Vallance Organisation Limited

Vallance Residential 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

We inspected Vallance Residential Care Home on 13 December 2016. The inspection was unannounced.

The home provides residential care for up to 19 people. People required support with their personal care and had additional needs, including frailty associated with old age and poor mobility. Some people were living with dementia.

Vallance Residential Care Home is situated in Hove. There are two communal lounges and dining room and a well-maintained garden. The home is the sole location owned and run by Vallance Organisation Limited.

As part of this inspection, we checked what action had been taken to address the breach of legal requirements we had identified at our last inspection on 16 December 2015. Breaches were identified for staffing levels and training, monitoring of incidents and accidents and systems to monitor or review the quality of the service provided. After our last inspection, the provider wrote to us to say what they would do to meet legal requirements and sent us an action plan detailing how they intended to ensure they met the requirements of the law. At this inspection we found improvements had been made and sustained and the breach previously identified was addressed.

There was a registered manager in post but they delegated the day to day running of the home to the deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

People and visitors we spoke with were complimentary about the caring nature of staff. The delivery of care was tailored to individual choice. Care plans had sufficient information on people's likes and dislikes and information about people's lifestyle choices was available for staff. The provision of meaningful occupation positively influenced people's well-being. A relative told us, "Carers are very accommodating. [My relative] lives with their condition of dementia which means that she can push people away but they managed to get her into art and other interests and her quality of life has improved." There were sufficient suitably qualified and experienced staff to deliver care.

People and their relatives told us they felt safe living at Vallance Residential Care Home. The relative of one person said, "[My relative] lived on her own and now we know she's well looked after. Staff are attentive without a doubt. Mum is safe and happy." Staff had a good understanding of safeguarding and their responsibilities with regard to maintaining people's safety.

Care plans reflected people's assessed level of care needs and care delivery was person specific. For people with health problems, there was guidance in place for staff to deliver safe care. A health care professional told us, "What I really like about [the deputy manager] is whenever they discuss mental health referrals they

are extremely practical and forward-thinking in how to look for solutions to behavioural problems, especially within dementia care. She and her team have shown great interest and are keen to learn more about dementia, its symptoms and more practical dementia friendly interventions."

People's medicines were stored safely and in line with legal regulations and people received their medicines as prescribed.

The provider was meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were completed in line with legal requirements. Staff were following the principles of the MCA. Consideration was made of people's ability to make individual decisions for themselves, as required under the MCA Code of Practice.

Staff received the training and support they needed to be effective in their roles. People said they felt confident in the ability of staff to care for them. One person said, "Staff are trained carers, they have the skills and know their job."

People and their relatives were complimentary about the meal service at the home. One person said, "Yes, very nice meals, I am catered for very well. They know that potatoes are not a favourite of mine, so they leave them out but I eat all the vegetables and meat." The dining experience for people was social and enjoyable. People were supported to eat and drink enough to sustain their health and well-being.

Feedback had been sought from people and their relatives in the 2016 questionnaire and through residents meetings held on a regular basis to provide a forum for people to raise concerns and discuss ideas. One person said, "You can always talk to someone either individually or in the meetings. It wouldn't worry me to walk into [the deputy manager's] office."

Quality assurance systems were in place. Incidents and accidents were recorded and provided an overview, so that identified actions could be taken and plans put in place to prevent a re-occurrence. People knew how to make complaints if they needed to and the deputy manager took appropriate actions to address their concerns.

People were protected by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications.

People had access to appropriate healthcare professionals. One person said, "I have doctor out when I need one. There is the visiting dentist and the chiropodist comes every month." Staff told us how they would contact the GP if they had concerns about people's health. Care plans included all the information about people's health related needs.

Staff were supported within their roles and described an open door management approach. One member of staff said, "[Named deputy manager] is very supportive. I can raise any problem and know it will be dealt with." People, relatives and staff spoke positively of the deputy manager. One person said, "[Named deputy manager] is very kind indeed. They understand if you are worrying about anything and can untangle anything you are worrying about."

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

Vallance Residential Care Home was safe.

Risk assessments were in place and up to date.

There were enough suitably qualified and experienced staff to meet people's needs.

The management and administration of medicines was safe.

