Methodist Homes

Moorland House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 30 November 2016 and was unannounced. The service was last inspected in April 2014 when it was compliant in the areas inspected. The service is registered to provide care for 48 people. There were 45 people living there on the day of our inspection.

There was a registered manager in post. 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 were safe at Moorland House. Staff had the skills and knowledge to keep people safe from harm and abuse and policies were in place to support this. Risks to people were identified and managed, whilst continuing to promote independence. Medicines were generally managed well, errors were identified and staff supported to improve their practice.

Staff had the skills and knowledge to care for people effectively. New staff completed a thorough induction and all staff received on-going training and support. People were supported to make their own decisions about their care. Where they lacked capacity to do so, appropriate arrangements were in place for staff, family and appropriate professionals if necessary, to make decisions in their best interest. People were supported to access community health services and appropriate referrals were made. Meals were nutritionally balanced and special diets were catered for. However, we found the lunchtime service was poorly managed and people waited a long time for their meal.

People were cared for by staff who were kind and compassionate. There were good relationships between people, staff and families. Staff clearly knew the people they cared for and were aware of their interests, wishes and preferences.

There was a comprehensive activities programme for people from Monday to Friday. The activities available were based on individual interests; and included group and individual activities, within and outside the home. A minibus was used to take people on trips in the local area. This enabled people to maintain their sense of identity and remain part of the local community. There was a complaints policy in place and people and their families were consulted about service improvements and encouraged to make suggestions. People told us they knew who to complain to and most people were happy with the response they received. However, some people told us they felt the response depended on how busy the staff were.

There was a positive and welcoming atmosphere in the home. The registered manager was available, approachable and was supported in their role by a team of regional managers. Staff we spoke with were motivated and supported in their personal development. However, we found that at times of staff shortage, staff did not always feel supported or valued by the provider as they felt their concerns regarding the quality of care, were not always acknowledged or acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were recruited safely and all pre-employment checks were completed before they cared for people. Staff understood their responsibilities to keep people safe from harm. Medicines were managed safely and staff received relevant training.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff clearly knew people's care needs and had the knowledge and skills to meet these needs. People were supported to access community healthcare services. However, the meal experience we observed was disorganised; and was not a positive or enjoyable experience for people.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and compassionate. People and staff developed positive relationships based on dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a comprehensive activities programme in place, based on individual interests and abilities. Some people and their relatives were not happy with the lack of action when they raised concerns directly with staff. They felt staff were too busy to listen or respond positively.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although staff attended team meetings and one-to-one support meetings, they did not always feel their concerns regarding staffing, were acknowledged or acted upon by the provider.

However, they felt the registered manager was available, approachable and supportive.

Moorland House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 November 2016 and was unannounced.

The inspection team consisted of one inspector and a specialist advisor. The specialist advisor was a nurse with experience of caring for older people.

Before the inspection we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR). A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We also reviewed any notifications the provider had sent us. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred.

In order to gather information to make an assessment of the quality of the service, we looked at a variety of records and spoke to different people. We reviewed five care records which included needs assessments, risk assessments and daily care logs; management records which included three staff records, policies, development plans and evidence of training. We also spoke to the registered manager, a regional manager, five care staff, two visiting healthcare professionals and eight people who used the service or their family visitors.

Good

Is the service safe?

Our findings

People told us they felt safe living at Moorland House. One person said, "Yes, I feel quite safe" and another said, "I am very much safe, the staff are very good". A relative told us their family member was, "Very safe, the staff know what to do". We saw some people, when in their own rooms, wore a 'call alarm' pendant. They said this enabled them to ring for assistance if they needed it. Staff told us they kept people safe, they said they had training on how to safeguard people and protect them from harm or abuse. Staff provided examples of abuse and explained how they would respond if they suspected a person was at risk of harm or abuse. One staff member said, "Staff keep people safe, we know the residents. We are told about new residents at handover, when their needs and mobility are discussed". Staff have the skills and knowledge to keep people safe.

