Williams & Spenceley Limited

# Howlish Hall Nursing and Residential Home

**Inspection report**

Howlish
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## Ratings

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

## Overall summary

The inspection took place on 9, 10 and 11 September 2015 and was unannounced. This meant the registered provider or staff did not know about our inspection visit.

We previously inspected Howlish Hall Nursing and Residential Home on 8 August 2013, at which time the service was compliant with all regulatory standards.

Howlish Hall Nursing and Residential Home is a home in Bishop Auckland providing accommodation and nursing care for up to 40 older people who require personal care. 34 people were living in the home at the time of our inspection, 15 of whom were living with dementia.

The service had a registered manager in place. A registered manager is a person who has registered with

# Summary of findings

the Care Quality Commission [CQC] 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.

We began the inspection on the evening of 9 September 2015 in response to concerns raised with the CQC about levels of staffing overnight. We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service. All staff were trained or had training scheduled in core areas such as safeguarding, moving and handling, infection control and first aid. The service had a dedicated member of staff who organised training. We found that staff had an adequate knowledge of people's preferences, needs, likes and dislikes.

We observed discreet and thoughtful interactions during our inspection and saw evidence in recorded documentation of the promotion of people's right to dignified care. Relatives and external stakeholders told us that people were treated well and mostly agreed that the service was welcoming and effective.

There were effective pre-employment checks of staff in place and effective staff supervision and appraisal processes.

The service was mostly clean throughout and had acted on the majority of recommendations by the infection control team, although we did observe one requirement had not been acted on. During our inspection we also found a room used for storage and a sluice room left unlocked, which presented hazards to people using the service; these were rectified immediately.

Person-centred care plans were in place for all people using the service and the registered provider sought consent from people for the care provided. We saw that the registered provider was in the process of revising care planning and handover processes. We saw that there had been a number of failures to record aspects of care given, such as hourly positional checks and fluid intake records. The registered provider was able to show us that they had identified failings in the handover system used and had started the process of reviewing how all care plans and handovers were recorded.

The registered provider ensured relatives and healthcare professionals were involved in ensuring people's medical, personal, social and nutritional needs were met.

The service had a robust set of policies and procedures to deal with a range of eventualities. Most people using the service we spoke with, relatives, staff and external professionals were complimentary about the management and ethos of the service.

The CQC monitors the operation of the Deprivation of Liberty Safeguards [DoLS], which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The registered manager was knowledgeable on the subject of DoLS and had provided appropriate paperwork to the local authority to deprive people of their liberty, where it was in their best interests.

# 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?**

Requires improvement

The service was not always safe.

A number of hourly checks had not been documented in handover documentation.

The service had a clear disciplinary policy that had been implemented fairly when concerns were raised.

Medicines were administered and disposed of safely and securely and in line with the National Institute for Health and Social Care Excellence [NICE] guidance.

Safeguarding training had recently been completed and staff displayed a good understanding of risk and the types of abuse people could be at risk of. Staff were able to explain what actions they would take should concerns arise.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service.

**Is the service effective?**

Good

The service was effective.

People's medical needs were met through ongoing involvement of a range of healthcare professionals.

People's nutritional and hydration needs were met through the effective monitoring of potential malnutrition, dietician involvement and the use of relevant nutritional tools.

Staff training was up to date and, where training was required we saw that this had been booked.

**Is the service caring?**

Good

The service was caring.

Interactions between staff and people were warm and fun where appropriate; staff had built good levels of rapport and meaningful relationships with people using the service.

People who used the service and their relatives felt at home and there were no restrictions on visiting times.

The management team and all staff had a good understanding of people's needs, preferences, likes and dislikes.

**Is the service responsive?**

Good

The service was responsive.

# Summary of findings

When people's needs changed, the service promptly ensured that relevant healthcare expertise was sought and people's needs met.

Regular meetings with people who used the service, relatives and staff ensured the service took into account and acted upon preferences regarding group and individual activities.

All complaints were handled seriously and sensitively, with information on how to make a complaint easily accessible.

**Is the service well-led?**

Good

The service was well-led.

All people who used the service, staff, relatives and healthcare professionals agreed the atmosphere of the service was welcoming and homely and that privacy and dignity were valued.

The culture at the home was one of openness, where challenge was welcomed from people using the service or staff, alongside regular review meetings.

The registered manager had implemented or was implementing a range of measures to tackle challenges the service faced, such as sickness absences, in order to ensure there was not a detrimental impact on the care people received.

