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Littlebourne House Residential Care Home

Inspection report

Littlebourne House Residential Care Home
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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 took place on 1 and 2 August 2017 and was unannounced.

Littlebourne House Residential Home provides personal care and accommodation for up to 64 adults. Accommodation is flexible with a detached house with a new extension for 42 people, a separate detached house, the King William for 18 people and four one bedroom self-contained flats. At the time of the inspection 64 were living at the service.

There was a registered manager working at the 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 and associated Regulations about how the service is run.

We last inspected this service in August 2016. We found shortfalls in the service. The provider did not have sufficient guidance for staff to follow to show how risks were mitigated to keep people living with diabetes, epilepsy and behaviours that challenge as safe as possible. Staff were not recruited safely. The service had not been working within the principles of the Mental Capacity Act 2005. There was a lack of oversight of the service, there were no quality assurance systems in place to monitor and drive improvements within the service. Staff had not received training appropriate for their role, staff were not deployed effectively to meet people's needs.

We asked the provider to provide an action plan to explain how they are going to make improvements to the service. At this inspection we found that improvements had been made.

At the last inspection, there were no detailed guidelines for staff to mitigate risks to people and keep them safe. Improvements had been made. There were risk assessments in place to identify potential risks to people's health and safety. The risk assessments gave staff detailed guidance to mitigate risks to individuals living with diabetes, epilepsy and behaviours that may challenge. Accidents and incidents were analysed for trends and action had been taken to prevent them from happening again.

Improvements had been made in the recruitment of staff and their development. Staff were recruited safely and received training to perform their roles. Staff received supervisions and appraisals to discuss their development. There were sufficient numbers of staff. The provider had reviewed the deployment of staff, as recommended at the last inspection, to meet people's needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At the last inspection, staff had not received training about MCA and were not working within the principles of the Act and DoLS applications had not been made when appropriate. Improvements had been made at this inspection. Staff had received training and were aware of their responsibilities under MCA. Appropriate DoLS applications had been made and some had been authorised.

At the previous inspection, there were no effective systems in place to assess and monitor the quality of the service provided. There were no formal checks to ensure that all records were up to date. Care plans and assessments had not been consistently reviewed. Improvements had been made, care plans and assessments were reviewed monthly and before if needed. There was now a system in place to check the quality of the service, shortfalls had been identified and action plans had been put in place to rectify the shortfall.

People told us that they felt safe living at Littlebourne House. Staff knew how to keep people safe from abuse. Staff were confident that if they had any concerns they would be addressed quickly by the registered manager. People received their medicines safely and on time.

People enjoyed a choice of healthy meals and told us they had enough to eat and drink. Relatives were able to eat with their loved ones. People's health was assessed and monitored. Staff took prompt action when they noticed any changes or a decline in health. Staff worked closely with health professionals and followed guidance given to them to ensure people received safe and effective care.

People said they were happy living at the service and that their privacy and dignity were respected. Staff spoke with and engaged with people in a kind, caring and compassionate way. People, when able, were involved in the planning of their care and support and told us that care was provided in the way they chose. People's confidentiality was respected and their records were stored securely.

Each person had a care plan that contained details of their choices and preferences, and how they wanted their support to be provided. People's religious and cultural needs were recorded and respected.

Staff supported people to maintain friendships and relationships. People's friends and family could visit when they wanted and there were no restrictions on the time of day. People were encouraged to be as independent as possible.

There was a range of activities and outings available to people, staff including the activities co-ordinator spent time with people on a one to one basis.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy. Resident and staff meetings were held so that suggestions about improvements could be made. The management team had implemented suggestions made at the meetings. Quality assurance surveys had been sent to people, staff and stakeholders such as GP's and the results were being analysed.

People spoke positively about how the service was run. The management team were visible and people were comfortable with them. People and staff told us the management team were very approachable and supportive. The management team and staff understood their roles and responsibilities and shared a vision for the service.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had

submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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.

