Hopton Care Cottages Limited

Hopton Cottage Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Hopton Cottage Care Home took place on 22 June and 1 July 2016. The home was last inspected during January 2014 and was compliant in the areas inspected. This was the first inspection of the home under the current provider. The registered manager was taking leave and not available to speak with us in person on the first day of our inspection. We therefore met with the care manager. On the second day of our inspection we spoke with the registered manager.

Hopton Cottage Care Home is a purpose built care home which provides accommodation for up to 60 people who require personal care. Accommodation is provided across three different units. One unit is for people who do not have any specific mental health needs such as dementia, one is for people with mild memory problems and one is specifically for people with a diagnosis of dementia. Of the 60 rooms, 50 are at ground floor level. Every ground floor room has access to a private patio garden through patio doors. At the time of our inspection there were 59 people living at the home.

The service had 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 living at the home and appropriate procedures were in place to help keep people safe. Risk assessments had been completed and measures taken to reduce risks. The building was well maintained and regular safety checks took place.

Medicines were managed and stored in a safe way and staff who were responsible for administering medicines had received training to do so safely and their competency had been assessed.

Appropriate recruitment procedures were followed and staff had received necessary training to enable them to provide effective care and support to people. Staff were aware of people's individual care needs.

Consent to care was sought from people and staff acted in accordance with the principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

The design and layout of the home was appropriate to meet people's needs and the home was fresh and clean.

People and their relatives told us staff were caring. We observed a pleasant, relaxed atmosphere in the home and people's privacy and dignity were respected.

Care and support was provided in a person centred manner. Care needs were regularly reviewed and people were involved in their care planning. People told us they could make their own choices.

The home was well led by a management team that communicated their aims and visions to people who lived at the home and to staff. Staff were motivated to provide good care to people.

Regular staff meetings and resident meetings were held and the registered manager sought feedback from people.

Audits took place regularly and action plans were developed and acted upon to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe.

People were kept safe because sufficient numbers of staff were available and responded promptly to people's needs.

Medication was managed well and was administered in a safe way by staff that had been trained to do so.

Risks to people were assessed and measures were in place to reduce risks.

Is the service effective?

Good

The service was effective.

We observed staff knew the people who they were supporting well.

Staff were trained in, and had a thorough understanding of, the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were given support to ensure their hydration and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's preferences, choices and personal histories.

We observed people making their own choices.

People were involved in a variety of activities according to their interests.

Is the service well-led?

Good

The service was well led.

Staff told us they were supported by the registered manager and they felt the service was well led.

The registered manager held regular meetings with staff and people who lived at the home.

Regular audits and quality checks took place and these resulted in improvements to service provision.

Hopton Cottage Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 22 June and 1 July 2016 and was unannounced on the first day. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. 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 we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with 13 people who lived at the home, seven relatives, two visiting professionals, a member of catering staff, six care and support staff, the care manager, the director and development manager and the managing director who was also the registered manager.

We looked at five people's care records, five staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

All of the people we asked told us they felt safe living at Hopton Cottage Care Home and all of the relatives and visitors we asked felt people were safe. One person said, "I have been poorly for many months now. At last I am in a safe place." Another person told us, "I always call for help if I need it. The staff come straight away, including the night staff." A further person said, "I feel safe here. I have nothing to worry about."

A relative told us, "This place is so safe. I would not hesitate in reporting any concerns to the manager." Another relative said, "We feel a weight has been lifted. [Name] is so well protected here."

The registered manager, care manager and staff we spoke with were clear about safeguarding reporting procedures and were able to outline different types of abuse and give examples of potential signs to look for, which may indicate if someone was at risk of harm or being abused. We spoke with an ancillary worker who told us they had recently completed safeguarding training and they now felt more confident and understood what, 'Being safe,' meant.

A member of staff told us, "If I had any concerns, I am fully aware of whistleblowing. I would go straight to the manager." However, a further two members of staff lacked knowledge of who to report concerns to if they were not happy with the management response. We shared our findings with the registered manager who advised this was shared in training and induction but they would take immediate action to address this.

