The Green Nursing Homes Limited

The Callywhite Care Home

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 inspection was unannounced and took place on the 12 May 2017. This was the first inspection following our registration of the services under the Health and Social Care Act in March 2017. The Callywhite Care Home provides accommodation and personal care for up to 39 older adults, which may include some people living with dementia. At the time of our visit, there were 34 people living at the service.

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

People received care in a clean, safe and well maintained environment. Any equipment used for people's care was routinely serviced and maintained up to date. Planning and contingency arrangements helped to ensure people's safety in the event of a foreseeable emergency.

Staff understood and followed nationally recognised practice principles to help protect people from the risk of infection through cross contamination when they provided people's care.

People's medicines were safely managed. Known risks to people's safety from their health condition or environment were assessed before they received care and regularly reviewed. This helped to consistently inform people's care and related safety requirements, which staff understood and followed.

The provider's arrangements for staff recruitment and deployment helped to ensure people were protected from the risk of harm and abuse. Staff were visible, available and provided people with prompt care and assistance when needed.

Overall people and relatives were happy with the care and meals provided. Staff supported people to maintain their health and nutrition. This was done in consultation with external health professionals and staff followed their instructions for people's care when required.

People received care from staff who mostly understood their health conditions and related personal care requirements. This was provided by staff who were well supervised and mostly received the training they needed to ensure this. Additional staff training and competency measures together with care planning improvements in progress helped to fully ensure this.

People were provided with care in line with legislation and guidance in relation to consent. People's consent or appropriate authorisation for their care was obtained when required. This helped to ensure people's rights and best interests.

People received care from staff who were kind and caring. Staff treated people with respect and ensured

their dignity, comfort, rights and independence in their care.

People received individualised care from staff who knew them well. Staff knew people well and had established positive relationships with people and their relatives.

People and relatives were regularly informed and involved in home life and to help agree people's care and daily living arrangements. Care planning improvements either planned or progress helped to further info people's care in this way.

Staff took time and communicated with people in a way that was meaningful to them. Staff understood and followed what was important to people for their care and responded promptly when people needed assistance.

People were supported to engage in social and leisure activities of their choice, within and outside the home. Changes and improvements were made or planned from people's views about this.

Environmental adaptations enabled people's mobility, orientation and often their recognition within their surroundings when required. Aids and arrangements to enable people's recognition and choice at mealtimes; and to promote relatives understanding of people's experience of life with dementia, was either agreed or planned.

People were informed and confident to raise a concern or make a complaint if they needed to. The provider regularly took account of people's views, comments and any complains about their care to help inform any improvements needed.

The service was well managed and run by a visible, approachable registered manager. People, relatives and staff were confident the management of the service.

Staff were motivated and enthusiastic to provide care in a way that ensure people's rights and best interests. Staff understood their roles and responsibilities and were informed and supported to raise any concerns they may have about people's care if they needed to.

Management arrangements for the quality and safety of people's care helped to ensure accountability and improvement when required.

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. People received safe care and support from sufficient staff. The provider's arrangements for people's care, equipment, environment and medicines helped to protect people from the risk of harm or abuse.

Is the service effective?

Good

The service was effective. People were supported to maintain and improve their health and nutrition by staff, in consultation with external health professionals when required. Staff mostly understood people's health conditions and related personal care requirements. Additional staff training and competency measures helped to fully ensure this. Staff followed the law to obtain people's consent or appropriate authorisation for their care and to provide care in people's best interests when required.

Is the service caring?

Good

The service was caring. People received care from staff who understood and promoted their dignity, comfort, rights and independence in care. Staff were kind, caring and respectful; they knew people well and how to communicate with them. People and relatives were often informed, involved and consulted to help communicate and agree people's care. Care planning improvements either planned or in progress helped to further ensure this.

Is the service responsive?

Good

The service was responsive. People received individualised and timely care. Staff knew people well and ensured people's inclusion and engagement in home, family and community life. Thought was given to people's experience of their health

condition, which helped to ensure the provision of relevant aids and adaptations for people's independence and orientation. People and their families were informed and confident to raise concerns or make a complaint. Their views were regularly sought and used to make care and service improvements when required.

Is the service well-led?