Risks to people were assessed and there was guidance for staff on how to reduce risks. Staff knew how to keep people safe and how to recognise and respond to abuse.

People received their medicines safely and on time. Medicines were stored and managed safely.

There were enough staff to meet people's needs. Staff were recruited safely.

Is the service effective?

Good

The service was effective.

Staff completed regular training, had one to one meetings and an annual appraisal to discuss their personal development.

People were supported to make decisions. Staff understood the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People's health was assessed, monitored and reviewed. Staff worked with health professionals to make sure people's health care needs were met.

People had enough to eat and drink and enjoyed a choice of meals.

Is the service caring?

Good

The service was caring.

Staff were friendly, compassionate and kind. They promoted people's dignity and treated them and their relatives with respect.

Staff knew people well. Including their likes, dislikes and life histories. They knew how people preferred to be supported.

People's confidentiality was respected and their records were stored securely.

Is the service responsive?

Good

The service was responsive.

Each person had a care plan which centred on them and their wishes. People told us they had been involved in planning their care. Care plans were regularly reviewed.

There was a programme of activities available to people.

People knew how to complain. Complaints received had been responded to and resolved in a timely manner.

Is the service well-led?

Good

The service was well led.

People, relatives and staff were asked their views on the quality of the service provided.

There was an open and transparent culture. People, relatives and staff were encouraged to make suggestions to improve the service.

Regular, effective audits were completed. Actions were taken when shortfalls were identified.

Notifications had been submitted to the Care Quality Commission in line with guidance.

Littlebourne House Residential Care Home

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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 2 August 2017 and was unannounced. The inspection was carried out by one inspector and an expert by experience who spoke with people who used the service, families and relatives. Our expert by experience had knowledge and understanding of residential services or caring for someone who uses this type of care services.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law.

We spoke with 11 people who use the service. Conversations took place in people's rooms and communal rooms. We observed how staff interacted with people when supporting them. We 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 to us.

We spoke with four relatives who were visiting people, the registered manager, training manager, administration manager, the provider and seven staff. We spoke with two health professionals who visit the service.

We reviewed records including ten people's care records, which included care plans, health records, risk assessments and daily care records. We looked at four staff files, audits, quality assurance, staff rotas and

policies and procedures.

The previous inspection was carried out in August 2016. There were five breaches of regulations identified at this inspection.

Good

Is the service safe?

Our findings

People felt safe living at the service. One person told us, "I feel safe here as I know staff will help me." Another commented, "They make sure I am as safe as possible."

At the last inspection in August 2016, the provider did not have sufficient guidance for staff to follow to show how to mitigate risk to people living with diabetes, dementia, and epilepsy. The provider had introduced an electronic care plan system called Care Management System (CMS) in February 2016 and risk assessments were not person specific.

At this inspection records had been reviewed and risk assessments contained detailed guidance for staff to mitigate risks to people's health and safety. For example, people who were living with epilepsy, risk assessments contained information about what the seizure may look like, what action to take to keep the person safe and when to call for medical assistance. One risk assessment explained that the person had not had a seizure since 2006 and information about what the seizure may look like had been given by the family. Another person had recently experienced seizures, staff had provided support as detailed in the risk assessment and this had been effective.

Risk assessments for people living with diabetes contained details about the signs and symptoms of high and low blood sugar. Staff had guidance about the action to take if the person had high or low blood sugar, with timescales for staff to follow. For example, 'If blood sugar below 4 mmols give 125mls of Lucozade. Recheck in 15 minutes if above 4 mmols give a carbohydrate snack. If not give more Lucozade and ring for medical assistance. If above 20 mmols encourage fluids and check again after 30minutes.'

Staff knew about people's risks and health needs. They were able to explain how they would support people with their health needs. Staff told us if they felt people's needs had changed the registered manager would assess the person and review the risk assessment. People who needed support with mobility were assessed by occupational therapists to ensure that the correct equipment was in place. This had been recorded in the risk assessments and staff knew what equipment people needed to mobilise and be transferred safely.