The care manager explained the home was designed to have many, "Safe, outdoor areas." People had access to the outdoors directly from their own rooms. The care manager advised that risk assessments were in place in relation to security, safety, whether doors should be locked or unlocked and moving and handling for example. We saw a falls risk assessment which took into account factors such as the person's level of consciousness, specific aids used, gait, balance and falls history for example. The registered manager told us the fundamental ethos of the home was to encourage a sense of independence and this was achieved through effective staffing levels, accurate, up to date care planning and risk assessments.

We saw Herbert protocol plans were in place in some care plans we sampled. The Herbert protocol is a national scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. This demonstrated that steps had been taken to further reduce risks to people.

We saw from accident records a person had experienced an unwitnessed fall. This was recorded appropriately and actions were taken. We looked at records which showed observations took place following the fall to ensure the person's wellbeing. The registered manager completed a falls audit tool which considered the date, time and location of the fall, as well as brief details. This helped to identify any trends and appropriate measures to be put into place such as pressure mats and corner furniture protectors to reduce risks associated with falling.

Emergency contingency plans were in place and these had been recently updated. Plans were in place in the event of a fire, gas failure, electrical failure and flooding for example. The plans included photographs of alternative routes to and from the home in the event of local flooding.
This showed plans were in place to help keep people safe in the event of an emergency.

Fire equipment servicing was up to date and records showed fire tests took place regularly. Emergency lights were tested regularly. We saw lift servicing and portable appliance testing took place, as required. The nurse call bell system had been recently serviced and inspected and gas safety checks were completed. This demonstrated steps had been taken to ensure the premises and equipment were safe.

There was an external keypad and access to the home was secure, with closed circuit television which covered the main door entry. This helped to reduce the risk of unauthorised access to the home.

The staff we spoke with told us they felt there were sufficient staff to meet people's needs and provide effective care and support to people. A member of staff told us, "We use bank staff if we need to, to cover sickness, but we don't use agency staff." The helped to ensure continuity of care for people.

The care manager told us they felt there were sufficient numbers of staff to meet people's needs. The registered manager told us a dependency tool was used and we saw an example of this. Staff numbers were above the level identified by the dependency tool to meet people's needs. We saw people's needs being met by staff who had time to talk with, and show compassion towards, people.

We looked at five staff files and found safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Deputy care managers, supported by the senior care manager, were responsible for administering people's medicines. Staff who were responsible for administering medicines had recently completed training in the area. Following training, staff completed a written test to consolidate their training and ensure they had understood safe processes.

We found medicines were managed safely. Medicines were stored securely and at the correct temperature. Dates of opening and dates of expiry were recorded on medicines once they had been opened. This reduced the risk of out of date medicines being administered.

We observed the member of staff responsible for administering medicines ensured the trolley was kept locked. This prevented unauthorised access to medicines. The staff member was very patient and sat with each person until their medicine had been taken. The staff member signed the medication administration records (MAR) to show the medicines had been administered only once they had been administered. This demonstrated good practice. We checked a random sample of medicines against the MARs and found the medicines remaining reconciled with the MAR. All the MARs we sampled were clearly and fully completed.

The medicine trolley was well organised and this helped to reduce the risk of errors occurring. Records showed regular blood sugar testing had taken place when necessary and this was recorded. The records we sampled showed stable and regular testing.

There was an infection prevention and control champion, who had received additional training in this area. This staff member told us they shared their knowledge with other staff and encouraged good practice. We

observed staff to be wearing personal protective equipment appropriately and we found the home to be clean and odour free. This showed the home had developed good infection prevention and control measures.

Good

Is the service effective?

Our findings

People were complimentary about the food. One person said, "The food is fabulous," and, "All the food is to a very high standard and there's plenty of it," and, "Nothing is too much trouble for the cooks. If you don't like something, they offer you something else straight away."

A relative told us, "My [Name] is very fussy but loves the food here. That makes me feel happier."

A number of relatives commented on the good quality of the laundry service. We observed people to be wearing clean and well cared for clothing. A relative told us, "The laundry system is amazing. Everything comes back looking beautiful."

We spoke with a visiting professional on the day of our inspection and we were told, "The staff know the residents very well. They always know the background to their problems," and, "Staff really know what they are doing."