We saw training records that confirmed staff undertook training to keep people safe and the registered manager told us this was refreshed each year; and there were polices in place to support staff to care for people safely. We had received whistleblowing concerns prior to the inspection, which indicated that staff took responsibility for sharing any concerns they had, regarding people's care or safety. We followed these up with the registered manager before and during the inspection. We had received notifications from the registered manager prior to the inspection, advising us they had made safeguarding referrals to the local authority when they had concerns about people. The local authority confirmed these had been made and staff acted appropriately in identifying and responding to the concerns. This demonstrated policies and procedures were in place, to keep people safe at Moorland House.

Care plans included risk assessments, which identified known risks to people and plans were in place to reduce the risk of harm. For example, we saw risk assessments in respect of moving and handling, which identified the most appropriate intervention to help people mobilise, including the type of sling if a hoist was used. Care plans showed people were included in decisions regarding managing risks and their views and preferences were noted. The registered manager told us even though risk management plans were in place they encouraged independence. We saw that many people were independently mobile and people were encouraged to walk around independently, where appropriate. We saw that equipment used to assist people to move around or transfer was serviced on site, this meant it was fit for purpose and safe to be used. Staff told us they were trained and their competency assessed before they used any specialist equipment with people. One staff member said, "People are safe, staff have lots of training on moving and handling". Each person had a personal emergency evacuation plan (PEEP's) in place, which helped staff identify who needed assistance during an emergency. We saw incidents were reported and reviewed, to ensure measures were put in place to reduce the risk of them re-occurring. This demonstrated that risks were managed in ways that helped to keep people safe.

One person told us, "Yes, there's enough staff, they are very good". The registered manager explained they used a needs and dependency tool to assess the number of staff required to care for people each shift. They said this was reviewed every two weeks or sooner if there was a change in a person's care needs or a new admission. We saw records of staff meetings where concerns had been made regarding low staffing levels due to staff leaving, holidays and sickness. Staff were concerned about the impact on the quality of care and

examples were provided of tasks not completed at the required times and of the impact on motivation and team work. However, there appeared to be plenty of staff on the day of inspection. This was especially the situation at lunchtime when there were lots of staff standing around the dining room when people were waiting for their meal. We were later advised that three new staff were attending an induction day and were observing routines and practice. The registered manager told us there was usually enough staff to care for people and when they used agency staff to cover vacant nursing posts, these were covered by the same agency staff, to provide consistency of care. They told us they did not use agency staff to cover absent care staff, as the care team worked well together and 'covered for each other'. Many staff worked part-time and were flexible enough to pick up extra shifts where needed. There were enough staff to care for people on the day of the inspection.

We found suitable storage arrangements for all medicines, including controlled drugs and those that had to be kept in a fridge. Medicines were administered by nurses or trained care staff. Staff told us they were not allowed to administer medicines until they had completed all the necessary training and their competency was checked by a senior nurse or the registered manager. We saw policies in place to support staff with the management and administration of medicines. One person told us, "I can ask when I need pain relief for my back". We saw this was recorded on this person's medicines administration record (MAR) chart. There was a policy in place for when people needed medicines 'as required' and when people needed non-prescription medicines. We found 'patch charts' were in place to support the application of patch medicines; however, we found that the records were not signed consistently every day, which meant staff could not always be sure that the patches were still in place and people were receiving the prescribed dosage of medicine

Medicine administration records (MARs) were completed and when errors were identified, they were addressed quickly. We discussed a recent medicine error that the registered manager had notified us of. They advised us that the staff member in question had received additional training, observation and their competency assessed again, before they returned to administering medicines. The registered manager was aware of their responsibility for ensuring people had safe access to medicines; and to ensure that only suitably trained and competent staff administered medicines to people. There were policies and processes in place to support the management of medicines.

Requires Improvement

Is the service effective?

Our findings

On the day of the inspection we saw there were three new staff taking part in 'an observation day' as part of their induction. One of them told us the induction was, "Really useful, it's nice to get to know the people we will be caring for and working with". A staff member told us they had access to 'Some very good training" and another said, "You can never have too much training; there's so much to learn and things change". We saw the training matrix and the registered manager explained how this helped them to keep up with staff training needs. The provider expected new staff to undertake the Care Certificate as part of the development of their caring role. The Care Certificate identifies a set of care standards and introductory skills that non-regulated health and social care workers should consistently adhere to. This showed the provider recognised the need to ensure staff had the necessary training and skills to meet people's needs. Staff told us they completed a thorough induction which included observing experienced care staff and completing training that helped build their knowledge of how to care for people. This demonstrated how staff were prepared and supported to maintain the skills and knowledge, required to care for people effectively.