Accidents and incidents had been recorded and analysed. When trends and patterns had been identified action had been taken to reduce the risk of them happening again. One person had slipped from their wheelchair twice while watching television in their room. The registered manager had discussed this with the person and it was agreed that they would sit on the bed instead. The person told us that they were happy with this as they were now safe.

At the last inspection staff had not always been recruited safely. At this inspection improvements had been made. Recruitment files for staff recently employed had an application form, references, full employment history, job description, photo identification and interview questions. Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were sufficient staff on duty to care for people and meet their needs. There were systems in place to provide cover for sickness and annual leave. At the last inspection we recommended that the registered manager sought guidance about the deployment of staff within a care home.

At this inspection a review of the deployment of staff had been completed. Previously, two staff were providing support to people in the King William house, when medicines were being administered there was only one member of staff available to support people. The administration manager told us that a staff member from the main house went to King William at each medicines round to support people. Staff confirmed that staff from the main house did support people in King William during the medicines rounds and we observed this during the inspection.

People were protected from the risks of abuse. Staff knew what to do if they suspected any incidents of abuse. The provider had systems in place, including policies and procedures, for staff to refer to. Staff told us they were confident they could speak to the registered manager if they had a concern and that they would be listened to and action would be taken. The management team knew what should be reported in line with current guidelines. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner.

People were supported to take their medicines safely and on time. Staff were trained in how to manage medicines safely and their competence to do so was regularly checked. Medicines were stored, managed and disposed of safely. Temperatures in the medicines room and fridge were checked each day to make sure medicines were stored at the correct temperature for them to remain effective. Some medicines were prescribed on an 'as and when' basis, such as pain relief. There were guidelines in place for each medicine, to ensure that staff knew how and when to give these medicines.

People were encouraged to be as independent as possible with their medicines. Some people had asked for their medicines to be left with them and not to be watched by staff when taking them. These people had capacity to make this decision. The request had been recorded in the person's care plan and risk assessment completed with guidance about how to check that the person had taken their medicines. Staff had recorded that they had handed the person the medicines but had not recorded that they had checked the person had taken their medicines. People confirmed that staff checked they had taken the medicines but there was no record of this. This was an area for improvement.

Checks had been completed on the environment and equipment used by staff and people. A fire risk assessment had been completed by an outside contractor. The risk assessment had identified improvements that needed to be made. There was an action plan in place, with timescales, some improvements had already been completed. Further work was being completed at the time of the inspection. Fire drills had been completed and been used as a learning opportunity for management and staff.

There was a plan in place for staff to use in the event of an emergency. Each person had a personal emergency evacuation plan (PEEP), this details people's physical and communication needs, so that they could be safely evacuated in an emergency.

Good

Is the service effective?

Our findings

People told us that staff supported them when they needed them. People had confidence in the staff and told us they knew them well. People enjoyed the food, one person told us, "The food is excellent."

At the last inspection, staff had not received appropriate training and support to develop their skills to enable them to perform their role. At this inspection, improvements had been made. The service had a training manager in post, they were responsible for ensuring staff received training appropriate to their role. The training manager had completed training to be able to train staff and certify them as competent.

The training manager had given staff a personal training time table. Training was a mixture of face to face and online training. The training manager was always available when staff were completing online training to give support and answer any questions they may have. Staff received training in essential skills such as moving and handling, fire safety, safeguarding and mental capacity. Staff also received training to support people living with diabetes, epilepsy, dementia and behaviours that may challenge.

The training was ongoing and nearly all the staff had completed all the training. Staff told us that they had completed training and felt that it was appropriate. One commented, "I work in the kitchen but I have completed training in dementia, epilepsy and diabetes. It helps me understand people's needs and I am able to help if needed."

