welcoming here, doesn't feel like a care home but a home."

Staff involved people in their care and supported them to make daily choices. People confirmed they were given choices about how and where they spent their time. Comments included, "Now I just watch the TV. I have meals in my room. I prefer it in here (bedroom)", "They say, shall I do this, will that be alright?", "They say, do you mind if that's done? If they have to do something very personal they say, is it alright?" and "You tell them (staff) what time you want to go. They know our set routine. It goes like clockwork and if we wanted it earlier, that's ok."

People's relatives and friends were able to visit without being unnecessarily restricted. Visitors were made to feel welcome when they came to the home. During our visit the Orchard lounge was used by a person who had visitors. The visitor's children were able to play in the garden while the person watched from the Orchard lounge. People had developed small friendship groups and were seen interacting and chatting with each other throughout our visit.

Good

Is the service responsive?

Our findings

People said the service was good at meeting their individual needs. It was evident from speaking with the registered manager and staff that people mattered at the service, they spoke with pride about the people they cared for and wanting to make it a lovely place to stay.

Wherever possible a pre admission assessment of needs was completed prior to people coming to live at the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop care plans. It was evident staff were familiar with people's history and backgrounds and supported them fairly and without bias. When people first came into the home they were allocated staff chaperones to support them each day until they felt settled. Staff completed a dependency assessment which took into account people's needs which included, communication, nutrition, mental state, mobility and continence. This was reviewed monthly to monitor if people's needs changed.

People's care records included personal information and identified the relevant people involved in their care, such as their GP, optician and chiropodist. Care plans gave information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary. The registered manager explained they had recently put in place new care plans. Some people's health information had not been transferred into the new folders. This meant that relevant information was sometimes in archive folders and not in people's current folders for staff to refer to when required. The registered manager and deputy manager said they would review everybody's care folders to ensure all relevant information had been transferred and were reflective of people's needs.

The provider operates a keyworker system. The keyworker meets with people they are designated to support each month to review their care needs. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Each day care workers complete daily progress notes recording the care they have supported people with. Senior care workers in charge of the shift also complete an overview of the person's day. The senior care worker highlighted any important information for example a GP visit or change in presentation. The deputy manager said this remained highlighted each day until all senior care workers had been informed.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had information about their communication needs in their care plans to guide staff how to ensure they had the information required. Staff ensured people had their hearing aids in place and had their glasses cleaned. The registered manager said some information was provided to people in accessible formats where needed, to help people understand the care and support available to them. For example, if people could not read the minutes of residents meetings or their emails or post, staff would read it to them. Staff also supported people to write letters if they required assistance.

However, not all information at the home had been provided to people in differing formats if they had a communication difficulty. We recommend the service consider how information could be made available to people to support assisted communication where they may benefit from this.

There was no one receiving 'end of life' care at the time of our visit. The registered manager said they liked to think when people came to the service it was their "forever home". People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse.

The registered manager showed us a memorial book they were introducing for people and staff to record their memories and condolences when someone at the home passed away. They said the memorial book would then be given to the person's family as a memento so they knew the person had been highly thought of.

Relatives had sent thank you cards to the staff thanking them for the care the staff had given their loved one. One of these said, "We would like to say a big thank you to you and all your lovely caring staff. We are so grateful for the loving way you looked after Mum. You made her last few month's happy ones…and thanks for always being there to support us (person's) family you made us feel part of your lovely homestead."

People were able to choose what activities they took part in and suggest other activities they would like to do. The provider employed an activity person to coordinate activities. They produced a monthly activity list setting out what was on offer each day. These were given to people, placed in the lift and in the main entrance to advise people and visitors. The day before our visit an external entertainer had been which people had enjoyed. The registered manager said they had celebrated Valentine's day with heart shaped confetti amongst other things and pancake day which included a discussion about the origin of pancakes as well as eating them. The registered manager had recently introduced a new chaperone system. Each morning the senior carer would allocate a person who staff would visit every hour for a chat and to check their wellbeing for the whole of their shift. A staff member said, "It is very social based here, activities every day. A chaperone spends five minutes every hour with a resident, we sing with (person)."

People with spiritual needs had the opportunity to follow their faiths. People said there was a monthly communion at the home. Comments included, "The Methodist superintendent comes once a month. We don't go to the church services in the home", "The church bring communion. The Baptist minister. That's very nice" and "The vicar comes once a month with communion." Staff were aware that one person at the home had a different faith to others there. They had discussed the person's needs with them and supported them to maintain their faith.