Staff told us they had regular supervision with either the registered manager or senior staff and they found them to be 'useful'. The registered manager told us staff had five supervisions each year plus an annual appraisal; this matched the supervision and appraisal policy we saw. We saw minutes of team meetings and saw that improvements were discussed along with the changing needs of people. One staff member said, "We have whole staff meetings every quarter and it's useful to catch-up with everyone and review things, as we are such a big team". Staff told us there were daily meetings at 11.00am for heads of departments and information was cascaded to the teams as necessary; as well as shift handover meetings twice a day. One staff member said, "We have good communication, staff are good at sharing information and take ownership"; and another told us they had access to meeting minutes, handover records and care plans in order to keep them up-to-date with people's needs. This demonstrated staff were supported to develop in their roles and had access to the information they required to care for people.

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. We checked whether the service was working within the principles of the MCA, we found 'best interest' decisions had been made where necessary. For example we saw a 'best interest' meeting had taken place with a person's GP and family to decide whether it would be appropriate to administer this person's medicines covertly. Staff told us they had received training on MCA and were able to explain to us, how they considered a person's capacity when decisions had to be made regarding their care. They also told us they knew the people they cared for, along with their wishes and preferences; so they felt confident they were making appropriate choices for people on a day to day basis, when they were unable to do so themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found DoLS were in place for people who required

some form of restrictive care to keep them safe; and authorisations had been requested from the local authority, as appropriate when people's needs had changed. This showed that the provider took responsibility to ensure that they were operating under the principles of the MCA and were not placing unlawful restrictions on people.

People told us they enjoyed the food. One person said, "The food is very nice, there's a good variety and a nice atmosphere. It's as near as you can get to home" and another person said, "The food is quite nice, there's usually a choice of two things". Other people told us, "The food is very good" and "There's plenty to drink". We saw drinks and snacks were offered to people throughout the day. A person told us they had problems swallowing due to surgery and staff blended their food to make it easier to eat and gave them cold milk to soothe their throat. They said "I like to go to the dining room if I can", but if they were not well, they ate in their room. Another person told us they did not have a big appetite because they had lost their sense of taste, but they said, "If I do fancy something they (the kitchen staff) will make it for me. They're very good". We saw that individual dietary needs were met and people at nutritional risk were monitored and weighed regularly to ensure they were not losing weight.

There were two dining rooms, one upstairs for people who were more independent and a larger one downstairs for people who required some assistance to eat or mobilise. We observed the lunchtime service in the larger downstairs dining room, where we found the service to be disorganised and overly long. We arrived at the dining room at 12.35 and 25 people were already seated; having been assisted from the lounge or their bedroom. People were still arriving and there were not enough seats for everyone. People were moved around in order to squeeze extra people in; and we saw one person who was sat in a wheelchair, was moved around the table without the staff member asking their consent. Food was not served for 25 minutes after we arrived and some people did not have glasses or water on the table. Whilst people were waiting for their meal, staff did not attempt to engage with people sitting at the tables and no explanation was offered for the delay. Staff appeared to be more focused on the task of serving lunch than on people.

It was 1.00pm before people were served with soup and 1.50pm before people stated leaving the dining room, having finished their meal. We overheard people saying to each other, "It's a bit disorganised isn't it"; and "I've got no spoon, have you got a spoon?" and "It's not very warm, it's only luke warm". There was not enough soup and some people had to wait for more to be heated. There did not appear to be enough sandwiches for everyone in the dining room and little choice of fillings. We were later told there were three new residents who needed assistance to get to the dining room and staff were a bit nervous because we were there. However, we observed there was no one 'in charge' of the lunchtime service, which meant it appeared disorganised and left staff with no clear direction and people without any stimulation or food.