Good

The service was well led. The service was generally well-managed and run. Staff were motivated, engaged and understood their role and responsibilities for people's care. Management met their legal obligations and made regular checks of the quality and safety of people's care, which helped to ensure accountability and continuous improvement.

The Callywhite Care Home

Detailed findings

Background to this inspection

We carried out this inspection on 12 May 2017 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.

Our visit was unannounced and the inspection team consisted of an 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 service.

Before this 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. We also spoke with local community professionals and care commissioners and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

During our inspection we spoke with 10 people who lived at the home and four relatives. We spoke with 5 care staff, including two senior, an activities co-ordinator and a cook. We also spoke with the registered manager and the provider. We looked at four people's care records and other records relating to how the home was managed. For example, medicines records, meeting minutes and checks of quality and safety.

As some people were living with dementia at the service, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us

Good

Is the service safe?

Our findings

People, relatives and staff told us they thought the home was safe and overall felt people were safe there. One person said, "Staff are very good; they are very careful if they help me to stand up." Another said, "This is a very safe place; my family are happy that I am well looked after." A relative told us, "Yes, this is a lovely place; [relative] can get confused and think they are at work; but staff keep an eye on where [relative] is going; it's very reassuring."

Information was visibly displayed, which informed people, relatives and staff how to keep people safe and how to recognise abuse. This included information about what to do if they witnessed or suspected the abuse of any person receiving care. Staff knew how to recognise and report abuse and the provider's training and procedural arrangements supported them to do so. This helped to protect people from the risk of harm and abuse

People received care that took account of known risks to their safety. We observed staff supported people safely when they provided care. For example, supporting people to take their medicines, to eat and drink and to move safely. People's care plan records showed that potential or known risks to their safety associated with the health condition or environment were identified before they received care. People's care plans mostly accurately showed how those risks were being managed and reviewed, which staff followed. For example, risks from falls, pressure sores or poor nutrition. Management plans showed that related record keeping improvements had commenced to help fully ensure this.

People and relatives said the home was well maintained, clean and hygienic, which we also observed. One person said, "It's very good; my bed is always kept clean." A relative said, "It's really good here; everything is always very clean."

We observed that staff wore the correct type of personal protective clothing (PPE) such as disposable gloves and aprons when required. For example, when staff handled waste products or for food handling and hygiene purposes. Hand sanitiser and hand washing equipment was suitably located around the home together with laminated instructions to ensure correct use. This helped to protect people from the risk of infection through cross contamination.

Records showed that safety checks and the required servicing and maintenance of equipment in the home were regularly undertaken. For example, checks and maintenance of hoist equipment used to help people to move and checks of hot and cold water temperatures. Emergency plans were in place for staff to follow in the event of any unforeseen emergency in the home. This included for any event of a fire alarm. Routine fire safety checks were also regularly undertaken and recorded. Reports of recent visits from the local fire and environmental health authorities found satisfactory arrangements at the service for food hygiene and handling and for fire safety.

People's medicines were safely managed and people received their medicines when they needed them. People we spoke with said they received their medicines when they needed them. One person said, "Staff

make sure I take the tablets and have some water to drink with them." Another person told us, "The always bring me my tablets in the morning, lunchtime and at bedtime; so I don't have to worry about it." Records kept of medicines received into the home and given to people showed that they received their medicines in a safe and consistent way.

We observed staff responsible, giving people their medicines safely and in a way that met with recognised practice. For example, one person was prescribed medicines, which were given to them regularly and a pain relief medicine, to be given at the times they needed it. At lunchtime we observed that, staff took the person's regular medicines to them. They took time to check with the person if they needed any of their pain relief medicine and the reason for this. This helped to make sure the person received their medicines safely and for the reason they were prescribed.

Staff told us about some people, who were not always able to ask for medicine when they needed it because of their health condition. Written care plan protocols were provided for each medicine that a person may need to be given in this way, which staff understood and followed. This helped to ensure people received their medicines consistently when they needed them

All staff responsible for people's medicines were provided with relevant training and information to support their role. This included an assessment of their individual competency and periodic training updates. Staff training records, the provider's medicines policy and related guidance supported this and helped to make sure people's medicines were safely managed.