# Howlish Hall Nursing and 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 registered 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.

We visited the service on 9, 10 and 11 September 2015 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service.

We spoke with six people who used the service. We spoke with ten members of staff: the registered manager, the registered provider, one nurse and seven care staff. We spoke with two visiting nurses and a podiatrist. We also spoke with five relatives who were visiting their family members.

During the inspection visit we looked at five people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

We spent time observing people in the living rooms and dining area of the home.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC.

Before the inspection we asked the provider to complete a Provider Information Return [PIR]. The PIR is a document that the CQC ask providers to populate with key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. The PIR had been completed and we used this information to inform our inspection.

Requires improvement

# Is the service safe?

## Our findings

One person who used the service told us they felt, "Perfectly safe here" whilst another told us they felt looked after by the service. One relative we spoke with told us there were, "Never any concerns" with regard to safety.

We reviewed four staff records and saw all underwent pre-employment checks including enhanced Criminal Records Bureau [now the Disclosure and Barring Service] checks. We also saw that the registered manager verified at least two references and ensured proof of identity was provided by prospective employees' prior to employment. This meant that the service had in place a robust approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

Most staff we spoke with felt staffing levels were appropriate. One person who used the service told us, "Night staff responded quickly" when they needed help and that they never had to wait long for staff to support them. All relatives and people who used the service we spoke with agreed there was adequate staffing and during our observations we saw that all people using the service were supported without delay. This meant people were protected against the risk of neglect through insufficient staffing.

We spoke with four members of staff about their experience of safeguarding training and all were able to articulate a range of abuses and potential risks to people using the service, as well as their prospective actions should they have such concerns. We saw that details for local safeguarding contacts and reminders about the need for vigilance were clearly displayed on posters in communal areas. This demonstrated that the service had ensured that appropriate safeguarding training had been delivered and that staff were able to identify situations where it would be applicable.

We saw that individualised risk assessments with clear descriptions of risk were in place to complement care plans and these were reviewed monthly and accordingly updated where, for example, professional advice had been sought. This meant the service had in place a risk assessment regime tailored to individual need.

Where staff, relatives or members of the public had raised concerns with the management, we saw the registered manager and registered provider had investigated the matter promptly and thoroughly. We saw that, since our last inspection, two people had been dismissed. When we reviewed the reasons for these dismissals we saw that the provider had investigated the concerns thoroughly and ensured vulnerable people using the service were protected from harm or abuse. We saw that the disciplinary policy that had been followed was current, clear and robust. This meant that, where concerns regarding the safety of people using the service were raised with the provider, those concerns were taken seriously and, through the application of disciplinary procedures, appropriate action taken.

We reviewed the administration, storage and disposal of medicines and found some discrepancies. For example, medicines fridge temperatures had not been consistently recorded on all days in one treatment room and some eye drops were out of date. We raised this with the registered manager who immediately destroyed them. We reviewed the medicines policy and found it to be clear and concise, whilst we saw that staff training in medicines management was current. We sampled the Medication Administration Records [MARs] and controlled drugs records and saw there had been no errors. We also saw that the registered manager had undertaken regular MAR audits. The MAR file did not have a signatures sheet in the front but we found that one was available in the nurse's office. A copy was made and placed at the front of the MAR file. A signature sheet helps anyone checking the use of medicines to see at a glance who has signed various parts of the MAR. We also saw that the MAR file did not have allergen information readily accessible at the front of the file. This meant the service had not always adhered to National Institute for Health and Social Care Excellence [NICE] guidance regarding the administration of medicines. The registered manager in this case took immediate action to rectify the situation, updating the MAR file in response to our findings and was also able to show us the job description for a newly-created role, which incorporated additional medicines audits into the role. This meant that the service had in place measures to improve its management of medicines and could provide assurance that it would protect people from the risk of the maladministration of medicines.

We reviewed the handover system used by the service to document regular checks undertaken by care staff and the sharing of this information between day and night carers.