Staff had received training in how to safeguard people from abuse and staff recruitment practices were safe.

Is the service effective?

Good

Vallance Residential Care Home was effective.

Staff had received essential training to carry out their roles effectively.

Staff received on-going professional development through regular supervisions and appraisals.

Staff understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Vallance Residential Care Home was caring.

Care took account of people's individual preferences.

People's dignity was respected.

Staff interacted positively with people. The support people received was provided by staff who were kind and thoughtful.

Is the service responsive?

Good

Vallance Residential Care Home was responsive.
Care plans accurately recorded people's likes, dislikes and preferences.

Staff had information that enabled them to provide support in line with people's wishes.

There were meaningful activities for people to participate in groups or individually to meet their social and welfare needs and to prevent isolation.

A complaints policy was in place and people and visitors felt their complaint or concern would be resolved appropriately.

Is the service well-led?

Good

Vallance Residential Care Home was well led.

People and their relatives were able to comment on and influence care in the home.

People, relatives and staff spoke positively of the deputy manager.

Quality assurance was used to help improve standards.

Vallance Residential Care Home

Detailed findings

Background to this inspection

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

We previously carried out a comprehensive inspection at Vallance Residential Care Home on16 December 2015. At that inspection, we identified areas of practice that needed improvement in four of the key lines of enquiry (KLOE). We found areas of practice that needed improvement included staffing levels at night, staff training, monitoring of incidents and accidents and systems to monitor or review the quality of the service provided. The home received an overall rating of 'requires improvement' from the comprehensive inspection on16 December 2015.

This inspection took place on the 13 December 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. 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 checked the information that we held about the home and the service provider. This included statutory notifications sent to us by the deputy manager about incidents and events that had occurred at the home. A notification is information about important events that the service is required to send us by law. We used this information to decide which areas to focus on during our inspection. A Provider Information Return (PIR) was considered as part of the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During our inspection, we spoke with six people and three relatives or friends. We spoke with the deputy manager, four care staff, including the member of staff who was working in the kitchen on the day of our visit.

We reviewed a range of records about people's care and how the home was managed. These included the care plans for five people and the medicine administration (MAR) records. We looked at three staff training, support and employment records. We examined records relating to the management of the home including quality assurance audits, survey feedback and incident reports.

We contacted six health and social care professionals after the inspection to gain their views of the home.

Good

Is the service safe?

Our findings

Previously, we found the provider had not made suitable arrangement to have sufficient numbers of suitably qualified, competent, skilled and experienced staff and that staff had not received the appropriate training as is necessary to meet people's needs. Therefore, we could not be assured people received care in a safe way. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had followed their action plan, the breach had been addressed and the improvements had been sustained. The provider had taken action to ensure that, as far as possible, the risks to people's safety were addressed. This was because the provider had additional staff on duty at night and had introduced additional staff training and recording of it to reinforce good practice.

People and their relatives told us that they felt safe. One person told us, "I feel very safe, staff are very nice and I have a call bell and they come straight away when I press it." A relative told us, "[My relative] lived on her own and now we know she's well looked after. Staff are attentive without a doubt. Mum is safe and happy."

People received their prescribed medicines safely. The deputy manager and senior carer described how they completed medication administration records (MAR) and ensured people received their prescribed medicines. MAR were completed and included prescribed creams. Staff followed the provider's medicine policy with regard to medicines given 'as required' (PRN), including medicines prescribed for pain relief. Records completed included details of why they had been given and recorded the effectiveness of the medicine. There were systems in place to manage the storage, ordering, disposal and practical administration of medicines safely. We saw medicines were given to people individually and staff signed the MAR only when people had taken the medicine. The clinical room was maintained and staff ensured that the medicine cabinet temperatures were checked daily.

Carers were responsible for the administration of medicines and did so sensitively and appropriately. People expressed confidence around the administration of their medicines. One person told us how they managed their own medicine with appropriate support from staff. They told us, "I have medicines for all sorts of things and I do them myself. The tablets are in my room I have my meds every day." Another person said, "Staff do it and I have complete faith in them."

