Autumn House Care Limited

Autumn House Residential Home

Inspection report

21-27 Avenue Road
Sandown
Isle of Wight
PO36 8BN
Tel: 01983 402125

Date of inspection visit: 19 & 22 October 2015
Date of publication: 17/12/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 19 and 22 October 2015 and was unannounced. The home provides accommodation for up to 44 people, including people living with dementia care needs. There were 41 people living at the home when we visited.

There was a registered manager in place. 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 told us they felt safe at Autumn House. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. When people were

Summary of findings

found to have unexplained bruising, the cause was investigated in all but one case. The systems used to manage medicines were safe, although the application of some creams was not always recorded accurately.

People received enough to eat and drink. However, practices used to support people did not always follow accepted best practice and a plan to protect one person from the risk of malnutrition had not been followed.

Staff followed legislation designed to protect people rights and freedom, although they had not complete the process fully for one person due to a misunderstanding between them and a health professional.

Risks to people's health were assessed, reviewed and managed effectively. When people fell, action was taken to reduce the likelihood of further falls. There were enough staff to meet people's needs and keep them safe. The process used to recruit staff ensured that only suitable people were employed.

People received effective care from staff who were suitably trained and supported in their role. Staff had good working relationships with external professionals, which allowed them to develop effective interventions to support people.

Best practice guidance had been followed in the design of the home. Good lighting levels, bright colour schemes and pictures placed at appropriate heights were used to create a pleasant environment suitable for people living with dementia.

People were cared for with kindness and compassion and we observed positive interactions between people and staff. Staff used their knowledge of people's lives and backgrounds to build meaningful relationships. People were encouraged to be as independent as possible and their privacy and dignity were protected. People were involved in assessing, planning and agreeing the care and support they received.

People received personalised care from staff who understood and met their needs well. A new, computerised, system of care planning was being introduced, which would help make sure that people receive consistent and effective care and support. People were encouraged to take part in activities and had formed a number of social groups.

Staff understood the needs of people living with dementia who had difficulty expressing themselves verbally. They picked up on changes in people's mood or behaviour and provided reassurance when people became anxious.

People felt the home was well-run. There was a close working relationship between management and staff. Staff were happy, motivated and worked well as a team. They understood their roles and were organised well.

There was an open and transparent culture, good working relationships with external professionals and appropriate links with the community. The provider sought and acted on feedback from people. Audits were conducted to assess, monitor and improve the quality of service. A development plan was in place to improve the home further.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff knew how to identify, prevent and report abuse. Medicines were managed safely. Risks to people's health and safety were managed effectively.

There were enough staff deployed to meet people's needs. The process used to recruit staff was safe. Staff were aware of action to take in an emergency.

Good

Is the service effective?
The service was not always effective.

People were not always supported to eat appropriately. Legislation to protect people's rights had not been followed in one case.

Staff were suitably trained and supported in their work. The environment was supportive of people living with dementia. People had access to healthcare services when needed.

Requires improvement

Is the service caring?
The service was caring.

Staff were kind, caring and compassionate. People were encouraged to remain as independent as possible and treated with dignity and respect.

Staff supported people to build relationships and form social groups. People's privacy was protected and they were involved in planning their care.

Good

Is the service responsive?
The service was responsive.

People received personalised care. Staff were skilled at communicating with people and understanding their individual needs. Comprehensive assessments were conducted before people moved to the home. Care plans were reviewed regularly.

People were encouraged to engage in a wide range of activities. The provider sought and acted on feedback from people, relatives and professionals.

Good

Is the service well-led?
The service was well-led.

Management and staff had a shared vision to provide high quality care. There were good working relationships between the management and staff. Staff understood their roles, were happy in their work and motivated.

There was an open and transparent culture in the service. Staff worked well with external professionals and visitors were welcomed.

Good

Summary of findings

Quality assurance systems were in place, together with a development plan to improve the service further.

Autumn House Residential 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 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 19 and 22 October 2015 and was unannounced. The inspection team consisted of an inspector, a specialist advisor in the care of older people and an expert by experience in dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the 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 reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 11 people living at the home, five family members and two visiting health professionals. We also spoke with a senior representative of the provider, the registered manager, the deputy manager, eight care staff, two members of kitchen staff and three housekeepers. We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas. 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 with us.

