Primula Care Limited

Primrose Lodge Weymouth

Inspection report

121-122 Dorchester Road
Weymouth
Dorset
DT4 7LG

Tel: 01305786568
Website: www.primroselodge-weymouth.co.uk

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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

Primrose Lodge is residential care home registered to provide care for up to 38 people in a residential area of Weymouth. At the time of our inspection there were 32 older people with residential care needs living in the home. Some of the people living in the home had a dementia, other mental health needs or a learning disability. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good.

The home has 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. Although the registered manager was away during our inspection we spoke with the deputy manager and the regional manager.

People felt safe. Staff had a good understanding of how to safeguard people from harm and abuse. They understood what signs to look for and how to raise a concern. The home had robust recruitment processes to ensure that the staff were suitable to work with vulnerable adults. People had risk assessments that staff understood and used to help the risk of avoidable harm. Medicines were managed safely and staff had formal observations to check their competency when supporting people with this task. The home conducted audits to ensure incidents or issues were recorded, resolved and lessons learnt to prevent things going wrong in future.

People's needs and choices were assessed with their involvement. This included listening to them and noting aspects of their lives that were important to them and made them individuals. This diversity was acknowledged, respected and supported. People were supported by staff that had received training that gave them the skills and confidence to meet their needs. People were supported to have a balanced and varied diet. People were supported to maintain their health and wellbeing. This included support to attend routine appointments or with visits from health professionals.

Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people living at there. The MCA 2005 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 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.

Staff consistently demonstrated a kind and caring approach towards people. Staff knew people well and respected them as individuals. People were consulted with about the care they received and were actively encouraged to express their views. People were supported to make decisions about things that could affect their health, well-being and quality of life. This included what they wanted to eat or drink, what they wanted to wear, and who and how they wished to spend their day.

People had their care needs met by staff who knew them well. The home had a complaints process. People and relatives were aware of it and had confidence if they raised a concern they would be listened to and timely action taken. Staff had experience of supporting people at the end of their lives. Relatives and health professionals spoke highly of when this had happened.

There was a positive, friendly and open culture at the home where everybody's views were sought and considered. The service understood their legal responsibilities for reporting and sharing information with other services including CQC and local authorities. Staff felt supported by management and their colleagues. Staff had regular supervision where they received both praise and had time to develop their practice. The home had established collaborative working relationships with health professionals which were helping people to stay well for longer. Audits and quality assurance processes were used to identify opportunities for service improvement.

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**

Primrose Lodge Weymouth

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 comprehensive unannounced inspection took place on the 15 May and 16 May 2018. Day one of the inspection was carried out by one inspector with support from 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. Their experience related to people with dementia. On the second day the lead inspector was joined by another inspector.

Before the inspection we reviewed information we held about the service. This included notifications the home had sent us and information received from other parties. The provider had completed a Provider Information Record (PIR). A PIR 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. We contacted commissioners prior to the inspection which helped inform the questions we asked.

During our inspection we spoke with 14 people living in the home and 15 relatives (four of these by phone). We also spoke with the deputy manager, the regional manager, and 15 other members of staff (one of these by phone). We spoke with a GP, a district nurse, a community psychiatric nurse, and a trainer to get their views on the home. We also spoke with a local pharmacy manager by phone.

We observed care practices and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records, including risk assessments and Deprivation of Liberty Safeguard applications where required. We also reviewed records relating to the running of the service including three staff recruitment files, medicines records, quality monitoring audits, and meeting minutes.

Good

Is the service safe?

Our findings

People said they felt safe. They told us, "I do feel safe – they [staff] are so kind if I want anything", "It's my home now – I live here and it couldn't be better. Staff are enthusiastic and capable and I feel safe." Relatives comments included, "It was the best thing I did to bring [name] here – I have no worries [name's] just safe and secure and I sleep well now", "I used to not take a holiday in case something happened" and "I feel very confident that the staff will keep [name] safe."