New staff completed training as part of their probation. Staff were offered the opportunity to complete a trial day, to see if they liked the service, before committing to the job. Staff completed training and theory tests about the essential skills. The registered manager would then complete a competency assessment to ensure new staff were working to the standards of the service. Staff shadowed more experienced staff for two weeks, learning about people's preferences and choices, this would be extended if the staff member had not worked as a carer before.

At the last inspection, staff had not received supervision and appraisals to identify their training and development needs. At this inspection improvements had been made. Staff had received formal one to one supervisions and appraisals with their line manager. Staff discussed their practice and any concerns they may have, and timescales for any training and development.

Staff told us that they felt supported by the management team, one commented, "I can go to the registered manager at any time. We have supervisions but I don't have to wait till then, I talk to them when I need to." The registered manager worked with the staff on a day to day basis and would speak to staff directly if there were any problems with their practice.

At the last inspection the service was not working within the principle of the Mental Capacity Act 2005 and had not applied for Deprivation of Liberty Safeguards when appropriate. Improvements had been made at this inspection.

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 make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedures for this in care homes and hospitals are called 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 management team had completed DoLS applications where appropriate and some had been authorised. People's mental capacity had been formally assessed to determine if people were able to make complex decisions about their care and where to live. People who were assessed as not having capacity to make complex decisions had not been formally assessed for specific day to day decisions. This was an area for improvement.

However, staff had a good understanding of the principles of MCA, and this was seen in their practice. People with capacity had requested bedrails to be in place, this had been recorded in their care plan. People told us that they felt happier with the bedrails in place. People were supported to go out independently if it was safe for them to do so.

Staff gave people choices and asked consent before giving support. People were asked where they wanted to spend their time and what they wanted to eat and drink. Staff acted in people's best interests when needed. For example, one person had been hoisted by staff and had appeared to be in discomfort, when asked a couple of minutes later if they would like pain relief they said no as they were not in pain. They had forgotten about the pain, staff brought them pain relief and touched their wrist. The person's wrist was sore and because the tablets were there at the time they were in discomfort they took them.

People told us that they liked the food at the service, they had enough to eat and drink. People were given a choice of foods. We observed lunch in the main dining room and the King William dining room. The food looked and smelt appetising, the portions were generous and seconds were given when requested. The atmosphere in the main dining room was quiet at times, people preferred to concentrate on their meals rather than chat.

People who needed support with their meals were supported discreetly. Staff sat with them and chatted, giving them time to enjoy their meal. The kitchen staff were aware of people's dietary needs and supplied meals in line with the guidelines from health professionals.

Staff encouraged people to be as independent as possible, plate guards were put on plates to enable people to eat independently. People were given the choice of where they wanted to eat. One person did not want to sit with other people. Staff brought their meal out on a tray and followed the person trying to encourage them to sit and eat, eventually the person agreed to have the meal in their room. The member of staff had been patient with the person and this meant that the person had eaten when they might not have if the meal had been left at the table.

Staff supported people to maintain good health and were supported to see health professionals when they needed to. People's health was monitored and when it was necessary health care professionals were

involved to make sure people were supported to be as healthy as possible . When a person was unwell their doctor was contacted. When people had problems eating and drinking they were referred to dieticians and speech and language therapists. Health professionals told us that staff followed the guidance given to them and recorded in the care plans.

Good

Is the service caring?

Our findings

People told us that staff treated them with kindness and respect. There was a warm and caring relationship between staff and people. People were relaxed in the company of staff and management.

Staff spoke with people in a friendly, kind and compassionate way. They showed a genuine interest in what people had to say and were patient. One person approached the administration manager and asked about an appointment, this was explained to the person and they went away happy. The person came back half an hour later and asked the same question, the administration manager explained it again and said, "Come back again if you need to."

People's privacy and dignity was respected. Staff were transferring a person in the lounge using the hoist. A screen was used to give the person privacy. Staff took time to explain what they were going to do at each stage, taking their time so that the person was reassured. Staff explained how they respected people's dignity by closing the door and making sure the person was covered while giving care.