Requires improvement

# Is the service safe?

We saw that the system involved a handover book as well individual hourly check sheets held in people's rooms. We saw that in one instance the appropriate checks had not been documented regarding one person who required two-hourly positional checks to protect against the risk of pressure sores, whilst another person who was at a heightened risk of bladder infection due to catheterisation had similarly not had their fluid intake chart updated. This meant that some risks were not being managed effectively. The registered manager and registered provider acknowledged their current system of ensuring hourly checks and any issues handed over between shifts was flawed. The registered provider was able to show us evidence that they had already started to revise the current handover and care planning system. We also reviewed the job description of the new senior care role the service was implementing and saw that it incorporated responsibility for sustaining improvements to the handover process through audits. The registered manager was also able to show us the new schedule for handovers between shifts, which built in a 15 minute period explicitly for handovers at the end of each shift. This meant that, whilst people had been placed at risk of unsafe treatment, the provider had acted proactively to address the issue.

We also spoke with the relevant healthcare professionals who had involvement with people using the service and asked them specifically about the areas of care where we had identified the lapses in recording care. We did this to see whether the lapses were errors in the documenting of care or whether there were more fundamental concerns with the nature of care provided. They told us that, in relation to both fluid intake and pressure sore care, the service was proactive in raising concerns with healthcare professionals and had a history of working closely with them to resolve potential risks at an early stage.

With regard to environmental risks, we observed areas where the service could improve. For example, one redundant bathroom had been left unlocked and contained a range of broken furniture and building equipment, presenting a range of trip hazards to people who used the service. Similarly, a sluice room had been left unlocked. This meant that people who used the service were placed at risk of unnecessary trips, falls and exposure to unclean conditions. When we raised these issues with the registered manager they undertook to ensure that similar mistakes would not reoccur. We saw that during our inspection both these rooms had been locked, the former with clear signage added.

A recent infection control visit raised areas where improvements were required. We sampled a range of these suggestions and saw that the majority had been addressed immediately. We did find that personal toiletries had not been moved, as required, from a communal bathroom and raised this with the registered provider. We saw that this required action had been communicated to staff via a minuted meeting and the registered provider undertook to reaffirm the importance of infection control with staff. This meant that people's experience of the cleanliness of the service was a broadly positive one, as was that of relatives and staff. Where improvements were required we saw that the registered manager and registered provider had engaged with external professionals, made changes and were committed to ensuring a sustainable approach to infection control. This meant that people were better protected against the risk of infection.

The Food Standard Agency [FSA] had given the home a 5 out of 5 hygiene rating, meaning food hygiene standards were very good. This meant people's meals were prepared in an environment protected against the risk of infection.

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans [PEEPS] were in place, meaning that people could be supported to exit the building by someone who would have access to their individual mobility and communication needs in the event of an emergency. Fire extinguishers had been recently serviced, whilst there were also regular internal checks of the home's fire equipment and regular emergency lighting tests. Call bells, all accessible, were also tested regularly. We saw that all water temperatures were tested regularly to protect against the risk of Legionnaires. All staff were either trained in First Aid or had their training course date planned and we saw that First Aid equipment was clean and complete. This meant the service was helping to protect people using the service from risks brought about through fire or accident.

We saw documentation confirming up to date maintenance of the stair lift, hoist, gas boiler, electrics and catering equipment. This meant that the service had ensured that people were not put at risk through a failure to upkeep premises or equipment.

Good

# Is the service effective?

## Our findings

One relative told us, "I cannot fault the staff" and that "They are aware of [person's] needs", specifically referencing the need for high levels of fluid and how there was always water easily accessible for the person who used the service, as well as cups of tea. We explored this in more detail and saw that the person who used the service had in place a specific fluid intake care plan to ensure their hydration needs were met. One healthcare professional described staff knowledge of people who used the service as, "Very good." People who used the service told us the care they received was effective and that staff knew them well. One person told us, "Staff are very nice".

Staff told us they felt sufficiently trained to carry out their roles. We saw that staff training was relevant to people's needs, with all members of staff undergoing safeguarding, first aid, risk assessment, dignity, manual handling, fire safety and infection control training. This meant people could be assured that staff providing care had good basic training.

We saw that care plans contained good levels of detail with regard to people's preferences, whilst consent had been sought regarding people's care and, when we spoke to people who used the service and their relatives, they confirmed that their consent was sought regarding treatment. We also observed medicines being administered on one morning of the inspection and saw that medicines were patiently explained to people and consent was sought before they were administered.

CQC monitors the operation of the Deprivation of Liberty Safeguards [DoLS], which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where that freedom is restricted a good understanding of DoLS ensures that any restrictions are in the best interests of people who do not have the capacity to make such a decision at that time. We saw that the registered manager had a clear understanding of mental capacity issues, including DoLS and had submitted appropriate applications to the local authority.