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. The deputy manager was supported by senior care staff and care assistants. Other staff shared duties working in the kitchen, housekeeping and laundry. Staffing numbers were detailed on the rota. The staff ratio reflected positive outcomes for people. For example, people received the level of personal care, including washing, continence care, dressing and oral care required to meet their needs. Staff told us they were busy but made time to give people the individual attention they needed and followed people's individual preference. One staff member said, "When we finish our morning routine we have got time to sit and chat. For example, today we've been doing the Christmas cards and about eight people joined in with this." A person said, "There are enough staff, they never take ages to get to me. There is everything from

gardeners to carers and they are all very friendly and greet you by name'." A health care professional told us, "There are enough staff to cope. It doesn't ever appear that there are not enough. I see lots of one to one time."

Safeguarding policies and procedures were up to date and provided appropriate reference to the local authority and relevant national guidance. There were notices to guide staff about who to contact if they were concerned about practice. There was a whistle blowing policy. Whistleblowing is when a member of staff reports suspected wrongdoing at work. Staff told us what they would do if they suspected that abuse was occurring at the home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

People's risk assessments were accurate and provided sufficient guidance to keep people safe. Individual risk assessments were in place and covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at identified risks and included a plan for care staff to follow. For example, where there was an assessment of risk of skin damage, documentation reflected what had been done to prevent or mitigate the risk. These included consideration of factors such as recent ill health, deterioration of mobility and incontinence. People may be at increased risk of skin breakdown through prolonged sitting in one position and therefore may require regular continence care, such as changes to their position and assistance to access toilet facilities. Risk assessments were updated and protected people from harm. A member of staff told us how they influenced a person's assessment of risk, "If I see an area of redness to a person's skin when I'm giving personal care I will note it and ask for a referral to the district nurse or GP. For example, [named person] is one hundred years old and was using a normal cushion and over time it caused her skin to break down. A risk assessment was done and now she is on a pressure relieving cushion."

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment was regularly serviced and maintained. Regular fire alarm tests, water temperature tests and regular fire drills took place to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. There was a business continuity plan. This instructed staff on what to do in the event of the home not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. Generic and individual health and safety risk assessments were in place to make sure staff worked in as safe a way as possible.

Good

Is the service effective?

Our findings

People spoke positively about the home. One person said, "I just feel very comfortable, very welcoming." We found staff and management spoke positively about the home. Comments included, "Staff are trained carers, they have the skills and know their job." We found staff and management at Vallance Residential Care Home provided care that was effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff worked within the principles of the Mental Capacity Act 2005 (MCA). The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. The reference to people's mental capacity in people's care files recorded the steps taken to reach a decision about a person's capacity. Staff told us how certain decisions were made, for example, consenting to the use of photographs and use of continence aids. Consideration was given for those whose mental capacity fluctuated. Documents held details of, for example, best interests decisions. For example, one person had supporting documentation that explained the reasons for the provision of care and considered whether any other option had been considered.

The Care Quality Commission is required by law to monitor the use of the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS are applied for when people lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The deputy manager understood their responsibilities under DoLS and submitted applications to the supervisory body, the local authority.

People received the nutrition required to maintain their health. People ate in the dining room or lounge areas, or received meals in their bedrooms. Some people received support to eat their meal from staff as, without prompting, they were at risk of not eating unless reminded. People who required assistance were given one to one, person centred support with their meal. Food and fluid charts were consistently completed for those identified at risk. Food returned to the kitchen uneaten or partially eaten was monitored. Staff said they noticed if a pattern of poor eating or appetite had developed, to inform and assess whether people were receiving adequate nutrition to maintain their health. One member of staff described how they supported a person with their nutrition, "One resident does not have a good appetite

anyway but they have been under the weather. Following the GP's visit they are now on complan, (nutritional dietary supplement drink), we've got a food chart started and I stay with her to support her to eat. It's all handed over in the care plan so everyone is doing it." People told us that the food was good. Comments included, "Yes, very nice meals, I am catered for very well. They know that potatoes are not a favourite of mine so they leave them out but I eat all the vegetables and meat." Another person said, "There's a pretty good choice. You get more than enough food and drink when you want it."

Staff assisted people with a variety of care needs, including support to eat and drink for those that needed the additional support. There was plenty of verbal interaction, eye contact and other non-verbal cues to people throughout the mealtime. We observed that a care staff member sat by persons side to assist them in a professional and respectful manner.