Staff received a thorough induction and were given the opportunity to shadow more experienced members of staff before performing their caring duties. Induction had been devised in conjunction with a local company, who delivered the training. This showed the registered provider had participated in partnership working and had taken steps to ensure staff received appropriate training prior to providing care and support to people. Staff who were new to care were given the opportunity to complete the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. A member of staff we spoke with told us they felt they had received a good induction that prepared them for their role.

As well as completing an induction, staff had received ongoing training in areas such as person centred care, safeguarding, dementia awareness, health and safety, moving and handling, infection prevention and control and safe administration of medicines where appropriate. We saw new staff had been issued with notices stating, 'You are hereby officially instructed that, until you have received our manual handling training, you are not permitted to lift, transfer or move any resident.' This demonstrated staff who were providing care and support to people had received appropriate training.

We spoke with the care manager who told us the registered provider's policy was for staff to have a minimum of three supervision sessions each year. We were told 'on the spot' supervisions also took place if these were deemed necessary, for example if poor practice was identified. However, in the five staff files we sampled, we found a lack of formal supervision, although recent annual appraisals were evident. We discussed with the registered manager the importance of staff having regular opportunities to reflect on their practice through supervision. The registered manager was receptive to this and highlighted this was an action on their continuous improvement plan. We saw evidence of this, with an ongoing action for staff to have three fully documented supervision sessions per year.

Appraisals of staff performance took place annually. A new policy had recently been introduced, whereby staff rated their own performance and their performance was then discussed with their manager who also rated the staff member's performance. Objectives were then agreed and formulated. Bronze, silver and gold awards were achieved at appraisal. Staff that had completed their probation and achieved a gold award were recognised as advanced carers and received a financial increment. Advanced carers who then became champions in a particular area received further financial incentive. This helped to motivate staff and showed staff received support to develop.

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

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

The registered manager, care manager and the staff we spoke with demonstrated a clear understanding of the principles of the MCA. Staff were mindful of the requirement to presume that people have the capacity to make their own decisions and informed choices unless assessed otherwise. A member of staff we spoke with told us they felt it was important to give people choices. We were told, "We assume people have capacity. We try and help people to make choices, for example, by using pictures. Or we show a choice of clothes for example."

There was a DoLS procedure and policy in place. This clearly outlined what a deprivation of liberty was and the procedures that must be followed, in order to comply with the requirements of the law.

We saw evidence the registered manager had sought advice and guidance from the supervisory body in relation to the correct process and procedures when someone was deprived of their liberty. The registered manager had submitted appropriate applications to the supervisory body. Two had been approved and the others were awaiting consideration. The registered manager demonstrated an awareness of the need to maintain people's safety but without overly impacting upon their quality of life and right to liberty.

Consent to care was sought from people. We saw, throughout the day, staff requesting permission from people before providing care. We also saw people had consented to their care and treatment in a more formal sense in their care plans, such as in relation to equipment being used, visits from health professionals, medications being administered and photographs being taken.

Consideration had been given to improved methods of providing texture modified meals for people with chewing or swallowing difficulties and people who required soft or pureed meals. We saw an open invitation food taster session and food forum meetings were held. This was to gain feedback from people and their relatives. As a result, a new provider had been sourced and food was more visually appealing and precisely textured, according to people's individual needs. This also meant people's diet intake could be more effectively monitored, as the accurate nutritional content of every meal could be recorded.

We saw a signed that stated, 'Fresh fruit, fresh salads, healthy and high calorie snacks available at any time, as well as a variety of hot and milky drinks.' We looked at the menu and saw it stated, 'Special requests can be accommodated. Anything to make your stay with us a home from home,' and, 'You can have snacks any

time of day or night.' We observed there to be fresh fruit available throughout the day.

We observed a mealtime experience. The food looked fresh and appetising. A range of drinks were offered with the meal, including a choice of juices, water and wine, as well as hot drinks. Music was playing at an appropriate volume in the background. We found the mealtime to be a pleasant, sociable experience. The menu on display reflected the choices available on the day of the inspection. People were asked which vegetables they would like. Sauces were brought in small individual boats so people were able pour their own.