Staff had a good understanding of how to safeguard people from harm or abuse. They understood what signs to look out for and knew what they needed to do if they had a concern including if a person lacking capacity left the building unaccompanied. On an occasion when this happened management had conducted a thorough and timely investigation involving the person, their family and relevant health professionals. This had helped them understand and reduce the causes of the behaviour that had put the person at risk of harm. The home had informed the local authority safeguarding team and taken immediate action to reduce the chance of it happening again. Information about the incident was shared with staff at handover so that all were aware of the potential risks and how to manage them.

People had individualised risk assessments that looked to maintain their safety whilst respecting their right to live fulfilled lives. One person had fedback in a survey response that 'if it is safe to do so I am encouraged to do as much as I am able.' Staff understood how to support people to manage their individual risks. For example, people at risk of malnutrition or dehydration had risk assessments in place and these cross referenced to their care plans. One person's mobility had recently declined and, in response, was now being supported by two carers when mobilising. Referrals were made appropriately and in a timely way for example to district nurses and a pressure care nurse. During a handover staff were reminded to encourage people to drink sufficiently given the warm weather.

Equipment and the home environment were checked to ensure they were in good working order and did not present a risk to the people living and working there. Staff had received fire training and knew what to do in the event of a fire. People had regularly reviewed Personal Emergency Evacuation Plans (PEEPS) in place which guided staff on the most appropriate way to support people to get out of the home safely in the event of an emergency such as a fire or flooding.

The home had enough staff to meet people's identified needs although there were occasions during the inspection when staff appeared to be more task focused with this limiting the length of time they spent talking with people. Despite that the time they did spent with people was person-centred and unrushed. Staff said "the majority of the time" they had the time to spend meaningful time with people. Every month a dependency tool was used to match staffing levels with the needs of the people living there. Feedback on the staffing levels varied with one person expressing in the recent survey that 'more staff would be beneficial' whilst two other people stated '[there] are always plenty of carers on duty' and '[there] are always staff available even at busy times.' Some people told us that staff were busier in the mornings. They also said there were fewer staff on shift at weekends. This was mentioned in the most recent staff meeting minutes. The management said to resolve this they had advertised on a local radio station. Additional staff had been

recruited who were going through the necessary recruitment checks and would be able to support people once these were complete. The home rarely used agency workers as it wanted to maintain a consistency of approach and ensure that people were supported by staff that knew them well.

The home had safe recruitment practices. Checks were done to ensure staff were suitable to support people at the home. Pre-employment and criminal records checks were undertaken. Records included employment history, interview records and two verified references.

Medicines were managed safely. We observed people being supported with their prescribed medicines and also the storage and record keeping associated with this. We saw that people were asked if they wanted to take their medicines. Staff explained to them what was being administered and what it was for. Staff knew the procedure to follow if a person continually declined their prescribed medicines. Where people administered their own medicines this had been risk assessed. One person said, "My medicines are absolutely always given to me on time." A local pharmacy manager advised "They are brilliant. So well organised. Monthly orders are always on time."

The home was visibly clean and free from malodours. The service had a weekly cleaning schedule which was up to date and audited. There were supplies of hand gel and personal protective equipment such as gloves and wipes. Soiled and clean laundry was kept separate to reduce the risk of contamination or infection. One relative said, "the standard of cleanliness and comfort is very good." Another said, "the home is nice and clean." Our observations confirmed this. The home had received an annual environment health inspection. The detailed 'excellent standards throughout and up to date records.' The home had an infection control policy and all staff had received training in infection prevention and control.

The home conducted monthly accident and near miss audits. This meant that the home could identify potential patterns to prevent more serious incidents occurring in the future. Outcomes were shared with staff in team meetings and supervision to embed learning. During the cold weather at the beginning of the year the home had experienced a problem with its hot water boiler. The home arranged for engineers to attend and this issue had been resolved. People confirmed that they had been aware of problems with the boiler but that action had been taken to fix this.

Good

Is the service effective?