People were supported to access specialist health services to ensure they maintain their health. We saw records of referrals to dieticians, speech and language therapy (SALT), physiotherapy as well as dentists and GP's. People told us that staff accompanied them to appointments, if a family member was not available. We spoke briefly with two visiting healthcare professionals, who advised us that staff followed advice and direction regarding peoples care and nursing needs. They said communication was good between the service and the community health teams, staff made appropriate referrals, when people's needs changed and were knowledgeable about individual health conditions. Anticipatory medicines were in place for people approaching their end of life and staff were trained in supporting people and their families at this time. People were supported to access healthcare services and received on-going healthcare support.

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind and compassionate. One person said, "I'm very lucky to be here" another person said, "The staff are wonderful" and a third person said, "Where else can you spend the last days of your life, where everyone is happy and laughing, everyone is so friendly". We observed friendly and kind interactions between people and staff, and staff clearly knew people's personalities and preferences. For instance we overheard a staff member say, "Would you like to sit by the window in your favourite chair" and another reminding a person that one of their favourite programmes would be starting soon. A relative told us, "Staff are engaging, caring, good fun and appeared to listen to what residents are saying" and another said, "I am confident she is well looked after". We talked to people whose relatives had previously been in the home and they told us they came here because of the good care their relative had received. This demonstrated that staff had positive and caring relationships with people and people felt they mattered.

People were involved in planning their care and making decisions that affected them. One person told us they got up and went to bed at times that suited them and staff changed the time of their evening medicines to fit in with their early bed time. This person said, "Staff are very good to me, I can't fault them". Another person said, "Staff understand me, some are brilliant, we have our own little jokes, they listen to me". A third person told us, "I find the staff very nice, you respect them and they respect you. I'm very happy. I have high standards, they know what I like". We saw people had been involved in developing their care plans and their views and preferences were recorded. People told us they were encouraged to be as independent as possible and to maintain their routines, they told us this helped them feel at home. People said they were able to spend time in their rooms, admiring the wonderful view from the windows, or to go to the lounge and sit with other people, it was their choice. One person said, "I like my own company, I like to stay in my room and read, I have plenty of visitors. I can go (to the lounge) if I want to, but I like it here". This showed people's views and preferences were respected.

People said staff respected their privacy, dignity and individuality. One person explained how staff gave them privacy during personal care, whilst remaining close by in case they needed assistance. People had their post delivered to their rooms and they were able to meet their visitors in the privacy of their own rooms, which were spacious and welcoming. People were well presented and the hairdresser was present on the day or our inspection, some people had pre-arranged appointments and other people were asked on the day. People enjoyed having their hair done and we saw ladies wearing jewellery and scarves; one person showed us their 'happy socks' which they liked to wear. This showed that people's individuality and appearance was respected.

Requires Improvement

Is the service responsive?

Our findings

Staff were aware of people's choices and preferences. They knew how people liked to be cared for and when they needed assistance. Independence was promoted and people made their own choices regarding how they spent their day. Visitors were encouraged and people were supported to go on trips with family and friends. This enabled people to maintain relationships with the people who were important to them, which had a positive effect on their well-being and individuality. There was an extensive activities programme and three part-time activity staff, who provided planned group activities from Monday to Friday. There were also lots of resources and games that staff could access at weekends for people. One person showed us the weekly activity newsletter which was given to people and their relatives, who were encouraged to join their family members if they wished. They said, "There's lots going on, lots of choice; but I don't usually join in, I have lots of visitors and prefer my own company". A second person told us they planned their week around the activities they wanted to attend. A staff member said, "You're never too old to learn something new" and "We try to cater for everyone's interests and keep their mind and body active".

There was a table-tennis activity taking place on the day of the inspection and we saw people enjoyed playing table tennis and others enjoyed just watching and joining in the fun. There was also a bible-study class and a newspaper group which provided opportunities for people to join less active groups and discussions about things that interested them. The service had recently been presented with a new mini-bus from a local benefactor and they told us this had made a positive difference to how they supported people to access activities outside of the service. People were able to access and participate in activities of interest to them. This had a positive impact on their wellbeing.