On the dementia unit, staff interacted well with people and explained what the meals were to people as they were served. Plate guards were used where appropriate. Plate guards can prevent food from falling from a plate and can make it easier for a person to eat their meal independently. People received appropriate support to eat their meals where this was required. When a person refused their meal, they were offered alternatives and given respectful encouragement to eat. Staff were observant and this helped to ensure people's nutritional needs were met.

A person wished to have their meal in their own room. We saw a carer took the person's meal to their room. The meal was covered and the sauce and gravy were separate so the person could pour their own. We observed a different person did not wish to go to the dining area so staff brought a small table to the person, so the person could remain seated in their chosen chair in the lounge area.

We heard staff say, "Would you like me to cut it up for you?" At the end of the meal, staff could be heard saying, "May I take your plate? Have you finished?" before clearing plates away. This helped to ensure people had their nutrition and hydration needs met.

The layout of the home was appropriate to meet people's needs. The home was large, with bright and airy spaces. In communal areas, some chairs were arranged in clusters which can help facilitate conversation. There were bookcases with books, plants and flowers and appropriate ornaments displayed. Positive homely signs were displayed such as a sign saying, "Smile and the world smiles with you." This helped to create a positive, homely atmosphere. People had access to their own individual rooms, with private outside space.

We saw a notice displayed on the entrance to the dementia unit which stated, 'Our philosophy is, 'how can we care for somebody if we don't know them?' To this end, we will be developing training programmes and approaches that put our residents' histories at the forefront of their care.' The notice requested help from families, asking them to provide photographs and special items from different eras. This showed the registered manager and registered provider were seeking to improve the dementia care provided.

Within the dementia unit, there were posters displayed from bygone eras and old style furniture. Photographs and pictures were placed outside people's rooms in an initiative called, 'Trees of Life.' These pictures were of people, places and things that were important to the people. They encouraged staff and people to have positive conversations and bring up happy times from the past. It also helped staff recognise who people were before they had dementia and helped orientate people with their rooms. This helped to create an appropriate environment for people living with dementia.

People had access to health care and we saw referrals were made to other agencies or professionals. For example, we saw referrals had been made to a GP, speech and language therapist and district nurse. A relative told us, "They call the opticians and chiropodist for [Name]. They always let me know when they do it." Another relative said, "[Name] always get to see the community nurse regularly." A person living at

Hopton Cottage Care Home told us, "When I told the staff I felt unwell, they called the GP in later that morning." This showed people using the service received additional support when required for meeting their care and treatment needs.

Good

Is the service caring?

Our findings

All of the people we asked told us staff were caring. One person said, "The staff are smashing. I get on with all of them." Another person commented, "There is such attention to detail. The staff think of everything." A further person told us, "The staff here are absolutely marvellous and the night staff are so kind to me."

A relative told us, "The staff work so hard to keep [Name] happy." Another relative said, "I live so far away. The staff encourage [Name] to phone me. They know [Name] likes that."

A member of staff said, "I have worked in a number of care homes. This is by far the best."

We spoke with some visiting professionals during our inspection. One visiting professional told us, "This is a lovely environment. All the staff are friendly, caring and respectful." Another said, "I have every confidence in the staff here," and, "I will certainly be recommending this home to my [relative]."

We saw a letter sent to the registered manager from a relative which stated, 'We felt [Name] received loving care during their illness and [Name] was treated with respect and dignity. We couldn't single out one member of staff as all did their best for [Name].' The letter also commended the chef for taking such pride in their work and respecting their relative.

Throughout the inspection we heard and saw many positive, caring interactions between staff and people who lived at the home. It was clear staff had time to spend talking and interacting with people.

We observed a carer speaking to a person and the carer knelt down to the person's level. The person appeared completely at ease with the member of staff. Friendly chatter was evident, but staff also retained the appropriate level of professionalism. There was a pleasant atmosphere.

Staff were very kind and attentive to people. We overheard a member of staff ask a person if they were okay. The person did not hear the carer properly. The carer stopped and repeated the question again to the person and waiting for person to answer. This showed a genuine interest in the person's welfare. We observed another person was becoming tearful in the one of the lounge areas. Staff immediately went to reassure the person and their mood soon lifted as a result.