Our findings

People's needs and choices were assessed. This included aspects of their lives that made them individuals. These were acknowledged, respected and supported. People were assigned a named carer on moving in so that they could get to know their background, important past events and their experiences. Staff had knowledge of the people living there and viewed them as individuals. This meant that they were able to provide personalised care and more meaningful interaction. We observed staff and people talking enthusiastically and sharing stories. We observed a new resident being introduced to a person that had lived at the home longer. They immediately started chatting and were seen later on during the inspection sat together. The staff member had supported this person to settle in and both to make new friends. Staff practice was underpinned by a policy of 'giving people all the information they need to help them make a sound choice.' People were offered support in a way that enabled them to retain the abilities that they still had. One person said, "They allow me to do what I can do."

People were actively encouraged to live their lives how they wanted to live them. This included meeting people's preference for a shared room if this was their wish, respecting that they may want to lie in, and also helping them maintain their spiritual and religious interests. People were supported to attend spiritual and religious meetings and, if they were unable to attend in person, they were helped to attend virtually by use of an internet link. A relative said how important this had been for her family member explaining that it had "given them a lift to remain active in their faith." A church service at the home had recently been reinstated following the appointment of a new vicar in the area.

People felt staff were attentive to their specific needs. One person said, "I feel looked after…the staff are extraordinarily good." A relative said, "The staff here are brilliant…exceptional. They are aware of [name's] needs and adapt the care accordingly." Another relative said that when they mention to friends where their family member is living they respond "I'd put my [relative] there."

People were supported by staff who had regular training. One of the staff told us, "I have training that helps me feel confident [in supporting people] and they ask in supervision if I want any more training." Another staff member said, "I feel I have enough training. I was supported to redo safe handling of medicines training when I returned to the home." One person said, "It is good here. The staff are most excellent." Another person said, "The staff here have the skills." An external trainer was at the home on the first day of the inspection. This person told us that they were currently supporting six staff with their care apprenticeship. They said that the home was "keen on ensuring their staff are trained." Recent training had been provided in dementia awareness and learning disabilities.

Staff told us that they had regular supervision and records demonstrated that this was seen as an opportunity to acknowledge when they had been working well, to check on their well-being, and to improve their understanding of policies such as the MCA 2005 and the Deprivation of Liberty Safeguards (DoLS). One record noted, '[Name] is an excellent carer and nothing is too much trouble for them. They are a real team player and an asset to [the home].' People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and

legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). For a person that required DoLS we saw that it had been applied for and authorised. A review date had also been set.

People were supported to have a balanced and varied diet. We saw people being offered choice and support in accordance with their assessed needs and preferences. This included where people had complex needs such as swallowing problems. Pictures of food and drink were used when people needed extra support to make choices.

Most people expressed satisfaction with the food and drink at the home. One person said, "The food is fine…." Two relatives said, "[Name] loves the food and the variety" and "[Name] enjoys the food – there are choices on the day and [name] likes the type of food they cook." One person said they liked some of the food but felt that the menu was "a bit repetitive with every Friday being fish day." Other people said they liked the fact that they knew what the menu would be on a particular day. We spoke with two of the cooks. One told us that people were always offered alternatives if they wanted something different to what was on the menu. The other confirmed this approach when stating "If [people] want it I can get it. It's their home."

People who chose to eat in their rooms were supported to do that. People said they had choice over what they ate and drank and could change their mind or ask for as much or as little as they wanted. People had said that they wanted gravy boats on the table rather than having gravy put on meals in the kitchen and this request had been accommodated.

Meal times were relaxed, social occasions with people chatting freely with each other and the attentive staff. One person was heard joking with staff that her peaches had "too many legs" as she was chasing it around her dish. A staff member quickly brought a fork so the person could "catch it."

People were supported to maintain their health and wellbeing. This included support to attend routine appointments (for example opticians or audiology), support with particular needs and in response to acute illness. A health professional said that staff at the home were "very knowledgeable about the people living there." This professional added, "They treat everybody as individuals and they are quickly on the phone if they have concerns. The staff are very good here [and] update us on changes." Another health professional who visits the home weekly told us, "This is a great home. The staff are very receptive to ideas. They take on board advice." One relative told us that the staff had been "wonderful" in liaising with relevant health professionals to help ensure their family member's health and quality of life.