People, relatives and staff felt that staffing levels were sufficient to provide people's care. One person said, "There's enough around to help." Another said, "I have waited for a drink when they are busy, but it doesn't happen often." Another said, "I've never had to complain about having to wait for help." A relative said, "There must be enough staff as [person] gets the care when [person] needs it."

Throughout our inspection we observed that staff, were visible and available when people needed assistance. Although staff seemed rushed when they served people's meals at lunchtime, we saw they provided people with timely assistance when they needed it. The registered manager told us their staff planning arrangements took account of people's dependency needs, staff absence and recruitment requirements to help inform staff deployment arrangements. Records showed recognised recruitment procedures were followed to check that staff, were fit to work in the home before they commenced their employment. This helped to ensure sufficient and safe staffing arrangements for people's care.

Good

Is the service effective?

Our findings

People and relatives were satisfied with the care provided. All felt that people's health needs were being consistently met by staff who knew them well. People said they were supported to see their own doctor if they needed to and the district nurse who provided for their nursing care if required. One person said, "Fantastic staff – well looked after." A relative said, "From what I've seen, the staff here are really good." Another relative told us, "What we really like is that there is good staff continuity." They explained this was important for the person who was living with dementia, because it provided a consistent approach to the person's care from staff who understood them and their related care requirements."

People were supported to maintain and improve their health and nutrition. People were supported to see their own GP and other health and social care professionals when they needed to. This included the arrangements for people's routine and specialist health screening, such as optical care or diabetic health screening. People's care plan records reflected this and showed that staff followed relevant instructions from external health professionals when required. For example, in relation to people's nutritional needs and particular dietary requirements.

Staff mostly knew people's personal care requirements relating to their health conditions and people's care records often provided information about their health conditions and related care and support needs. However, staff's knowledge about important aspects of two people's health conditions and their related personal care requirements was variable. Related instructions and information from external health care professionals was difficult to find in both people's care folders because it was not translated into a clear written care plan for staff to follow when required. For example, in relation to specified dietary or fluid intake requirements. This meant there was a risk to people from this of receiving inappropriate or ineffective care. We discussed our findings with the registered manager and provider who told us about their action to address this, which helped to reduce that risk. Their introduction of a revised electronic care planning system had commenced along with related staff training, with an identified timescale for completion. This aimed to ensure timely, accurate and concise care planning information for staff to follow for people's care.

People received sufficient meals and drinks, which they usually enjoyed. People and relatives were overall satisfied with the meals provided and their feedback about this was generally positive. One person told us, "I've no complaints about the food; they bring a menu so I can choose' there are two choices at lunchtime." Another said, "I like the food." A few people felt their meals were not always kept hot enough when they received them, mainly due to being served onto cold plates, which we observed and referred to the registered manager. However, people said they were regularly consulted about their meals, which mostly helped to ensure their satisfaction. Related records such as meeting minutes also showed this.

We observed that a choice of drinks and snacks were offered with and between meals and also provided at people's request Individual jugs of water or juices were offered in people's own rooms and regularly replenished to ensure freshness. Food menus provided showed a varied and balanced diet with a hot and cold choice at each mealtime. At lunchtime there was a sociable, calm atmosphere. The food looked appetising, was well presented and received by people who appeared to enjoy the mealtime experience.

Some people chose to eat in their own rooms and were supported by staff to do so. People were provided with the support they needed to eat and drink. We saw staff served different types and consistencies of foods to people, that met with their correct dietary requirements and related instructions from relevant health professionals.

Staff said they received the training, support and supervision they needed to provide people's care, which records mostly reflected. All staff were positive about the arrangements for their support. For example, one staff member said, "We are supported well, with regular one to one supervision; but if you need additional time, it's always made for you." Staff training records we looked at showed there were training gaps for some staff. However, a plan was identified to address this with dates for completion. This included subjects such as dementia care and delirium, infection control, positive behaviour support, care planning and understanding specified health conditions. Work had also commenced to introduce a recognised self-assessment competency tool to support staff induction procedures. This helped to assure staff competency to provide people's care.

Staff, were supported to achieve a recognised vocational care qualification. Most care staff had either achieved at least the minimum level of related training or higher and remaining newer staff were enrolled to commence this. The Care Certificate was recently introduced for new staff to complete. The Care Certificate identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to provide compassionate, safe and high quality care.