We saw that staff supervisions were undertaken regularly along with an annual appraisal. Staff we spoke with were positive about the opportunities they had to raise concerns and seek support. This meant people could be assured they were cared for by staff who regularly had the opportunity to challenge practices.

We saw that staff meetings were also held monthly and feedback was given to staff to ensure they adhered to external and management instructions, such as adjustments following an infection control inspection.

We saw that people who had a Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] decision in place had been fully involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. Anyone with a DNACPR in place had this reviewed regularly. This meant people were involved in regularly monitoring their needs and making prompt changes where required.

We saw that people were supported to maintain health through accessing healthcare such as opticians, podiatrists, occupational therapy, speech and language therapy, GP appointments and District Nurse visits. We spoke to a number of healthcare professionals who were visiting during our inspection and they consistently agreed that the service sought specialist help when required. One told us, "We have built up a good working relationship" and "Information gets disseminated to the people who need to know". This meant the service ensured that people who used the service received appropriate medical support through seeking and acting on feedback from healthcare professionals.

With regard to staffing, one visiting healthcare professional stated that, whilst they were aware the service had experienced pressure to ensure adequate numbers of staff were available recently due to sickness, "They always try their best to find cover if people are sick."

With regard to nutrition, one person told us, "The food is very good" and another person complimented the cooking stating, "Proper miner's food." We saw that there was a four weekly menu system and people were given a choice of food each meal time and that, where they preferred something else to that served, alternatives were prepared. The dining experiences we observed during our inspection visit were calm and unrushed with people who required help supported by adequate numbers of staff. One person

Good

# Is the service effective?

chose to eat in their room and we observed them being given a choice of main course shortly before lunch was served. This meant people's dining preferences were respected and acted on.

We saw that anyone assessed as at high risk of malnutrition via the Malnutrition Universal Screening Tool [MUST] was supported with fortified supplements. MUST is a screening tool using people's weight to identify those at risk of malnutrition. People with diabetes had the option of low sugar desserts and puddings and we saw that the risk of diabetes had been noted via the MUST screening tool. We saw that people were weighed regularly in accordance with their assessed needs and action taken where a person's weight dropped significantly. For example, we saw that one person's weight had dropped markedly in a short space of time. The service ensured, through dietician involvement, that an action plan was in place and the person supported to regain weight. This meant the service ensured that risks to people through malnourishment were managed successfully.

One visiting healthcare professional, when asked about whether the service had contributed positively to people's wellbeing stated, "Some of them are really flourishing."

We observed that the environment of the home was not dementia friendly. For example, doors to people's rooms had small nameplates and no distinguishing features, whilst one toilet whose door closed flush with the corridor wall was painted the same colour as that wall, making it difficult to distinguish the toilet door from the wall. Clear signage had not been used throughout the home to indicate, for example, the dining area or bathrooms. The registered manager acknowledged this was an area the home could improve and agreed to improve signage immediately and review best practice guidance regarding dementia friendly environments in line with standards set out by the National Institute for Health and Care Excellence [NICE]. The registered manager was also able to show us that the home had recently had all doorways widened through the removal and refitting of old door frames, meaning doorways were now more accessible. This meant the service had made some alterations to the premises that had a positive impact on the mobility of people who used the service.

Good

# Is the service caring?

## Our findings

One relative told us, “If anybody asked me where to go for a loved one, I’d recommend it,” whilst another said; “The care is wonderful.” One person who used the service told us, “They can’t do enough to help.”

Staff had a good understanding of people’s interests and were able to articulate individual likes and dislikes, as well as act on these preferences during the inspection. For example, during our inspection we saw that one person preferred to stay in their room. We saw that a member of staff checked on them regularly and asked if they would like to listen to their preferred music. We also saw one member of staff holding a lively quiz with people and we observed laughter and positive interactions throughout the inspection.

We saw people supported in a patient and dignified manner. One relative commented that staff could sometimes be, “Abrupt” but, in line with what most people told us, we observed a range of warm interactions between staff and people who used the service during our inspection. We spoke to the registered manager about the comments made and they were able to show us evidence of when they had asked for an improvement of attitude by a member of staff. This meant that, where staff did not interact with people in an appropriately respectful and dignified manner, as set out in the Employee Handbook, people were listened to and action taken and that the registered manager actively promoted a compassionate approach to care.