One of the two lounges had a shop area including a retro till. This had been built in response to a request from people living at the home. A relative told us, "The facilities here are good." People's rooms had been personalised according to their tastes. One person said, "I like my room. It is nice and bright." People had objects and furniture in their rooms that acknowledged their individuality and made them feel settled. For some people with dementia this had created familiarity, reassurance and positively affirmed what they had achieved in their life. We saw staff using objects important to people when chatting with them in their rooms.

Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people living there. The MCA 2005 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.

Staff had received training to understand their responsibilities under the MCA and DoLS and were able to confidently tell us how they sought consent and worked in people's best interests. Staff understood the principles of the Mental Capacity Act 2005 and how it applied to the people living at Primrose Lodge. They were able to tell us when and who they would involve if a person lacked capacity. Where people lacked capacity best interest decision meetings had been held with relevant people including the person, staff familiar to them, relatives and health professionals such as a community mental health nurse. Alternatively, when people were assessed as having mental capacity they were encouraged to make their own decisions. At handover we heard staff being informed that a person with mental capacity had declined examination from a district nurse. This decision was respected as the person understood and accepted the increased risk this posed to their health.

Records showed, and people confirmed, that they were consulted about decisions affecting their day to day life. One person said, "the staff always ask for my permission before they do something." People's care plans included signed records detailing examples of consent being sought to provide support with personal care, assistance with medicines and the use of specialist equipment such as air mattresses.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people required these safeguards they had been put in place and review dates were scheduled. On occasions when people were at immediate risk because of their lack of mental capacity the home had responded in a timely way by making urgent applications for a DoLS alongside considering other practical measures to keep the person safe.

Good

Is the service caring?

Our findings

People were supported by staff who were consistently kind and respectful. Staff were patient and addressed people with their preferred name. One person said the best thing for them was that the staff were "very relaxed and easy to get on with." Another person said she was "surprised" how easily she had settled in and been accepted. Relative comments included, "The interactions between staff and people are "brilliant", "I'd like to be here if I had to go into a home. You don't find places like this" and "They are caring, lovely staff. We're really pleased with the home. I said to my [relative] if I need to go into a home I want to go there." With regards emotional support one relative said, "Because [name's] memory is bad [name] would become confused and worried, but here there is always someone to reassure [name] and help if necessary."

People were consulted with about the care they received and were actively encouraged to express their views as individuals and collectively at regular residents meetings. People were supported to make decisions about things that could effect their health, well-being and quality of life. This included what they wanted to eat or drink, what they wanted to wear, and who and how they wished to spend their day. One person said, "I can choose what time I get up – it's not a problem." Another person's care plan noted the colour of clothing that they liked to avoid wearing. We saw that this person was wearing clothing of colours acceptable to them during our inspection. We observed a staff member consulting with a person to get their drink exactly how they wanted it. One person said, "I am involved in my care plan" while another told us, "My care plan was reviewed recently and I was involved in that and the GP always comes round on a Tuesday and if we want we can ask to see her and she will see me in my room." This demonstrated that people were actively involved and influenced the care they received. The home had recognised that entries within electronic care records needed to become more personalised with less use of pre-set phrases. Staff were receiving training to make this improvement.

People's privacy and dignity was maintained by staff. One relative expressed happiness that her family member's aromatherapy and hair dressing sessions had made them "feel good about themselves." Relatives also told us that people's individuality was respected. One said they liked the fact that the home had "accommodated that [name] liked [their] own space. The staff always gave [name] the choice. They upheld [name's] dignity and privacy more than you could imagine." Another relative said, "they respected that [name] was not a person who wanted to join in. They supported [name's] independence. They are good at that."

Records were stored safely and access to information on computers was password protected. Staff understood the importance of keeping's people's private information safe. Management staff were booked to attend training on the new General Data Protection Regulation. This is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union. This means that people at the home will have more say over the information that the home holds about them.

Good

Is the service responsive?

Our findings

People had thorough pre-assessments that supported their move into the home and provided a starting point for staff to know their needs, skills, likes and dislikes. The home held regular meetings with people who lived there. The minutes for the most recent meeting noted that there had been 16 participants and that there had been agreement there was 'a good variety of activities' available for people to do. This was confirmed by people living at the home and their relatives. People and their relatives were fully involved in care planning before and after they had moved to the home. Care plans were personalised, well organised and regularly reviewed.