The provider had a written complaints policy and procedure. The procedure advised complainants if they were not happy with the outcome of their complaint to contact the Care Quality Commission (CQC). We discussed with the registered manager that it directed people to the CQC and this was incorrect as the CQC do not deal with individual complaints. The registered manager said they would amend the procedure to guide people to the appropriate external bodies, which they confirmed they had completed after the inspection.

People said they would feel happy to raise a concern and knew how to do this. One person said, "I would certainly go to (registered manager) and she would instantly pick up on the problem and deal with it. And (deputy manager) is superb." There had been no complaints received by the registered managers since our last inspection.

Good

Is the service well-led?

Our findings

People living at The Homestead and staff were positive about the management of the service. People's comments included, "She's (registered manager) excellent", "The manager comes in every so often and has a chat"; "The manager comes in once a month and has a bit of a chat with us. We have no moans or groans" and "She (registered manager) is very open and is very good."

Leadership at the home was very visible; the registered manager was in day to day charge supported by a deputy manager. The registered manager and deputy manager demonstrated a strong ethos about the service being people's home and kept them at the heart of everything that happened at the home.

The provider had recorded on the service's website, "Our goal is to treat our residents exactly as how I'd want my own mother or father to be treated." The registered manager and staff demonstrated this ethos during our visit and were passionate about providing a good service.

The provider visited the service regularly and completed an onsite inspection every two to four weeks and spoke with the registered manager weekly and as required. The provider used an audit report and completed one section each visit completing the whole audit over six months. During these visits the provider speaks to staff and people to ask their views. The provider discussed their findings with the registered manager added to the service improvement plan which is referred to at the service as a 'step up programme'.

The registered manager had been working at another home linked to the provider before returning to The Homestead. They were in regular contact with the manager at the other service offering advice and support and sharing experiences.

The registered manager and staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care.

There were accident and incident reporting systems in place at the service. The registered manager checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided. One person had had numerous falls; a physiotherapist had been consulted about how to support the person to reduce the amount of falls.

People were empowered to contribute to improve the service. The registered manager said residents meetings were held at the home every month. Minutes of these meetings were given to people as required and left in the communal area. The last meeting held in January 2018, discussed the new cook, activities and the foods on 'Tasty Tuesday and Fun Friday' which people had. At the meeting people were reminded that "Minutes can be read to them or provided to them for those who have difficulty hearing, reading or could not attend".

The registered manager walked around the home each day and would talk with a person to ask their views about the service they received. The registered manager said using this system, "I speak to everyone each month". There were surveys for people and visitors to complete in the main entrance to share their views.

The provider had a quality monitoring system in place. The registered manager had a monthly specific task sheet to complete to ensure everything was covered over the 12 month period. For example, in January they had reviewed and updated the fire and whole house risk assessment. In February they were required to check and where necessary update the emergency evacuation procedure. The registered manager and team also completed regular medicine audits, infection control audits, care records and environmental checks. The registered manager undertook daily walks arounds the service to undertake additional environmental checks.

Staff were actively involved in developing the service. The registered manager worked alongside staff and had an open door policy for staff to speak to them if needed. Full staff meetings were held twice a year and senior care staff meetings held monthly. Records of these meetings showed staff were able to express their views, ideas and concerns. Anonymous surveys had been sent to staff by the provider who collated the results in January 2018. The responses had been positive and action taken on staff suggestions. For example, increased the glove order to ensure there were plenty within the home, a quick reference training folder put in place, washing powder had been changed and a list had been put up for staff to request additional items like bedding.

Staff felt well supported and were consulted and involved in the home and were passionate about providing a good service. One staff member said, "I think it is friendly here, the level of care is good. They (the management) get you involved in things, we have discussions." Another said, "Everyone that works here gets on a bit like a family. I have never felt that anywhere I have worked before."

The service was inspected by the food standards agency in October 2017 to assess food hygiene and safety. The service scored five which was the highest rating. This confirmed good standards and record keeping in relation to food hygiene had been maintained. One small issue the officer found regarding a seal around the sink had been quickly actioned and resolved.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the Care Quality Commission (CQC) as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.