Staff also offered personalised one-to-one activities for people unable to participate in group activities. For example, a volunteer came in to read to a person in their room; and a volunteer supported people to take part in craft activities in their own room, when it was difficult for them to join in with the group activities. We saw individual activity records for people, that included their interests and preferences, as well as records of when they participated in planned activities and any feedback they gave on the quality and suitability of the activity. The activity co-ordinator told us they had analysed the activities and understood why some people did not attend group activities; and they were developing alternative activities for them. They said the records had helped them identify where to focus their support and encouraged them to think creatively about how they could provide interests for people who found it difficult to participate in group activities. This included, reading to people, reminiscence activities, knitting, drawing, listening to music, reading the newspaper and discussing current affairs and items of interest.

People's spiritual needs were met. There was a Chaplain on the staff team and Christian worship and communion took place weekly in the home. There were regular groups providing opportunity for people to meet and discuss issues and events that were important to them. For example, bible studies and learning about different cultures. Visits were supported from members of different faiths in order to meet the spiritual needs of people who followed different faiths. We saw a diversity display on a notice board which included information and pictures, which raised awareness of different cultures and cultural events.

People's preferences for the gender of their care staff was respected where possible. One person told us, "The male carers are brilliant" and another person said they were asked if they would find it acceptable for a male carer to assist them with bathing. Male staff we spoke with, told us they were happy to care for men and women, but understood some people preferred same gender care staff. People told us they could have different conversations with male and female staff, especially if they shared the same interests or sense of humour; however, they also said all staff were kind, friendly and understood their needs. This demonstrated that people received personalised care that was responsive to their individual needs.

People told us they felt staff listened to them. There were meetings for people and their families and we saw minutes from these meetings displayed on notice boards. People discussed activities, events, menus and made suggestions for improvements. Minutes of staff meetings demonstrated improvements were identified and discussed. Staff contributed to discussions regarding improvements and were involved in finding solutions. Staff were reminded of the values of the organisation which included listening and respecting people, as well as maintaining their dignity and independence.

There was a complaints policy in place and we saw that complaints were responded to appropriately with changes made, where necessary. The annual survey had only recently been sent out and had not yet been summarised by the time of the inspection. There was a suggestions box available for people to leave comments or suggestions. We saw a notice board full of thank you cards that were all complimentary of the care given to people. People and families told us they knew who to contact if they were unhappy with their care and most were sure this would be dealt with appropriately.

However, we spoke to some relatives who were disappointed in some aspects of the care their family member received. One relative was concerned that their relative always wore the same clothes when they visited, even though they had an extensive collection of clothes and loved wearing different clothes before they came into the home. They also said they had requested their family member was left with drinks, glasses and a remote control for the television within easy reach, but they frequently visited to find them out-of-reach and were concerned about the risk of falls if they leant out to reach them. Another relative told us their family members woollen cardigans had been washed and shrunk in the laundry, despite leaving instructions that they would be taken home to be washed by a relative. They said they had also arrived one day to find their family member slumped in a chair and were concerned that staff had not noticed or tried to reposition them. These relatives told us that staff were often rushed off their feet and either did not listen or did not have time to do everything; they said this was worse when staff were off sick or on holiday. This indicated that care was not always person centred and staff did not always respond to personal need, personal preferences or advice from relatives.

The registered manager acknowledged there had been staff vacancies this year, but said staff were flexible to cover extra shifts and they had just recruited new staff for care and kitchen duties. They hoped they would soon be fully staffed, especially as three new care staff were on their induction week at the time of the inspection. They acknowledged they had long term vacancies in the nursing team due to a national shortage of nurses willing to work in nursing homes and were supporting a newly appointed nurse during their probation period. We read staff meeting minutes over the previous six months where staff shortages were regularly discussed and how this impacted on the quality of care people experienced. Examples discussed, included people waiting too long for buzzers to be responded to, care records not being updated in a timely manner, mealtimes being delayed, care staff taken off care duties to help in the kitchen, and tasks not being completed eg, rooms not tidied, beds not made and bins not emptied.

The service had a very good activities programme that was personalised, creative and responsive to individual wishes and preferences. However, we were concerned that staff absences were not always

managed effectively and at times had led to a poor response to individual need; at such times staff became more task focused and did not work as well together as a team.

Requires Improvement

Is the service well-led?