The provider had ensured that people received suitable and nutritious food and hydration that is adequate to sustain life and good health. The menu demonstrated a wide range of nutritious meals. Information was held about the type of diet people followed and what support they required at mealtimes. The kitchen staff member had a good understanding of people's dietary needs and preferences and told us people's dietary needs and preferences were recorded so that people's nutritional needs were known and met on a day-to-day basis. Dietary and fluid requirement updates were included on the staff shift handovers, so that they could be familiar with people's up to date dietary and fluid requirements.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support people needed. On the day of our visit a training assessor was at the home working with staff one to one to complete their training. They told us, "The manager is very supportive with attendance at this training, they provide the motivation. For example, on DoLS one member of staff did a presentation to the others about what they had learned and included a question sheet to test their knowledge." The deputy manager said, "We support people to undertake their vocational qualifications. Funding for training from the provider is not an issue." The deputy manager ensured relevant training was available, reviewed and updated. Training records indicated that fundamental training was up to date for all staff in, for example, fire training, food hygiene, Control of Substances Hazardous to Health, (COSHH), health and safety. Specific training, such as end of life care, dementia, stoma care and nutrition had been undertaken or updated to ensure all staff followed effective best practice.

Systems to support and develop staff were in place through regular individual meetings with the deputy manager or identified supervisor. These meetings gave staff the opportunity to discuss their own developmental needs as well as any concerns or issues they may have. Mechanisms were in place for supporting staff in relation to their roles and responsibilities. Staff commented that if they had any worries they could approach the provider or deputy manager for advice or guidance. One member of staff said, "The deputy manager does my supervision. They are every three months and my last was in November. In between there are written supervisions where we will look at a topic. The current one is about DoLS and before that it was nutrition." Another staff member told us, "Supervisions are very supportive. I can raise any problems and they will be dealt with." Appraisals for staff meant that they were supported to undertake further training to develop their skills, such as through undertaking the health and social care diploma.

People received effective on-going healthcare support from external health professionals. People commented they regularly saw the GP and chiropodist. For example, one person said, "I have doctor out when I need one. There is the visiting dentist and the chiropodist comes every month." Visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the tissue viability nurse (TVN) and mental health nurse specialist as required. A healthcare professional told us, "What I really like about [the deputy manager] is whenever they discuss mental health referrals they are extremely

practical and forward-thinking in how to look for solutions to behavioural problems, especially within dementia care. She and her team have shown great interest and are keen to learn more about dementia, its symptoms and more practical dementia friendly interventions."

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. They told us caring relationships were developed with staff who supported them and that they were well cared for and treated with respect and dignity and had their independence promoted. One person told us, "They are just lovely people. They get to know your routine to help yourself. I have a commode and put it at the end of my bed. I emptied it myself that's what I mean help yourself'." A relative said, "Carers are very accommodating. [My relative] lives with their condition of dementia which means that she can push people away but they managed to get her into art and other interests and her quality of life has improved."

Individual needs were considered and met and this positively affected people's wellbeing. Staff focussed on people's comfort and gave appropriate care, treatment or support. For example, some people living with dementia found it difficult to initiate contact and staff were careful to give time and attention throughout the day. Staff responded to people appropriately and in a caring manner. Staff included people in their chatter and included them as partners in the conversation. People responded to the focused attention in a positive manner and this provided reassurance. People and their relatives spoke positively of care staff and communication, comments included, "Definitely I judge that there is a personal approach. [My relative] is not a number, all the staff have a nice little laugh with them."

People were treated with dignity and respect. People's preferences for personal care were recorded and followed for each person. For example, records showed people received personal care, which included taking a bath or a shower when they wanted it. People's personal hygiene needs were being met. Continence care was offered regularly. People appeared well, for example, their nails were painted by choice for some of the women, and their clothing was clean, pressed and reflected their personality and choice. This impacted positively on the individuals' dignity.

Staff were confident when they spoke about how they promoted people's rights to privacy and dignity. For example, they told us how they adapted the second, smaller lounge of the home when flu jabs were arranged to be given to people. They screened off the area for people who didn't want the jab to be given in their room. Additionally, they told us they always shut curtains and doors when assisting people with personal care and made sure people were covered when having a wash, bath or shower. For example, one member of staff told us they always covered the lower part of a person if they were washing the top. Staff told us it was important to tell people what they were doing when they were preparing to provide personal care. A person told us their experience, "Staff are very caring they help me with showering, comb my hair, we talk together and they are so friendly."