People were provided with care in line with legislation and guidance in relation to consent. 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.

We checked whether the service was working within the principles of the MCA. Staff had received training and they understood the basic principles of the MCA. People we spoke with said staff always asked for their permission before they provided care. One person said of staff, "Nobody does anything without asking first."

During our inspection we observed where possible, staff sought people's consent to their care; they offered choices and explained what they were going to do before they provided people's care. Initial assessments in some people's care records showed they were not always able to make important decisions about or consent to their care and treatment because of their health conditions. Staff we spoke with understood and were able to describe people's care requirements associated with their best interests. However, some people's care plan records did not always show how their mental capacity had been assessed for specific decisions about care that needed to be provided in their best interests. We discussed this with the registered manager who showed us their action plan in progress to fully ensure this, which they have since confirmed as completed.

People's care plans, relating to best interests decisions for their care, showed appropriate consultation with their relative and any relevant health professionals to help inform and ensure this. This included relevant information where people had others who were legally appointed to act or make important decisions on their behalf. For example, in relation to their health and welfare and/or finances.

Staff told us about some people whose care needed to be provided in a way that that continuously restricted their freedom but was necessary to keep them safe. This is known as a Deprivation of Liberty Safeguard (DoLS). Records showed the DoLS applications were made to the relevant local authority for formal authorisation where required. This helped to ensure people's rights and best interests in their care.

Good

Is the service caring?

Our findings

People and relatives said staff were kind, caring and felt they had good relationships with them. One person said, "They can't do enough for you; They are really kind.' Another said, "I am treated very well and am very happy here." A relative told us, "They're all lovely helpful staff."

We saw some written compliments were received from people and relatives about their care. General themes from this included regular reference to 'a lovely, homely atmosphere' and 'caring staff.' An online care homes survey conducted by Care Homes UK in April 17, found that seven relative respondents rated The Callywhite care home as either 'good' or 'excellent' and said they would be 'highly likely' to recommend the care home to friends and family. One of their comments posted stated, "I would like to say The Callywhite is second to none; I'd like to thank the staff, who through their caring at attitude and professionalism, transform the place into a true home."

Throughout our inspection we saw staff interacted and supported people in a kind, caring manner. Staff treated people with respect and ensured their dignity, rights and comfort when required. For example, staff noticed and provided timely assistance to one person who was uncomfortable in their wheelchair. The staff member helped the person to adjust themselves to a more comfortable position with the aid of a cushion, which they fetched from the person's room for them to use. The staff member also took time to check with person if they were happy, comfortable and had their drink to hand.

Staff took time with people to get to know them, their families and what was important to them. For example, we saw staff engaging in a conversation with one person about their life and where they had worked in the past. The staff member took time to listen and ask relevant questions to help the person recall their memories, which they visibly enjoyed.

People and relatives all confirmed that staff treated people with respect and ensured their dignity, privacy, choice and independence. For example, one person said, "I have my door open or shut as I want; staff always knock." Another person said, "I can shave and shower myself; they remind me when my hair needs cutting because I forget." A relative told us that staff always supported the person's right to private time with them when they visited the home.

Throughout our inspection we observed that staff interacted and supported people in a kind, caring and respectful manner. Staff were mindful of and ensured people's dignity and privacy when required. For example, they made sure that bathroom or bedroom doors were closed when they provided people's intimate personal care or offered napkins or aprons to people at mealtimes to protect their clothing from food spillages. We also observed that staff routines and visiting arrangements were flexible to ensure people's privacy and preferred daily living routines. For example, we saw domestic staff knocked on people's doors, checked with them whether or when people were happy for them to enter and clean in their bedrooms. Information such as polite discreet notices showed visitors, including external health and social care professionals that people's mealtimes were protected from any unnecessary interruption.

Staff we spoke with understood the importance of ensuring people's rights and choices when they provided care. This reflected the provider's written aims and values for people's care, which was stated in their service literature. For example, ensuring people's preferred daily living routines, such as rising and bed times, personal hygiene routines and how to and where to spend their time. Improvements were planned over the coming 12 months to agree advance care plans for people relating to their people's end of life care and wishes; to ensure this met with recent changes in nationally recognised guidance for this.