The home was last inspected on 5 June 2014, when we identified no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at Autumn House. One person said, "I feel safe and secure because there's plenty of [staff] around." A family member told us "Without any doubt [my relative] is safe here. I can't fault the place for that." Another family member said, "[My relative] is much safer now she is here and is much more secure on her feet." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. Staff were encouraged to raise concerns with the registered manager, or senior representatives of the provider, and were confident appropriate action would be taken. One staff member told us they had done this in the past. They said, "I was fully supported and the issue was dealt with."

Procedures were in place for concerns about people's safety to be reported to the registered manager and the local safeguarding team. At a recent staff meeting the registered manager had used a TV documentary about care homes as a discussion point to remind staff of the importance of protecting people from abuse. We saw the provider's procedures were followed in most cases. Where unexplained bruising to people was identified, staff recorded this on body maps and the registered manager investigated their cause. However, for one person we found two instances of bruising to their arms had not been brought to the attention of registered manager. The registered manager took immediate action to implement a new process to make sure this did not occur again and told us about a new computerised monitoring system that was being introduced which (amongst other features) would automatically notify senior staff of such incidents.

Medicines were managed safely. Systems were in place that ensured medicines were ordered, stored, administered and disposed of in a way that protected people from the risks associated with them. The recording of oral medicines was accurate and confirmed people had received their medicines as prescribed. However, the administration of some creams was not always recorded fully by staff, so the provider was unable to confirm people had received these as required. The registered manager took steps to address this during the inspection by introducing a new system of body maps to show where and when creams should be applied. Information about when staff should administer 'as required' (PRN) medicines, such as sedatives and pain relief, had been developed to help make sure people received these consistently.

Risks to people were managed effectively. For example, equipment such as bath hoists, lifts and wheelchairs were checked and serviced regularly. Windows of upper floor rooms had appropriate restrictors fitted so people could not fall through them and access to stairways was restricted in a way that protected people who were at risk of falling. Staff showed they understood people's individual risks; they assessed, monitored and reviewed these regularly and people were supported in accordance with their risk management plans. For example, clear guidance was available to staff about how to protect people who were at risk of skin breakdown, including the use of special cushions and mattresses, which we saw being used in line with people's care plans. When staff used hoists and stand-aids, they did so in pairs and in accordance with best practice guidance. This was confirmed by a visiting community nurse who said, "There's always equipment around and [staff] use it safely. I've never seen people in distress when being hoisted." When people had experienced falls, senior staff reviewed the risks and took appropriate action to reduce the likelihood of further falls. If the registered manager had any concerns about the way staff supported people, the staff members concerned were given additional support and training to make sure their practice was safe.

Sufficient care staff were deployed to meet people's needs at all times. A family member confirmed this and said, "There's always plenty of staff around." A regular visitor to the home told us there was "never a lack of staff". Staff absence was covered by existing staff working additional hours, which they told us worked well. The provider took appropriate action to manage unauthorised staff absence, using their disciplinary policy where necessary

The process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

Good

Is the service safe?

All staff had undertaken first aid and fire awareness training and were aware of the action they should take in emergency situations. Personal evacuation plans were available for all people. These included details of the support each person would need if they had to be evacuated. These were kept in an office and may not have been readily available in an emergency. However, the registered manager agreed to identify a more accessible place where these could be stored.

Requires improvement

Is the service effective?

Our findings

People were offered varied and nutritious meals appropriate to the seasons, including cooked breakfasts daily. Alternatives were offered if people did not like the menu options of the day. Drinks were available and in reach throughout the day and staff prompted people to drink often. People were encouraged to eat and staff provided support where needed. We observed a staff member supporting two people to eat, while at the same time prompting a third person on the same table to eat. Although this did not follow accepted best practice, the people involved ate well and the relative of one of them told us they were happy with this practice "as it works for [my relative]". However, at times one staff member offered people additional spoons of food before they had finished what was in their mouth, which meant they were being encouraged to eat too quickly. Pureed meals were presented as separate food items to make the meals look more appetising and help people distinguish the individual flavours. However, one staff member mixed all these together before offering the meal to one person, which made it less appetising.