People's independence was promoted. For example, people had access to a call bell to summon assistance. People told us, "I have a call bell and staff come straight away," and "Yes, I have a call bell. Staff don't take ages when I use it, do you want to see?" The deputy manager and staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do what they

wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We used to use hospital transport to get to and from appointments. One person said they would like to go on the bus and she loved it out in the fresh air with people, so now most people choose to take the bus." Relatives told us they were pleased with the care their family member received. They told us staff had taken time to get to know their family member and their personal preferences. Relatives told us staff kept them informed of any ill health, consultations, incidents or accidents. People were able to maintain relationships with those who mattered to them. They said they were able to visit at any time and were made to feel welcome. One person said, "I know the area, so I'm not in an unknown place. All my old friends pop in to see me."

Good

Is the service responsive?

Our findings

People and their relatives told us they were happy with the standard of care provided and that it met their individual needs. People had access to a range of activities and could choose what they wanted to do. One person told us, "I was going to do my Christmas cards today, I do my knitting and I am knitting some squares for the PDSA. Bored, not a bit." A relative said, "There always seems to be something going on, some kind of craft. The church goes there on a Sunday and [my relative] likes to help out, so they get them folding the laundry and the napkins for the dining room table."

Care plans and daily records were clear and comprehensive and staff were knowledgeable about the care people required. This helped ensure people received appropriate care and treatment. For example, some people were potentially at risk of developing pressure damage and contributing factors were recorded such as incontinence, immobility and risk of infection. Preventative measures were recorded to meet this need and staff recorded action taken when they noted skin changes or signs of physical health changes that may affect their skin.

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. Care plans contained life histories that had been completed with the assistance of relatives where it was available and gave a picture of each person's life and preferences. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care.

Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans also contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. The deputy manager told us that a significant amount of work had taken place on developing people's care plans and staff ensured that they read them in order to know more about people they were caring for. We spoke with staff that confirmed this and gave us examples of people's individual personalities and character traits that were reflected in peoples' care plans. One member of staff described how they supported a person to live well with dementia, they said, "I know the residents and what they like. We are given the time to get to know the residents, they are lovely."

There was a designated member of staff to arrange activities and occupation for people during our visit. The designated member of staff was supported to attend the local forum with other activity coordinators where they could share experiences of best practice. However, the whole staff team were included and involved in the provision of meaningful occupation. The deputy manager told us, "Care is not just about personal care but also includes so much more. Rather than focussing on the word 'activities' we occupy residents with meaningful tasks throughout the day." Group activities were undertaken in the communal areas of the home. In addition to these, one to one time was devoted to people who were unable or did not wish to participate in group activities to prevent people from becoming socially isolated. The deputy manager told

us people living with dementia were helped to orientate to place and time. For example, a member of staff told us about how they prepared and orientated people living with dementia to evening. They said, "At about 6pm with take off our tabards so that we're comfortable, we close the curtains and sit down to chat with residents. Last night we were talking about Strictly Come Dancing. [Named person] said she thought the dresses were lovely and reminded her of her own dancing days. Another resident on the other hand said she had no time for it." People also had engagement outside the home with the wider community, such as trips to the nearby shops. A relative said, "I'm not sure [my relative] has been out since she's been here but then her walking has been laboured. I've seen some others going out in their wheelchairs." The activities coordinator produced personal profiles for each person and these were available in people's rooms and were uniquely adapted to each person's interests and past. For example, one person had their profile adapted to fit an image of their favourite pet, while for another person their Welsh heritage was important and they had their profile page reproduced on the Welsh flag. The information the profiles held was used to generate ideas for activities and interaction.

Meetings with people were held to gather people's ideas, personal choices and preferences on how to spend their leisure time. The last was held in November and items discussed included the provision of posters to keep people informed of all the events going on in the lead up to Christmas. People were also approached individually and their opinions and preferences were gathered one to one.