People and their relatives were involved in their care and all rooms we saw were personalised and homely. When asked about their involvement in their care one person told us, “They’re very kind.” A relative told us they were always made to feel welcome and that they visited daily, at variable times, and were never restricted in terms of when they could visit. This meant the service did not put restrictions on the times when relatives could visit, contributing to a more relaxed and welcoming environment in which people could feel at home. One relative told us staff did not make them feel welcome but this was not the consensus with all other relatives, people using the service and healthcare professionals we spoke to.

We saw a range of recent thank-you cards, which contained comments such as, “Thank the staff for all the loving care and attention” and “Appreciation for the excellent care and many kindnesses shown.” Relatives we spoke with confirmed that they were invited to care review meetings. One relative told us, “They always have time to speak...I get involved in everything” and another one said, “They involve the family”.

The service supported end of life care where it was the individual’s choice to remain at the home. We saw that the person’s preference drove these decisions, which were also made through consultation with family members and healthcare professionals. We saw that the registered manager and two other members of staff were due to attend Gold Standard Framework training regarding end of life care. This meant the service provided dignified and compassionate end of life care within a familiar and caring environment, and was seeking further support through a recognised training scheme to improve that level of care.

We saw that information regarding advocacy services was readily available. No one who used the service had an advocate but family members were invited to regular resident/family meetings to ensure that people benefitted from informal advocacy and support.

We saw that a number of people using the service were regularly visited by the local priest, whilst two nuns also visited the service to provide support to people. This meant people’s religious beliefs were respected.

Each person using the service had a specific communication plan in place, meaning any new care staff would benefit from information about whether the person had any specific communicative needs. This meant people could be assured involvement in day-to-day aspects of their care, as well as more formal care planning reviews.

Good

# Is the service responsive?

## Our findings

One person using the service told us how they preferred to return to their room at a certain point in the afternoon to watch a quiz show on television as they did not always want to take part in a group activity. They told us that staff were always amenable to this and sometimes sat with them. This meant that individual preferences were recognised and people who did not participate in group activities were also supported flexibly to pursue their interests.

We also saw that part of the activities co-ordinator's time was spent with people who were unable or chose not to partake in group activities. These one-to-one sessions were factored in to the activity co-ordinator's weekly schedule and involved sitting with the person and partaking in an activity of their choice, for example, a game of cards or listening to music and chatting. We observed one of these sessions and found them to be engaging, patient and informed by a good knowledge of the person's interests. This meant that people who used the service received individual activities where it was there preference.

With regard to group activities, we saw that these were planned weekly with options visible on a noticeboard and included film nights, singers, bingo and quizzes. Group trips were discussed at resident and family meetings and one person told us, "The trips are great" and referenced a recent visit to the seaside. We saw that another trip to a local market had been arranged in response to suggestions from people who used the service. Other imminent events and activities included a visit from a wild animal sanctuary, a coffee morning and a project to produce a canvas with each person's life history on. The registered manager agreed this was also an opportunity to incorporate aspects of this project into making the premises more dementia friendly, for example having a version of the canvas on people's doors. This meant that the service was responsive to the interests of people who used the service and involved them in planning and carrying out activities that were varied and stimulating.

A pre-admission assessment was completed in every care file we looked at, which set out people's needs, likes, dislikes, personal history and preferences. The level of information in care files was variable as key workers were responsible for updating the plan of a specific one or two people, meaning there was not always a consistent standard across care planning documentation. The registered manager was able to show us the revised care planning system they were in the process of implementing, along with the job description of the new senior carer role containing specified actions in relation to implementing person-centred care. They were also able to show us that members of staff were attending person-centred care refresher training shortly, with a view to contributing to the updating of care plans. This meant the service was better placed to ensure all people who used the service had their preferences fully taken account of and acted on.

One relative told us how the service had supported them and the person who used the service at a time when they had received conflicting medical advice and were unsure how to proceed. The relative told us that the service had ensured that where the person had any potential changes in their care they had communicated with them clearly, which helped reduce their anxiety. The same person had recently moved rooms and they and their relative confirmed that they had been involved in the decision-making at all stages. Another relative told us, "[Registered manager] always seeks our views." During our inspection we observed another person being offered a move into a vacant room, which offered even more space. This enabled the person to bring in their own furniture and meant people's preferences were listened to and acted on where practicable.