We asked a member of staff how they ensured people's privacy and dignity were maintained. We were told, "We make sure doors are locked. We cover people with towels as much as possible. Do what the person wants us to do. We let people do as much for themselves as they are able." The member of staff told us, "People can choose whether they want their door locked or unlocked."

Details of an advocacy service were displayed in the reception area. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

Consideration was given to people's religious needs and bible readings took place weekly.

On many occasions throughout the day, when staff were assisting people to the lounge areas, we heard staff ask, "Where do you want to sit?" This meant people retained control and were able to make choices.

One care plan we sampled stated, '[Name] is a very proud person and has always looked after themselves until recently. This can be upsetting for [Name] and they can be reluctant to accept assistance. Staff to be extra sensitive to [Name], giving the opportunity to perform as many tasks as possible.' This demonstrated people's dignity, choices and empowerment were taken into account at the care planning stage.

A student had visited the home to speak with people about their life histories. We saw evidence that, following the death of a person who resided at the home, the registered manager had contacted the person's family, to share with the family that their relative had been able to share their story with the younger generation and that they had felt a sense of satisfaction at being able to do so. This showed the caring ethos of the home extended beyond solely the people who lived there, but also to their families and loved ones.

A person was being supported by staff to set one of the tables at lunch time. Staff used kind and supportive interactions with the person and gave assistance as necessary to complete the task. This showed people were encouraged to be independent and retain life skills, with support.

Staff showed respect for people and their belongings. We saw staff were mindful to ensure ladies handbags were kept close to them, so as to avoid any distress being caused.

Some people had 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders in place. There were discreet stickers inside people's wardrobes so staff were aware if someone had a DNACPR in place. The staff we spoke with were aware of the significance of a DNACPR and knew where to find this information. A member of staff had been designated end of life champion. This member of staff had received additional training in end of life care and shared their learning with other staff.

Good

Is the service responsive?

Our findings

People told us they enjoyed the activities at Hopton Cottage Care Home. One person said, "I love gardening. Me and [Name] do all the pot plants on my veranda." Another person said, "I take part in anything that's going on. They help me keep busy." A further person told us, "I really enjoyed the trip to the museum. It was really interesting."

A relative told us, "There are more than enough activities but [Name] loves the trips and outings."

We sampled five care plans. We saw there was a daily file, which carers completed, and this contained information relating to people's food and fluid requirements, relevant allergies, records of daily support which included information regarding whether the person had consented to care, activities undertaken and records of night checks for example.

In addition to the daily files, a care plan was in place for each person. Care plans contained a photograph of the person to whom the information related and pre-admission information was included. Personalised, detailed information regarding the support each person required in different areas such as keeping safe, physical health, night care and nutritional needs for example, was included. Care plans were person centred and included information such as, 'Important issues relating to my lifestyle, and, 'All about me.' This helped staff to be able to provide personalised care and support.

We saw evidence care was provided in line with people's care plans. For example, one plan stated, '[Name] to be checked every two hours during the night.' Records showed two-hourly checks had taken place. However, in one of the care plans we sampled we saw the person's plan stated, '[Name] does not like huge portions as [Name] finds this can be over-facing.' We observed the person to be given a large portion of food at lunchtime. Upon receiving the plate, the person said, "I can't eat all that. I don't want it." The person did not eat their lunch. We shared this information with the registered manager at the end of the inspection and they agreed to address this.

We saw people's life histories were recorded and this information was used to help develop meaningful activities. We saw family history was recorded as well as work history, hobbies, what was important to the person, what the person worries about and their proudest achievement. We saw staff knew people well and engaged with people with the knowledge they understood people's background and history. This further enabled personalised care and support to be provided.

The registered manager told us care plans were reviewed monthly and people were involved in reviews of their care whenever possible and we saw evidence of this. We saw a notice on display in the reception area, requesting relatives who held Lasting Power of Attorney for Health and Welfare to take time to view care plans. This showed people's care and support needs were reviewed regularly.