One person had been identified as at risk of malnutrition and records showed they frequently declined their meals. Their care plan required staff to monitor the person's weight, offer snacks and record their intake. Staff told us they offered the person snacks, but these were not recorded and we did not observe these being given. The person had not been weighed for over three months. We discussed this with the registered manager who arranged for the person to be weighed. This showed they had gained a small amount of weight, but remained at risk as they had a low body mass index (BMI). The registered manager also reminded staff of the need to record all food offered or consumed by the person.

People were satisfied with the quality of the food. One person said, "The food is very good and there is a choice." A family member told us "[My relative] wasn't eating well, but staff asked us what she liked and they got it for her. They also really push fluids, which is good."

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Staff showed an understanding of the legislation. Before providing care, they sought consent from people using suitable language and encouraged them to make as many decisions as they could. A family member said of the staff, "They're very respectful. If [my relative] says no they'll just walk away, leave them and go back later." In all but one case, where people had been assessed as lacking capacity, best interest decisions about each element of their care had been made and documented, following consultation with family members and other professionals. Staff recognised that people's ability to make decisions could vary from day to day and took account of this each time they offered support.

One person had been assessed by a consultant psychiatrist as needing to be given one of their medicines covertly, hidden in their food, without their knowledge. Staff had consulted the person's family about this and were administering it in a safe way. The person's care records stated that staff had been informed by a dementia care specialist that an additional medicine could also be given covertly under the Mental Health Act. However, the Mental Health Act did not apply to this person, and the prescribing doctor had not agreed to this method of administration. Therefore the provider was unable to show that administering it in this way was in the best interest of the person. We raised this with the registered manager who took steps to clarify the issue with the specialists concerned before administering any further medicine in this way.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. DoLS authorisations were in place for two people and further applications were being processed by the local authority. Staff were aware of the support people to keep them safe and protect their rights.

People received effective care from staff who were suitably trained. A family member told us "Staff all work hard and they all know every single resident. They do a great job and are very competent." Another family member said, "We're very pleased with how they're looking after [our relative]. They're greatly improved and much more mobile."

Requires improvement

Is the service effective?

Staff had completed a wide range of training relevant to their roles and responsibilities. They praised the range and quality of the training and told us they were supported to complete any additional training they requested. A high proportion of staff had also completed, or were undertaking, vocational qualifications in health and social care. Non-care staff attended most of the training that care staff attended, to help them understand the needs of people living at the home. We observed that non-care staff communicated with people effectively. A non-care staff member told us "[People] respond to a happy face; you have to involve them and 'light up' when you talk to them. It's good to give them five minutes rather than just bustle past them."

Staff were supported appropriately in their role, felt valued and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Staff who had worked at the home for more than a year also received an annual appraisal which assessed their performance. The registered manager recognised the impact that staff had on people living at the home and told us they were committed to supporting staff as much as possible. They said, "Our residents are very sensitive to subtle changes in staff, so we need to know that [our staff] are OK, happy and motivated."

Newly recruited staff worked with experienced staff until they had been assessed as competent to work unsupervised. They also undertook a comprehensive 12 week induction programme. The registered manager told us "Even if people have worked in care before, they haven't worked with our residents, so they have to get to know them." Arrangements were in place for staff new to care to gain the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Guidance from the National Institute for Health and Care Excellence (NICE) had been followed in the design of the home. Good lighting levels, bright colour schemes and pictures placed at appropriate heights were used to create a pleasant environment suitable for people living with dementia. Each corridor had a theme and a distinctive colour scheme which people had been involved in choosing. For example one corridor was called 'Rock 'n Roll Avenue' and contained posters of bands and musicians from the relevant era. Another corridor, 'Movie Mile', contained memorabilia from the classic movies that people knew well. Bathroom and toilet doors were painted in a contrasting colour to help people find them more easily. The registered manager told us they had chosen the same colour scheme for these doors as that used in the local hospital; consequently, if people had to be admitted to hospital they may be able to identify the bathrooms and toilets more easily. Other adaptations included handrails along all corridors to provide support to people and a passenger lift between the two floors of the home which some people were able to use independently.