We saw that a complaints policy was in place and guidance regarding how to make a complaint was clearly accessible to people who used the service, their relatives and staff. We reviewed all complaints and saw that each one had been considered and responded to comprehensively, with follow up actions taken where appropriate. We also saw that the registered manager had asked people who used the service if they had any complaints or concerns at each residents' meeting, also giving people the option to speak with them in private after the meeting in the interests of discretion. We saw that, when this had happened, the registered manager followed up the issue to the satisfaction of the person who used the service. This meant that people who used the service were fully supported by the service when they made complaints through a comprehensive, sensitive complaints process.

We saw evidence that the registered manager identified changing needs quickly then liaised promptly and proactively with healthcare professionals to ensure people

Good

# Is the service responsive?

who used the service received the best outcomes from treatment. For example, one person was identified as being at a heightened risk of pressure sores. We saw that the registered manager had involved healthcare professionals at an early stage and procured pressure-relieving equipment. The person had since suffered no pressure sores and a healthcare professional complimented the service on their proactive management of the risk of pressure sores. This meant the service was able to identify a potential risk at the earliest stage and ensure a positive outcome for the person through liaison with external healthcare professionals.

With regard to potential transition between services we saw that everyone who used the service had a document similar to a hospital passport in place. This documented essential information to be used if a person was admitted to hospital or moved between services.

Good

# Is the service well-led?

## Our findings

At the time of our inspection, the home had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service.

During the inspection we asked for a variety of documents to be made accessible to us. These were promptly provided, well maintained and mostly organised in a structured way, making information easy to find. We found the registered manager maintained up to date and accurate policy and procedure documentation.

The registered manager was clear about the values set out in the Philosophy of Care document and the employee handbook and was responsible for ensuring those values were held consistently by staff. These documents set out the priorities of the home as recognising each person's individuality and providing care and support within a 'safe and comfortable environment'. We found that this had broadly been achieved. We saw evidence of these values being promoted in staff supervisions and, at the time of our inspection the whole staff team were approachable and helpful. The staff we spoke with were passionate and dedicated to their caring work and, when asked, spoke enthusiastically and consistently about the values of the service.

With regard to the support offered by the management at the service, one member of staff told us; "They always listen" and another "They manage fairly." Relatives also told us that they felt the service was managed fairly. This meant people could be assured the service was managed fairly.

The registered manager showed us the staff rota and kept staffing levels under review regularly and adjusted levels according to people's needs and activities. For example, when particular activities were planned the home needed to ensure more staff were available. The registered manager told us that the greatest challenge the service faced was sickness levels and we saw that the registered provider had been using high levels of agency staff to cover these shortfalls. External healthcare professionals and other members of staff told us that the registered manager; "Does everything" to ensure staffing levels are adequate. We asked whether the registered manager could be assured that skill mix of staff on night shift was such that people could be assured high quality care. The registered manager agreed to ensure that the newest member of nursing staff working nightshift would be supported by an experienced member of staff until they were more confident. This meant that the registered manager took seriously the need for care to provide a familiarity and continuity wherever possible.

We saw that regular meetings were held with people who used the service and their relatives and that feedback, positive or negative, was acted on and outcomes were clearly communicated to people. Likewise we saw that staff meetings occurred regularly and there was an annual anonymous staff survey, the latest results of which showed that the majority of respondents rated their experience of working at the service and the care provided as 'Good' or 'Very Good'. This meant that people who used the service and staff were engaged through a range of forums through which to voice feedback or concerns.

We saw that the registered manager had made or was in the process of making, a range of changes designed to improve the care provided to people using the service, including revisions to care planning documentation, day/night shift handover procedures and a new senior carer role. This meant that the registered manager was aware of where the service needed to improve and had actively started to address these areas prior to our inspection.

The registered manager and registered provider had a sound knowledge of the day-to-day workings of the service and we observed both assisting people who used the service in a caring manner during our inspection. Staff and relatives praised the, "Hands on" approach of the registered manager. We saw the registered manager audited a sample of documents such as care plan reviews and had incorporated support on all aspects of auditing into the new senior carer job description. This meant the service valued quality assurance and was able to demonstrate how it would continue to assess its own performance and safety in the future.

People who used the service, their relatives and staff were encouraged to raise queries openly and we saw this management stance echoed in policies and procedures, meaning that people had the opportunity to make their concerns heard. This meant the management team were approachable, open and transparent in their handling of queries or concerns.

Good

# Is the service well-led?

Strong links were in place with the local church and a local school, who performed a nativity play at the home at Christmas. This meant the service maintained links with the local community that people who used the service could access.