There was a range of activities on offer and these were facilitated by an effective activities coordinator. Each person had an 'activities file' and this detailed people's life experiences and personal preferences with

regard to involvement in activities. The files contained pictures of people participating in various activities and this was used as a memory aid to review whether people had enjoyed particular events. Activities included guessing games, reminiscence, arts and crafts, knitting club, keep fit, jigsaws, bingo, poetry group, dog walking and a book club, as well as days out.

The registered manager was keen to highlight that activities were not dependent on a person's ability or disability and if people wanted to join in activities then this would be risk assessed and facilitated wherever possible. We saw a recent outing to a local museum had been assessed and the decision had been made to run the trip twice so those who wanted to attend could do so and have a positive, quality experience.

We saw people being offered choices throughout the inspection. This was embedded in the care planning process. For example, one of the care plans we sampled stated, '[Name] to be offered a shower or bath at a time that suits [Name].' Choices regarding whether the person had a preferred gender of carer were recorded. We heard a person ask a member of staff for a drink. The staff member asked, "Would you like a hot one or a cold one? Tea, coffee, juice, water?" We observed a carer assisting a person into the communal lounge area. The carer could be heard saying, "Where would you like to sit? Would you like a cushion? Would you like a drink?" This showed people were given choice and helped to ensure people retained control.

The care manager and registered manager were considering a name change for the dementia unit at the home. A suggestion box was placed in reception and on the dementia unit. We saw a notice which stated, 'All ideas from residents, friends and families, and of course staff, will be welcomed.'

The complaints procedure was visible throughout the home. People and relatives told us they knew how to complain if they were unhappy. A relative said, "If I ever had a problem, I would go straight to the managers. I am sure they would sort it out." We looked at records of complaints and found they were managed well. One relative told us they had made a complaint regarding a missing item of clothing. They were satisfied with the outcome and were given some clothing vouchers as recompense.

Appropriate information was shared between staff at shift handovers, both in a written and verbal format. A 'traffic light' system had been introduced, which highlighted people who may be at risk of falls and who may require closer observations for example. This had resulted in a significant reduction in the number of falls being recorded. Information regarding end of life care, health needs, messages, incidents, concerns, social visits and appointments were shared. This helped to ensure staff shared important information in order to provide effective care and support to people.

Good

Is the service well-led?

Our findings

During 2015 there had been some management changes and restructure at Hopton Cottage Care Home. The previous manager left the service and the home was now solely managed by the current registered manager, who had been registered with the CQC to manage the service since August 2015.

On the first day of our inspection, the registered manager was not present at the home due to annual leave. However, staff that were present at the home were confident in their roles and were able to assist with the demands of an inspection. This demonstrated the service was well led because the registered manager had ensured staff could access important information and perform their duties effectively in their absence.

People told us they felt the home was well led. One person said, "All the managers and staff are approachable. There is nothing that [name] will not do for you." Another person said, "My son chose this home. He said the manager was really nice – he didn't do them justice." A further person said, "The managers have made it clear that if we have any concerns we must tell them."

A relative told us, "The home is run to an excellent standard. There is no room for improvement as far as I can see."

We spoke with two visiting professionals during our inspection. We were told, "There has been a significant upward movement in the last six months or more," and, "Mine and my colleagues' visits are so well co-ordinated. My time here is used well," and, "All the managers and staff are approachable and communicate well."

The care manager and registered manager told us the culture of the home was open and honest. The care manager said, "We don't want a fear and blame culture. You have to learn from mistakes." The staff we spoke with confirmed this and told us they felt able to be open if they made a mistake, knowing they would be supported.

A member of staff we spoke with told us they felt the culture within the home was, "Open and supportive." We asked a member of staff whether they felt supported and they told us, "Supported? Very much so actually." This member of staff told us they felt able to acknowledge and learn from mistakes and they felt the management of the home was, "Open."

The care manager told us the vision was to be the home of first choice in the region. The registered manager said, "We want this to be the best home in the area. We want staff to be proud to work in the care sector." This vision was shared with people, relatives and staff.

In the reception area we saw service user guides were available, which included information in relation to points of contact, laundry facilities, housekeeping, safeguarding, fees, fire safety and an organisational chart for example. This meant appropriate information was shared with people living at the home and potential residents.