From people's reactions, it was clear they enjoyed the concept, which provided a topic of conversation and helped them reminisce about their lives. The themed and coloured corridors helped people navigate around the home, as did pictures or other individual signs on bedroom doors. A staff member told us "Some people used to struggle to find their rooms, but now we just remind them that their room is down the yellow corridor or along the movie corridor and they can find it." This helped promote people's independence and reduced their levels of anxiety. An accessible garden area had also been created, with level flower beds, seating and a shelter for people who wished to smoke.

Items of interest and amusement were available to people in various areas of the home. These included rummage boxes and bags and tactile materials, such as juggling balls and textiles for people to touch, and we saw people enjoying these. The registered manager told us that men were often forgotten when furnishings were being chosen, so they had made a particular point of including them. As a result, a mock-up of a garden shed had been built, together with objects that some men may find interesting to explore, such as tools and locks. These helped create interest and mental stimulation for people.

People were supported to access other healthcare services when needed. Records showed people were seen regularly by doctors, dentists, opticians and chiropodists. A visiting community nurse told us "This is one of the homes we can rely on. If we forget anything, they remind us. They refer people promptly, follow any advice and have very good working relations with them."

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff "They're very good here. They have a lot of patience and I appreciate the kindness." A family member told us "People are allowed to be who they are. It's lovely to see." A visiting healthcare professional described staff as "genuinely caring".

We observed positive interactions between people and staff and it was clear that staff knew people well. For example, when a person fell asleep holding a cup and saucer, a staff member removed the cup so it would not spill but left the person holding the saucer. They explained that they knew the person would become upset if they took the saucer. We later saw the staff member negotiating with the person to take their saucer when they had woken up. Another person who had difficulty expressing themselves asked staff for help. In an effort to find out what help they needed, the staff member patiently asked the person a series of simple questions. Between each question they allowed time for the person to process the information and respond. This showed they were skilled in understanding the communication needs of people living with dementia. When people became upset or anxious, they were comforted appropriately. Some were given a hug and others were reassured verbally. On each occasion the person appeared more relaxed and happy after the interaction.

Staff treated people with dignity and respect. For example, when a person's dress was riding up while they were asleep in a chair, a staff member covered them with a blanket to protect their dignity. When a person spilt a cup of tea on the floor a staff member mopped it up without making any negative comment and the mishap was kept between the two of them. During an activity a person started disturbing other people who were engaged with the activity by walking around. The staff member calmly reassured the people engaged with the activity, which allowed them to complete their activity while also giving the other person the freedom to continue walking around.

Staff used their knowledge of people's lives and backgrounds to strike up meaningful conversations and build relationships. We observed a member of staff asked if they could sit with a person while they completed some paperwork. The person agreed and then engaged in some friendly banter. A painted tree with staff photos and names was displayed in a prominent place to help people get to know the staff team. A number of large and small social groups had been formed at the home based on people's interests. For example, there was a men's group, a knit and natter group and an exercise group. These gave people a sense of belonging and opportunities for social interaction. Two people in particular had formed a friendship and told us they enjoyed spending time together. Arrangements had been made for people to practise their faith. Ministers from local churches visited regularly and there was also a bible reading group which some people attended

People were encouraged to remain as independent as possible in line with their abilities. For example, staff asked people where they wished to take their meals, where they wanted their drinks, and how they wished to be positioned in chairs. People who were able to mobilise without support were encouraged to do so. People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing to help make their rooms feel homely.

Staff ensured people's privacy was protected by closing doors when personal care was being delivered. They explained how they took time to ask what help the person wanted, made sure the person was at least partially clothed at all times and explained each step of the process. We observed staff adopted the same approach when using equipment, such as hoists, to support people to move. People were given a choice of receiving support from male or female staff and their choices were respected. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members were kept up to date with any changes to their relative's needs. A family member said, "If [my relative] has any problem, they're on to me in minutes." When decisions were made about resuscitation, relatives, or the people themselves if they had capacity, had been informed and involved in discussions about this.