The provider's complaint procedure operated effectively. People and relatives were aware of how to make a complaint and all felt they would be listened to if they raised any issues. A complaints procedure was in place to record and address issues with a detailed response. The complaints procedure was displayed in the home. People we spoke with told us they had not needed to complain and that any minor issues were dealt with informally. One person told us, "I don't have any complaints. If I did it would be dealt with by management." Another person said, "The [named deputy manager] takes meetings and asks if there are any complaints and suggestions. She brings up things you could be having a problem with, I said we seldom get salad in the winter and then we had tuna salad, so they listen." The relative of one person said, "Things have come up but never anything major and [the deputy manager] as always sorted it out." The home had not had any complaints since the last inspection and the deputy manager explained their approach to meeting people's concerns, "We can sort out issues by discussing it with the family member or resident. We try to get it right but we're not perfect and rely on residents and family members for feedback."

Good

Is the service well-led?

Our findings

Staff told us they felt supported and could approach the deputy manager with any concerns or questions. One member of staff told us, "[Named deputy manager] is very supportive. I can raise any problem and know it will be dealt with." A person said, "[Named deputy manager] is very kind indeed. They understand if you are worrying about anything and can untangle anything you are worrying about."

People and their relatives were actively involved in developing the home. As part of their governance, providers must seek and act on feedback from people, those acting on their behalf, staff and stakeholders, so that they can continually evaluate the home and drive improvement. Providers must ensure that improvements should be made without delay once they are identified. The deputy manager told us one of the organisational core values was to have an open and transparent service. Friends and relatives meetings were planned and surveys were conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. Feedback we received from relatives stated they felt the management at the home was approachable and the provider told us that people had opportunities to give feedback about staff and the home individually. People told us their views were actively sought and that residents meetings took place. We were told, "You can always talk to someone either individually or in the meetings. It wouldn't worry me to walk into [the deputy manager's] office," and "I remember talking about this particular member of staff. I brought it up at a meeting and that was good."

There were systems and processes in place to consult with people and relatives through satisfaction surveys. This year's satisfaction survey for relatives had received eight responses. The majority of responses were positive to the questions asked. Where concerns were noted and where the respondent's details were recorded the management followed up on individual concerns. For example, one relative raised a concern for the bed base and curtains in their relative's room. The deputy manager followed up the concern and changed the furnishings to the liking of the person. The deputy manager told us, "My door is always open."

A wide range of audits were carried out to monitor the quality of the home. Monthly checks were made of areas of the home, such as medicines, infection control and the safety of the premises to ensure that people were safe. The results of which were analysed in order to determine trends and introduce preventative measures. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. The deputy manager met with the provider to give regular feedback of progress. Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place when needed.

The deputy manager demonstrated strong values and a desire to ensure best practice throughout the home. A positive culture encouraged staff to strive for improvement. People were placed at the heart of the home and the deputy manager placed emphasis on continuous improvement in all aspects of their care. The deputy manager was proud of the achievements of the home and told us, "I love it here. It doesn't feel like work. Being a small home we can get to know residents as individuals." A member of staff said, "Things have improved since the last inspection. There's more time to spend time with residents but also to

complete the paperwork and record what needs doing. For example, nutrition and fluid charts for people that need them." Staff spoke positively of the culture of the home and how they all worked together as a team. Staff told us they felt well supported by the deputy manager and described their open door management approach. The deputy manager told us they were working to ensure good practice was maintained to make sure care remained person centred and regulations were met.

The deputy manager provided clear leadership for staff. They were actively involved and present on the floor of the home and kept themselves informed of the on-going care provided to people through handover and staff meetings. They were also seen to provide positive feedback and encouragement to staff working in the home. The deputy manager shared updates and learning with staff to ensure all staff were kept informed to changes to care practice. For example, staff were informed when people were referred to healthcare professionals. Communication with staff reminded them of their responsibility to read updated care plans and ensure appropriate support was in place.

Mechanisms were in place for the deputy manager to keep up to date with changes in policy, legislation and best practice. The deputy manager was able to meet and share practice learning with managers from other services in the forum facilitated by the care home in reach team. Up to date care information was made available for staff, including guidance around the care of people with dementia.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The deputy manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The deputy manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and sets out specific guidelines providers must follow if things go wrong with care and treatment.