The registered manager was actively trying to make links with the local community. We saw evidence the registered manager had contacted a local school in order to build a positive relationship. A student from the school had attended the home to talk with some residents about their lives.

People told us they were encouraged to speak out at meetings and to complete quality assurance surveys. Some relatives also told us they had attended meetings and felt the registered manager listened to them. We saw feedback from the Friends and Family Forum of 8 March 2016. 12 members of friends and family attended. The vision, 'To become the best home in the region,' was outlined to attendees. Following the forum, minutes were circulated which included answers to questions raised by attendees.

We saw head of department meetings took place regularly. Items discussed included the structure of the home, quality assurance, service improvement and acknowledging the work and staff commitment that had taken place. The commitment from the management team was clear and communicated to staff through staff meetings. We saw records of meetings that had taken place which stated, 'We will train and support and upskill seniors,' and, 'Recognise and reward achievers,' and, 'Encourage NVQ qualifications and support career development.' Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately.

We viewed some feedback questionnaires completed by family members. Comments included, 'The ethos of the home definitely shines through in how the staff care for our [Relative],' and, 'Very impressed with [registered manager] and team. The approach is open and honest with a real desire to gain feedback.' We shared with the registered manager there was no prompt on the questionnaire for a date to be included. We felt that, if the registered manager included a date on the form this would provide a more accurate reflection of how people felt about the home over a period of time.

The care manager had an understanding of different approaches to dementia care and told us their philosophy was, 'Engagement and interaction.' The care manager had clear knowledge and understanding and a genuine interest in dementia care. They had undertaken independent research and enrolled on a Dementia Care Matters programme. The senior care manager had been trained in dementia care mapping. Dementia care mapping is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence. This demonstrated the managers of the home were developing best practice and improving the service based on current research.

Emphasis was clearly placed on developing and motivating staff. We found there were clear lines of management, which offered appropriate levels of support to staff and meant there were opportunities for staff to progress their careers. We saw a 'Hopton Staff Member of the Month' award on display in the reception area. Senior staff were designated 'champions' in a particular area, for example in infection prevention and control, person centred care and dignity. These staff received additional training in these areas and made a commitment to share their knowledge with others. Having 'champions' helps to motivate staff and makes staff feel valued. Furthermore, this means good practice can be shared across the staff team.

The development manager had a background in health and social care lecturing and was working towards a continual staff development programme. Analysis had taken place regarding staff skills, knowledge and opportunities to progress. This had resulted in changes being made to the structure of staff within the home and clear opportunities for staff progression were evident.

We saw evidence regular auditing took place. The registered manager had used a nationally recognised

quality assurance audit tool, in association with the Alzheimer's Society, in order to identify areas of the home which may require development. The registered manager had developed an action plan which outlined the improvements they were making, for example in relation to care plans, risk assessments, training, mental capacity assessments and performance appraisals. The plan detailed how actions would be achieved, who was responsible and the date for completion. We could see this was a working document and included dates of actions completed.

A further pre-inspection quality assurance tool had been devised and was used to develop areas specifically in relation to the requirements of the Care Quality Commission and the Regulations associated with the Health and Social Care Act 2008. The tool prompted the registered manager to consider how people's needs were met in relation to specific areas such as nutrition and hydration, mental capacity, care planning, managing risk and infection prevention and control. Regular mattress audits took place and records showed new mattresses were replaced when necessary.

Medication audits took place regularly. However, records showed an audit that took place on 12 May 2016 identified the stock of one medicine did not reconcile with records and was, '19 over.' On 5 May 2016 records showed a medicine did not reconcile and had, '4 missing.' Although these errors were recorded, no actions were recorded as being taken so we could not be clear what action was taken. We shared this information with the registered manager. Following the inspection, the registered manager contacted us and told us there was a standard practice if any discrepancies were found. These would be traced, explained and formal supervision would take place, followed by training and disciplinary action if necessary.

Up to date policies and procedures were in place in relation to safeguarding, medication, MCA and DoLS, complaints and dementia care for example. This helped to ensure staff were following the correct guidelines in order provide effective care and support and keep people safe.