The home had a varied programme of group and individual activities. Relatives confirmed this with one saying, "There is so much going on to stimulate the [people living here]." People told us that, following feedback, there had been a move towards more frequent activities with fewer participants to help improve interactions. Activities included an art class, trips out supported by staff and the home's 20 volunteers,1:1 pamper sessions, and crafting. The home benefited from having an enthusiastic activities lead. One relative said that this staff member was "wonderful and very much involves people." We observed this during an afternoon activity attended by eight people. Each person was encouraged to participate as much or as little as they wanted. The activity produced lots of laughter, easy banter and friendly interaction.

People lived within an environment that had been made to look and feel homely. There were reminiscence areas which were used to stimulate memories and act as a point of conversation. The home had used colour around the home to meet the needs of people who were living with dementia. This made it easier for people with this condition to orientate themselves. Many of the walls around the home portrayed artwork that people had painted. These paintings were the result of the popular Monday morning art class and could be purchased. This served to celebrate people's skills and help to reinforce the fact that this was their home. One relative told us that she had bought her family member's painting and now had it displayed at home.

People were encouraged to maintain relationships with their family and friends. Relatives consistently told us that they were made to feel welcome and were invited to social activities. A relative said, "I feel welcomed. I am never made to feel as though I'm just a visitor. It is fair to say it is a community [here]." One relative told us that a staff member "had recognised a post on a [social media] group, told us about it and now we are in regular contact with a relative [abroad]. On the same theme another relative said, "If I want I can [contact my relative via social media] to settle [name] though [name] doesn't need much of that now!"

The home had developed community links including arranging visits from a local school on seasonal occasions. People told us they enjoyed the visits. This had created opportunities for cross-generational activities and awareness.

The Accessible Information Standard [AIS] is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff knew people well and communicated with them in ways they understood. Each person's care plan detailed their communication methods and how best to speak with them. The management had arranged for staff to

receive training in Makaton. This is the use of signs and symbols to help people communicate. This meant that staff could communicate more effectively with the people living at the home who had a learning disability. People with a learning disability had communication passports and hospital passports to help hospital staff to understand and respond to their needs.

Relatives expressed satisfaction with the home and the care provided to their family members. Comments had been captured in a compliments log which included, 'I loved the homely feel to the home and have treasured memories with my visits there', '[Name] misses you all very much and wishes [name] could return and enjoy your company once again' and 'we were so pleased to have chosen Primrose Lodge for [name's] home. It has been an absolute first choice in every way.' The home had a complaints policy and tracked all complaints from submission to resolution. All had been resolved within 4 days. One relative said, "if you have a concern they will stop there and then and deal with it until you are happy or agree a way forward."

Staff knew how to meet people's end of life care needs. A local GP told us that they felt the home managed this "very well." They added their view that people, at this stage of their lives, "will die here with dignity and be supported in the most amazing way." One relative, whose family member had recently passed away said, "I can't speak highly enough of the staff. The care was outstanding. By good fortune we chose this home for [name]. I would give them full marks out of 10." Another relative told us that staff had attended their family member's funeral and arranged for the wake to take place at the home after the service. Some people had made advance decisions (these are sometimes known as an advance decision to refuse treatment, an ADRT, or a living will). This is a decision a person can make now to refuse a specific type of treatment at some time in the future. Staff were aware of who had made an advance decision and what the individual wanted to happen.

Good

Is the service well-led?

Our findings

People were supported by staff who were happy working at the home and worked well together. The vision was of creating and maintaining a people and relative-led service supported by a wider 'community' consisting of the staff and visiting health professionals. There was an open and inclusive culture within the home. Staff were encouraged to submit suggestions and questions to be considered at future meetings. The deputy manager said, "if the [people] are happy [then] we're doing our job right. We just want to take the home further and further if that's what the people want." Staff comments included, "It's fun here. We always work as a team and I feel supported", "It's a happy home. My colleagues are great. I'd give it 10/10 here. It's a great atmosphere" and "It feels like a home. It feels right here. I can't imagine working anywhere else." Relatives also touched on this when telling us, "There is a family atmosphere", "[Name's] in a happy place… there is a nice feel to this [home]" and "If people are striving to get in [Primrose Lodge] there must be something good [happening] there."