We found a relaxed and sociable atmosphere at the service, where staff, people receiving care and their visitors were at ease and friendly with each other. People's relatives told us they were able to visit the home at any time to suit the person receiving care and they were invited to join key social events and seasonal celebrations.

People and relatives were regularly informed and involved in home life and to help agree people's care. People's care was discussed with them and care plans showed any involvement of family and friends who were important to them. A range of key service information was visible and accessible to people in a dedicated area of the home. The registered manager advised this could be provided in alternative formats such as large print or other language if required to enable people's access. This included home life arrangements such as mealtimes, laundry, social and recreational activities. A staff photo board with names and roles of staff was also provided to help people and visitors to identify staff. People and relatives told us they were provided with the information they needed to help them to decide whether to live at the service.

Good

Is the service responsive?

Our findings

People received individualised care from staff who understood people's needs and preferences for their care and what was important to them. People and their relatives said that staff acted promptly if there were changes in people's health condition or general wellbeing and were kept informed about this. For example, one person told us about when they reported a health matter to staff and said, "They called the district nurse before it got any worse; they gave me cream to put on and it's all better now."

Staff knew people well, understood how to communicate with them and responded promptly when people needed assistance. For example, if people needed to move, eat and drink or if they were uncomfortable, anxious or upset. Staff told us about two people who often experienced difficulty communicating their needs verbally because of their health conditions. During the course of inspection we saw that staff often recognised how those people were feeling and how to support them when required. For example, staff knew that when one person moved in a certain way, they needed help to use the toilet. When this occurred, we saw staff responded in a timely and sensitive manner to support the person to do achieve this.

Staff told us about another person who sometimes became disorientated and upset if they couldn't remember where they were or what was happening around them. We saw when this occurred a staff member approached the person in a sensitive manner; spoke to them in way that showed understanding of how the person was feeling and where they thought they were. After a short while the staff member gently diverted the person's attention by suggesting they go and have a cup of tea together. This was done by gentle encouragement, which helped the person to become engaged in a positive task that was meaningful to them. The person responded and subsequently became visibly calmer, happier and more relaxed in their demeanour.

Staff felt it was important to spend time to get to know people well. One staff member said, "This is their home; we are here to support people in a way they know and prefer." Another said, "You can't help people in the best way if you don't about their lives, what they like and don't like and what's important to them." Staff told us they got to know people by talking with them and gathering information from them, their relatives or others who knew them well when required. We saw this information was recorded in a document in people's care plans entitled, 'This is Me,' which helped to inform people's care. For example, information about people's social and family histories, their known daily living preferences and routines and their individual likes and dislikes. Care planning improvements were also in progress to further inform people's care in this way.

People were supported to engage in home life and participate in activities and events they enjoyed, both in and outside the home. The arrangements for this were co-ordinated by two dedicated staff members known as activities co-ordinators who were supported by care staff when required. People said there was a range of activities they could join if they wished and any suggestions they made about this were usually taken on board. One person said, "It's great here; we do have a laugh and some good singers come in from time to time." Another said, "We do armchair exercises, which I enjoy; I call it our PE lesson."

During our inspection we saw people were supported to engage in a range of group or individual activities. For example, singalongs which included World War II music; a game of bingo and hand manicures. Another person regularly went out of the home to play Bridge at a local club, which they enjoyed. Staff told us some people had asked for more gardening activities and craft sessions; which was acted on and included provision of a gardening club and more plants for the balcony. One person said they had particularly enjoyed a sunflower growing competition.

People said they were supported to engage in seasonal or important events and celebrations and in spiritual worship as they chose. A summer fayre was planned with the involvement of people and relatives, who offered to make and sell items for the residents' social fundraising. Following recent requests from people for more trips out, a programme was organised to enable people to visit places of local interest and also the seaside. We were also told that young people from the local school come into the home to run information technology (IT) sessions to support people who wished to keep in contact with family and friends in this way.

We observed environmental adaptations helped to support people living with dementia or with sensory of physical disabilities. The registered manager advised us environmental design at the service followed recommendations made by Stirling University for people living with dementia. This helped to promote people's environmental orientation and recognition. For example, accessible memory boxes were built into the wall at the side of each person's bedroom door to help them to locate their own room. The boxes contained personal items that were meaningful to people; such as a personal or family photograph, a favourite ornament item of memorabilia or personal achievement award. Large faced clocks and contrasting colour schemes were also used to aid people's orientation at the service.