Good

Is the service responsive?

Our findings

People received personalised care from staff who understood and met their needs well. One person said, "They look after you well here." Another person told us "They do everything for you; it's very good. They'll even take me shopping if I want to." A family member said of the staff, "They're very responsive. If [my relative] becomes upset, they take them somewhere quiet and give them some one to one time."

Senior staff conducted comprehensive assessments before people moved to the home. They told us they considered whether they could meet the person's needs as well as the impact they would have on other people currently living at the home. A visiting healthcare specialist confirmed this, and said "[The registered manager] will only take people into the home if they fit in with the home and other residents." The registered manager told us they also conducted assessments before people returned to the home after having been admitted to hospital. They said, "We have to make sure we can still meet people's needs."

Care plans provided sufficient information about how people wished to receive care and support. However, these were in the process of being updated and transferred to a new computer system. This meant information, in some cases, was difficult to access as it was split between the paper copy, the old system and the new system. However, staff were aware of this and were careful to cross reference the information they had to make sure it did not impact on people. Once the transition is complete, the new system should result in staff being better able to ensure that people receive consistent, personalised, care and support.

Staff used their knowledge of people, and good working relationships with professionals to design and develop effective interventions and support. For example, one person's physical and mental health was gradually deteriorating; after discussion with the person and a community nurse, it was decided to place the person on bed rest and care for the person in their room. As a result, the person's health improved and those involved in the person's care told us the person was now "thriving" and "much happier". Another person had a skin condition which the community nurses were struggling to treat. Staff suggested an alternative treatment, to help keep the person's skin cooler, which they discussed with a community nurse; this was implemented and the condition was starting to improve. The community nurse told us "The treatment [for this person] is working well. Staff know and assess people well and we're happy to take their advice."

Care staff understood the needs of people living with dementia who had difficulty expressing themselves verbally. The registered manager told us "We spend a lot of time understanding people, their behaviours and their worlds. People are complex and individual." A staff member said, "We pick up on everything, like changes in mood, behaviour or eating patterns." Another staff member told us, "People need lots of reassurance; you have to take your time with them, make eye contact and go with their conversation." We saw staff using these techniques effectively, particularly when people became anxious. A family member said of the staff, "They know when [my relative] is unwell or upset. If one thing doesn't work, they try something else."

Staff were aware of the many different types of dementia and the care and support each person needed based on this. For example, a staff member told us they had "happy hour" each week when they made cocktails for people and were aware that one person needed to have non-alcoholic drinks due to the type of dementia they were living with.

Staff had developed information to help identify when people were in pain and we saw people were assessed for pain relief at each medicine round. When a person started rubbing their head, a staff member told us "I will talk to [the staff member doing the medicines round] and ask about a PRN because she is rubbing her head". Within 10 minutes the person had received pain relief.

Reviews of care were conducted regularly by nominated key workers. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. As people's needs changed, the key workers developed the care plans to ensure they remained up to date and reflected people's current needs. People and their relatives were consulted as part of the review process and their views were recorded.

People were supported and encouraged to make choices. For example, a member of staff was playing dominoes with a person when their drinks arrived. The staff member offered the person the choice of finishing the game or having their drink first. The person chose to finish the

Good

Is the service responsive?

game, which they did. They then helped pack away the dominoes before enjoying a cup of tea together. The personal histories, interests and hobbies of people were recorded in care plans and these were used to tailor activities to meet their individual preferences.

People were encouraged to take part in activities to prevent them from becoming socially isolated. One person told us "We do game and exercises and keep fit. It keeps me mobile." We observed an exercise class which some people enjoyed, although at times the video being used went at too fast a pace for people. Some people later took part in a quiz which they enjoyed and a card game designed to stretch people's mental agility. A group of people also took part in two craft sessions, making lavender bags and Halloween decorations. One to one activities were arranged for people who preferred to spend time in their rooms and were at risk of social isolation. For example, we saw a staff member spent time with one person reading a particular newspaper that is designed to stimulate the mind and memories of older people, which the home subscribed to. Another staff member was trained in beauty therapy and delivered a range of beauty treatments and therapeutic massages to people in a purpose built room. Whilst engaging in activities with people, staff used the opportunity to talk and reminisce with people about their lives.