Our findings

It was clear from staff meeting minutes that staff had concerns regarding staffing levels at times of unexpected staff absence, or when people's needs increased. At such times, staff were under pressure and felt unable to provide the quality of care they wanted to. These concerns had been raised at staff meetings over the six months prior to our inspection, they were acknowledged by the providers management team and staff had been praised for their flexibility for picking up extra shifts. However, it was clear that this was only a short-term temporary solution that relied on the good will of the staff. It had not satisfactorily resolved the issue of insufficient staff available to cover periods of absences or increasing need. This had impacted on staff ability to cope and on the quality of care people experienced during that time. For example, staff had not always followed requests from relatives regarding how their family member preferred to be cared for or their clothes laundered. Lack of time had led to poor attention to detail and a poor living environment for people, with unmade beds, un-emptied sanitary bins and length of time taken to respond to people's needs, especially during handover or at mealtimes. The registered manager hoped this would improve now they had recruited new care staff. However, there were still vacancies for kitchen staff and nurses which impacted on all staff, as they were required to pick-up extra duties to ensure everything gets done.

The service had systems in place to ensure that people received good quality care and these were generally used effectively. However, they had not been used effectively to respond to the concerns raised regarding poor staffing levels, the impact on staff and on the quality of care people experienced. Staff had been offered coaching on how to respond to CQC questions, promote a positive picture and had been advised not to discuss poor staffing or 'wash their dirty linen' with CQC. There was an expectation that the service would receive an outstanding or good rating. This had resulted in staff being nervous throughout the inspection and concerned about 'saying the wrong thing'. This indicated that the provider was not always open or transparent; and did not always take responsibility for the overall outcomes regarding quality of the service and the care people experienced. This was an area that required improvement.

The registered manager was available and approachable. They participated in daily meetings with senior staff, to ensure they were up-to-date with incidents and events in the home. There were regular staff meetings and staff were encouraged to speak up and share any concerns or areas for development. We saw minutes of meetings and saw that topics of discussion included aspects of care, team work, events and the working environment. Staff told us they found the staff meetings, "Useful" and were "An opportunity to voice our concerns". Staff also received regular one-to-one supervision which they said supported them in the development of their role. The staff we spoke with were motivated and clear about their roles and responsibilities.

There were quality systems in place and these were used to identify areas for improvement, poor practice, as well as identify where the service was doing well. The registered manager conducted audits of care plans and records and fed back to staff at daily meetings, team meetings and supervisions. They also provided information to the provider who had their own quality assurance system in place to monitor their services and the outcomes for people. The provider was represented by regional managers during the inspection

and they told us they supported the registered manager in the development of the service. They told us they conducted monthly audits and visited the home monthly to ensure that quality was maintained. We saw records where they had highlighted areas for improvement and supported staff in preparing for an inspection. They said they were supportive of staff and appeared to have been a regular presence in the home during the previous 12 months. The registered manager told us they had good support and supervision from the regional management team. We discussed some recent concerns with the registered manager, which they had shared with us prior to the inspection. We noted they had responded appropriately to the incidents; conducted investigations as required and notified relevant people. The registered manager responded positively to feedback during the inspection and was open and honest about the areas that required improvement.

There was a positive, cheerful atmosphere in the home. People were content and felt included; staff enjoyed their jobs and liked caring for people. One staff member said, "I love working here, residents are lovely and staff friendly" another said, "I do enjoy it, it's a good home to work in, staff work hard they are brilliant". Staff told us the registered manager was, "Brilliant, supportive and fair"; another staff member was described as "Brilliant, the pivot that holds everything together". However, one staff member felt that staff could be praised more. People and staff were consulted about the development of the service and information was shared appropriately. Staff were encouraged to find solutions to problems and there was a system of staff 'champions' in place, where named staff took responsibility for keeping up-to-date with a particular aspect of care and sharing information with the staff team and registered manager. There were strong links with the local community and people from the community were invited to events, for Sunday lunch and to volunteer with activities for people. There was a volunteer co-ordinator and all volunteers completed DBS checks and provided references before supporting people. The service also mentored health and social care students on placement. There was an inclusive and empowering culture in the organisation.

Information was shared appropriately, safeguarding concerns reported to the appropriate bodies; and notifications and reports were sent to the CQC, as required under the terms of their registration. Feedback from community services who worked with the service to ensure people received safe care and treatment, advised us that the registered manager and staff team were responsive and effective, and shared concerns appropriately.