Staff were seen knocking on people's doors and waiting to be invited in. Some people preferred to spend their time in their rooms, staff asked them if they wanted their doors open or shut, and checked to make sure they were safe during the day. Staff addressed people by their preferred name and encouraged them to make day to day decisions about their care. Staff supported people to go between the main house and King William. One person told us, "I like to go for my meals at King William, I sit with my friend and we chat."

People and relatives told us they were able to visit at any time. Relatives had the opportunity to join people for meals if they wished. When people were unwell, relatives were supported to spend time with their loved one. A relative told us, "When my (relative) was ill, I was able to stay overnight. The staff were very kind and supportive."

Staff knew people well. They were able to talk to people about their past and people who were important to them. One person was well travelled and was married to a lady from Hong Kong. The person spoke several languages and staff were aware of this, they bid the person farewell in Chinese with a respectful bow.

Staff responded to people's needs quickly. A person had mislaid her watch and thought it was in their room. The person was becoming anxious, staff helped the person search their room, to find that it was in their pocket. Staff told them, "Never mind at least we found it."

Staff encouraged people to be as independent as possible, care plans gave staff details of what people could do for themselves and their choices and preferences. The electronic system meant that staff were able to access the person's care plan at all times. Staff told us, "If I have any problems I look it up on the tablet and this gives me all the information I need. I can support people the way they want."

People were encouraged to personalise their rooms with pieces of furniture and photos of their loved ones, so that they would feel comfortable in their surroundings.

People's religious and cultural needs and preferences were recorded and respected. A church service was held regularly at the service for those who wished to attend. Arrangements were made for visiting clergy so people could follow their beliefs.

Care records were stored securely, information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures in place to underpin this.

Good

Is the service responsive?

Our findings

People told us they were listened to and felt that they received their care and support in the way they preferred. One person told us, "I can go to bed when I want, I usually have a shower at 7am and the staff help me with this."

At the previous inspection, the service had recently introduced the electronic Care Management System (CMS) to manage people's care plans. The information held on the systems was generic and not relevant to individuals. At this inspection, improvements had been made and CMS was being used successfully to write and review people's care plans.

People met with the registered manager, prior to moving into the service, to discuss their needs to ensure that the service was able to meet people's individual needs and wishes. Care plans were then developed from assessments and discussions with people and their relatives.

Each person had a care plan that contained information about their needs and preferences. Care plans included details about people's health needs and risk assessments were in place applicable for each person. For example, one person liked to get up at 5am, as they had lived on a farm all their adult life and this was their routine. Risk assessments contained details of how to manage risks in the way people preferred. One care plan explained the person would become anxious after their evening meal and would have a disturbed night if they went to bed early. There was guidance in place for staff to reduce the person's anxiety and promote a settled night. Staff daily notes showed that the plan had been effective.

People and their relatives were involved in the planning and review of their care plan. Care plans were reviewed monthly or sooner if people's needs changed. The CMS showed the changes that had been made previously, charts were available to show if people's dependency had changed and care plans had been reviewed appropriately. Some people had mentioned at resident meetings that they had not seen their care plan. The registered manager told us they printed people a copy and discussed it with them. People were able to keep a copy of their care plan in their room and people confirmed this.

People and their relatives were invited to a yearly review to discuss their care and support. Each area of care was discussed, people and their relatives were asked if they had any feedback or complaints. An action plan was produced with the concerns raised and solutions that were suggested. One person had been refusing to have cream applied to their legs, different approaches were discussed and agreed, records showed that these had been successful on occasions.

The service did not currently have a full time activities co-ordinator, one had been employed since the last inspection but had recently left. The administration manager told us that a new activities co-ordinator would be starting in September. There was an activities assistant in post who was providing one to one activities and taking people out on trips. The administration manager told us that they tried to provide two organised activities each day, including cinema afternoons, music workshop and pilates. They had also introduced 'Try it Tuesday', people were encouraged to try food from different countries and 'Fizzy Friday'

where different drinks were tried.