The provider sought, and acted on, feedback from people, relatives, staff and professionals to help identify ways of improving the service. Following comments made by relatives in response to a recent survey by the provider, new flooring was laid in the front lounges. After comments we made about the dining room during our last inspection, we saw this had been redecorated. 'Residents meetings' were held regularly and were used to discuss activities, menus and any concerns. As a result of comments from people, we found more potatoes and a different brand of sausages had been incorporated into the menu. This showed people were listened to. There was an appropriate complaints policy in place, which people and relatives were aware of. No complaints had been recorded for the past year.

Good

Is the service well-led?

Our findings

People liked living at the home and felt it was well-led. One person said, "I can't fault the place, it runs well." A family member told us "The staff are brilliant; they work well together. The whole place is well-organised." A response from a person to a recent survey conducted by the provider stated: "Autumn House is an amazing care home and every member of staff is dedicated to their work."

The registered manager and deputy manager worked well together and complemented each other in their style. The registered manager told us "We're constantly looking at how to make things better for people. We just want the home to be the best we can make it." This vision was understood and shared by the staff. Staff appeared happy, told us they enjoyed working at Autumn House and felt supported. A newer member of staff praised the way they were "welcomed into the fold" when they started working at the home.

There was a close working relationship between management and staff. This was helped by the office being accessible, in the centre of the home, and an open door policy which meant staff and people could readily seek advice and support throughout the day. The registered manager started work at 7:00am on week days so they could support and keep in touch with night duty staff. They also took part in handover meetings at the start of the day, so they knew how each person was; this allowed them to organise any additional support that was needed.

There was a clear management structure in place, all staff understood their roles, were motivated, committed and worked well as a team. One member of staff told us "The home runs really well." Another said, "We all get along well; we're friends in and out of work." At the beginning of the shift, each staff member was delegated to perform a specific role to make sure people received all the care and support they needed. A staff member told us, "The delegation works well and everyone knows what's expected of them." Staff praised the management who they described as "approachable" and said they were encouraged to raise any issues or concerns.

Staff meetings were held regularly and provided opportunities for staff to make suggestions and raise concerns. One staff member told us "There's a good atmosphere. People will speak up and say how they feel; they are listened to." Another staff member said of the meetings, "They're good and give us a chance to share ideas."

The registered manager received appropriate support from the provider. They told us "We're blessed with really good directors. They trust us. They are always there if we need them and are very supportive." The registered manager was nominated by the provider and a staff member for an award for the 'best dementia care manager 2015'. Following assessment and interview, they were selected as a finalist and attended an award ceremony organised by a national charity.

There was an open and transparent culture within the home. Visitors were welcomed, the provider notified CQC of all significant events and there were good working relationships with external professionals. A community nurse told us "Everything here is organised and runs well." The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. The provider had recently introduced a 'Duty of Candour' policy, which they were developing further. The policy was followed when a person fell and sustained an injury; the necessary information was given promptly to the person's next of kin. There were links to the community, including visits from ministers of religion, a scouting organisation and 'buddies' from a national charity that supports older people. In addition, some relatives of people who had passed away at the home continued to visit and receive moral support. One relative told us "I think of this as my second home now."

Audits of key aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly to assess, monitor and improve the quality of service. Some of the audits, including the infection control audit, were very detailed, whilst others were in the process of being enhanced. An external audit had been conducted of medicines management, which showed the arrangement were safe and effective.

The provider had a development plan in place. This included installing en-suite bathrooms for every bedroom and the building of an extension to create a reception area with easier access for people with reduced mobility. A treatment and consultation room was being created to give people more privacy when they saw visiting doctors and

Good

Is the service well-led?

nurses. New technology was also being introduced to help staff perform their roles more effectively. This included hand-held computers to make it easier for staff to record the care provided and to prompt them when people needed support, such as regular turning to prevent pressure injuries.