The management demonstrated a solid understanding of CQC requirements including the type of events or incidents that we need to be informed of and where the Duty of Candour applies. This is when a provider is required to act in an open and transparent way by writing to a person, or the person or body who has the legal authority to act on their behalf, and apologise when a suspected or actual reportable incident has occurred with a person's care or treatment. They must provide an account of how it happened, investigate the incident and provide all reasonable support in relation to the incident.

Relatives felt that the management team kept them informed and knew their roles well. Comments included, "The managers are on the ball here. When I had a problem they solved it. When I had any questions they answered them" and "[The management] are very helpful and let me know if anything happens to [name]." Staff expressed, "I think the management listen. I've never had a problem" and, "If I have any problems I see the registered manager or deputy manager. They always listen."

Staff and relatives told us communication with management was excellent. One relative said, "Management are always around and will do anything to help – they go over and above all the time." Another relative told us, "[the registered manager] arranged for us to meet with some residents before [name] moved in. This gave us a good idea of whether the home was going to be okay for [name]. Staff commented, "We can freely relay problems. They guide us in how we can improve our practice" and "We have good discussions and managers take things on board." Records confirmed this open and receptive approach with one supervision detailing, 'The door is always open if you have any concerns. Just let me know.' The most recent quarterly staff meeting was attended by 21 staff. At this meeting the registered manager reminded staff that they 'always want to hear their ideas and views and to ensure they feel supported in the home.' The meeting ended with staff being told that they 'are appreciated' and giving them 'thanks for all [they] do for the [people] in [their] care.'

New people to the home received a welcome letter from The Friends of Primrose Lodge. This is a group made up of relatives of people who live or had lived at the home. There were posters and leaflets around the home inviting people and relatives to come along to the next meeting. One relative told us they had recently

joined the group. They said they now felt part of "one big family. We get to know other relatives of people living here." There was no pressure to join the group. One relative said, "you can get involved or not get involved." Notes from a peoples meeting detailed that they had been asked to 'come up with ideas' for a mission statement for the home. This would tell people and visitors 'what the home is about.' The home told us they are planning to include people in the staff recruitment process.

The home regularly sought peoples', relatives' and friends' views. In their most recent survey responses people had rated the service provided at the home as either good or excellent. One person had stated 'nowhere is like home but this is the next best thing.' Another expressed their view that 'the home is under excellent management.'

The home was focused on recognising what they do well and areas for improvement. This included a pro-active initiative where the home used an outside consultant to conduct periodic inspections and audits in order to understand if they were on course in meeting CQC's five key questions (is the service safe, effective, caring, responsive and well-led). In addition the home had produced a development issues and master action plan. This included reviewing accident/incident trend analysis, introducing an activities enjoyment engagement scale and updating electronic care notes so they were more person centred.

One relative expressed their view that the home was "way above others due to the registered manager and deputy manager. In essence they have created a community here." They added, "I think the registered manager is an exceptional leader. [This person] is good at managing change." An example of this was the successful integration of a number of people with a learning disability into the home. We observed how included these people were by staff and the other people they lived with. Management had invested in additional staff training so that they were able to meet these people's specific communication needs. The monthly team managers brief and team leaders meetings had been used to improve staff understanding on the core principles underpinning dignity in the adult social care sector and new safeguarding guidance in relation to pressure care.

There were good working relationships with outside agencies including a local surgery, a district nursing team and a training organisation. Staff linked with the local district nursing team twice a week to improve their help improve their understanding and knowledge of pressure care. A GP visited the home weekly as part of a local surgery's pro-active in-reach service to keep people well for longer and prevent unnecessary hospital admissions. This GP said, "The managers are good at liasing with me" before adding "this is one of the best homes I come to."