At lunchtime, people were provided with some aids to support their comfort and independence when required. For example, adapted drinking cups and crockery. However, food menus were not provided in any formats that may aid people living with dementia to recognise the meals offered. For example, picture menus. We discussed this with the registered manager and provider, who agreed address this. The registered manager also told us they were arranging a 'virtual dementia tour' through a recognised service provider. This is an inclusive approach to help inform and further staff and relatives understanding of people's experience of living with dementia.

People's views, comments and concerns about the service were routinely sought and usually acted on to make service improvements when required. People and relatives we spoke with were informed and confident to make a complaint about the service if they needed to. However, they all felt that any issues they raised were usually acted on to their satisfaction without the need to make a formal complaint. One person said, "I know how to speak up; if anything wasn't right I'd soon tell them; but at the moment I am quite happy." A relative told us, "There have been a few niggles we have had to ask them to put right; which they generally have."

Management records showed attempts to organise regular meetings with people and relatives to consult with them about home life and people's care and daily living arrangements. However, these had not been well attended. The registered manager told us they had arranged a further meeting at different times that may be more convenient to help increase relatives attendance. This information was also visibly displayed in the home.

Service improvements were usually made or planned as a result of people and relatives feedback. This included the provider's periodic care surveys with them. Recent examples included improvements to recreational and social activities arrangements, food menus and laundry arrangements. Results from the

most recent care survey conducted in December 2016 showed people and relatives were overall satisfied with the care provided and would recommend the service to family and friends.

Improvements were planned over the coming 12 months in relation to advance care plans relating to people's end of life care wishes and to ensure this met with recent changes in nationally recognised guidance for this.

Good

Is the service well-led?

Our findings

People, relatives and staff felt the service was well managed and led by the registered and deputy manager who were visible and approachable. One person said, "The manager is very good and the staff; they are all easy to talk to." A relative said, "I have no problems with the manager, her heart is in the right place." People and staff often referred to the ethos of the home as 'like a family." Staff comments also included, "It's100%; I love it here."

There were clear arrangements in place for the management and day to day running of the home. Records relating to people's care were safely stored. The provider regularly visited the home to check the quality and safety of people's care and they were present for part of our inspection. They had kept us informed about important events that had occurred at the service by sending us sent us written notifications when required.

Management and staff were open in their discussions with us and gave consistent information about what they did well, care improvements either made, planned or in progress. This demonstrated to us that staff were committed to providing a good standard of care. Staff often told us they 'loved' or 'really enjoyed' working at the service. Their expressed views showed they understood the importance of ensuring people's rights when they provided care, which reflected the provider's stated aims and values for people's care. One staff member said, "I feel really motivated; I've worked elsewhere and can't believe the care expected – people matter here – a good standard is instilled by management and the provider."

Staff understood their roles and responsibilities for people's care. For example, they understood how to raise concerns or communicate any changes in people's needs. This included, reporting accidents, incidents and safeguarding concerns. The provider's procedures, which included a whistle blowing procedure, helped them to do this. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their rights and how to raise serious concerns about people's care if they needed to.

The registered manager described comprehensive arrangements for regularly checking the quality and safety of people's care. For example, checks of people's medicines, care plans and the environment and equipment used for people's care. Regular checks were also undertaken of people's health status and their related safety needs for their personal care. Related records showed that the findings from this were used to inform and plan care improvements when required. This meant that improvements to care planning and related consent arrangements were assured.

Accidents, incidents and complaints were regularly monitored and analysed. This helped to identify any trends or patterns and was often used to inform any changes that may be needed to improve people's care. Staff confirmed that they were instructed about any changes that were needed to improve people's care, in staff group and one to one meetings, which records mostly showed.

There were clear arrangements in place for the management and day to day running of the home. Records relating to people's care were safely stored. The provider regularly visited the home to check the quality and

safety of people's care and they were present for part of our inspection. They had kept us informed about important events that had occurred at the service by sending us sent us written notifications when required. The provider's arrangements showed they continuously sought ways to improve and enhance people's care experience.