The provider had introduced a game table. It was a magic table game for people living with dementia. The table game was designed to encourage elderly people with Alzheimer's disease to be more active in an independent way during the day. Staff encouraged people to take part and they appeared to engage and enjoy it.

People were taken out on shopping trips to Canterbury when they wanted. Trips were organised for people to go as a group, as the service had their own minibus. People told us that they did not feel the entertainment was to their taste. This is an area for improvement.

The provider had a complaints procedure and this was displayed in the communal areas. One complaint was received in the last 12 months before the inspection. This was satisfactorily resolved within the stipulated time by the registered manager.

People and their relatives told us that they knew how to complain. One relative told us, "There were a few niggles to start off with but these were sorted out." People had daily contact with the management team and if they had any concerns that day they would speak to them, one person told us, "I speak to (name) and they always sort it out."

Good

Is the service well-led?

Our findings

People felt the service was well led. People knew the staff team and management by name. People told us they were able to speak to the management team at any time, one commented, "Their door is always open."

At the last inspection, the provider had not carried out surveys to gain feedback on the quality of the service from people, staff and stakeholder such as GP's. Records were not always clear and accurate. The provider did not have an effective system in place to audit the quality of care and support provided by the service.

At this inspection improvements had been made. Records relating to people's care and support were now accurate and contained details of guidance from health care professionals. Care plans were person centred containing detailed guidance for staff to support people and keep them safe.

The provider had an effective audit system in place to monitor the quality of the service being provided. The provider completed audits on staff files, infection control, health and safety and risk assessments. The management team completed a daily walk round audit of the service, to identify any shortfalls as quickly as possible. Any shortfalls identified had an action plan with date by which the action needed to be taken. At the next audit it was checked that the action required had been taken and been effective.

The provider had sent quality assurance questionnaires to people, staff and stakeholders such as community nurses and GP's. The results of the questionnaires returned by people or their relatives had been analysed and the feedback had been positive about the service. The training manager told us the results would be discussed at the next residents meeting.

The questionnaires sent to staff had to be returned by 31 July, staff had returned the survey but there had been no opportunity to analyse the response before the inspection. There had been no questionnaires returned from stakeholders. The questionnaires that were sent out were long and complex, there was a risk that people would not want to complete such a long form. The administration manager told us that they were going to simplify and shorten the form to make it easier for people to complete. In the main hall there were complaint/compliments sheets which could be completed by people, relatives, staff or stakeholders. People and relatives had used this to make comments about the service, these had been used as part of the quality assurance process.

Resident meetings had been held monthly, people were encouraged to express their views about the service. Any concerns, complaints or compliments were recorded and suggestions made about what could be done. An action plan was then put in place and updated when the action had been taken and discussed at the next meeting. One person had requested that people were ready by 2pm when going on trips so they could get the most out of the trip. Trips are now arranged to include lunch out so that the trip can be enjoyed. Topics raised that concerned staff were discussed at staff meetings and people were informed of the outcome at the next meeting.

Staff told us that they felt supported by the management team. The registered manager worked with staff

and ensured that people's care and support was effective and safe. The registered manager was supported by an administration manager and training manager, the provider regularly visited the service. People knew the management team by name. People were comfortable with the management team and stopped and talked to them as they walked around the service. The management team knew people well and the support they needed. The management team had an open door policy, the office was attached to the main lounge and people were happy to stop and discuss any concerns.

Staff understood their roles and responsibilities and told us they worked well as a team. They told us, "I know who to go to if I have a problem, the manager and administrator are very supportive." Staff felt that they were kept informed about what was happening within the service and encouraged to express their views.

Management and staff shared a vision for the service, it should be a home from home. One relative had written, "The care my (relative) received during their stay was excellent and our visits to your care home were like visiting extended family." Staff told us that they treated people like they were part of their family.

Staff had access to a range of policies and procedures, these had just been updated, to enable them to carry out their roles safely.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner and in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception.