

Dons Care Limited

Holly Cottage

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 6 March 2018 and was unannounced. Holly Cottage is a residential care home providing support to up to 12 people. At the time of our inspection there were seven people living at the service. People living at the service had learning disabilities and physical disabilities.

Dons Care Limited, became the registered Provider with the Care Quality Commission for the registered location of Holly Cottage in December 2017.

Holly Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Holly Cottage accommodates people in one building, which had been extended and adapted in some areas.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered Provider, 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.

At this inspection we identified a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This relates to obtaining peoples consent within the framework of the Mental Capacity Act 2005. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people and the management of these had not been regularly reviewed to ensure that they remained appropriate. When people's needs had changed, changes had not been made to reflect this. The Provider and registered manager had not identified this as a priority when taking over the running of the service in December 2017.

Staff understood their roles in safeguarding people from abuse and were clear who they would report any concerns too.

There were sufficient numbers of staff to meet people's needs and the Provider had carried out checks to ensure that staff were suitable for their roles. People received their medicines safely. Trained staff administered medicines and the Provider managed medicines in line with best practice and regularly audited them. The Provider had systems in place to ensure the risk of the spread of infection was reduced

and people lived in a clean home environment.

People were supported to access healthcare professionals when required with support from staff.

Staff received one to one supervisions and there was an appraisal process in place. Regular meetings took place that involved staff, people and relatives in decisions about the service.

The management of best interest's decisions and assessments of people's mental capacity was not always undertaken in line within the framework of the Mental Capacity Act 2005 (MCA). The registered manager did not fully understand their responsibilities in relation to this.

Staff knew people well and interacted with them with kindness and compassion. Staff were respectful of people's privacy and dignity when providing care to them. People were supported to maintain relationships that were important to them.

Care plans had not been regularly reviewed and changes in people's needs had not been identified in them. People and relatives were not routinely involved in care planning.

People had access to a range of activities that suited their needs and interests. The Provider had a clear complaints policy in place and had a proactive approach to feedback to identify improvements.

There was a variety of audits in place to monitor quality but this had not identified shortfalls in the provision of some aspects of care. The Providers' service improvement plan, implemented when they took over the running of the service, had not identified and prioritised areas which presented the highest and immediate risks to people.

The Provider had notified CQC of important incidents and events. Staff felt supported by the registered manager, team spirit and morale was positive.

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 consistently safe.

Potential risks to people were identified with actions for staff to use to minimise their impact. However, risk assessments were not always in place to detail how staff reviewed and updated in a timely manner when people's needs changed.

Staff knew how to recognise any potential abuse and so help keep people safe.

There was enough staff available to meet people's needs.

The service was clean and practices were in place to minimise the spread of any infection.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff had received training relevant to their roles. Staff had received supervision and good support from the management team.

People had choices of food at each mealtime, which met their likes, needs and expectations.

The registered manager and staff did not have a good understanding of the Mental Capacity Act. Consent for treatment for people's medical conditions had not always been sought with the legal framework of the act.

People received medical assistance from healthcare professionals when they needed.

Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect.

People were involved with their care. People's care and

treatment was person centred.

People were supported to maintain contact with their relatives.
Relatives were able to visit their family members at any time.

Is the service responsive?

The service was not consistently responsive.

Care plans had not been reviewed and updated to ensure they reflected people's changing needs.

People had access to a range of activities that reflected people's needs and interests.

People and relatives were informed of how to complain.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Audits had not always been effective in identifying shortfalls in the service.

The registered manager had reported incidents to CQC.

The provider had displayed the rating from the last inspection in the service.

People and staff felt the management team were approachable and would listen to any concerns. Staff felt well supported by the management team

Requires Improvement ●

Holly Cottage

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 6 March 2018 and was unannounced. Two inspectors carried out the inspection.

Before the inspection, we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC, which included notifications, complaints and any safeguarding concerns. A notification is information about important events, which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We used information the Provider sent us in the Provider Information Return. This is information we require Providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime meal, medicines administration and activities.

As part of our inspection, we spoke with the registered manager, two care staff and a director of the Provider. We also spoke with three people who used the service, observed the care that people received and how staff interacted with people. After the inspection, we spoke with two relatives. We reviewed care plans for three people, medicines records and the records of accidents and incidents. We also looked at mental capacity assessments.

We looked at three staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records about food, activities and minutes of meetings of staff

and residents.

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the home. One person told us, "Yes I do feel safe, If I have any concerns, they sit and listen." One relative told us that this, "The managers are open and honest with us; I feel that [relative] is safe living there."

People's care records contained assessment of potential risks to them. Risks to people had been assessed in a number of areas such as nutrition, skin integrity epilepsy and behaviour. However, not all of these plans had been updated regularly, and for some people no longer reflected their needs. For example, we saw that one person had a plan to support them manage their behaviour, which could at times be a challenge to others. This plan had last been reviewed in 2014, when the home was operated by a different Provider. Since the service was registered with the current Provider in December 2017, a review of this had not been completed. At the time the plan was last reviewed, the person had full mobility and would take themselves for a walk outside to reduce their distress. Since then, the person had lost their mobility and used a wheelchair. They would not have been able to take themselves outside for a walk, but the plan had not been adjusted to reflect this. No new support strategies had been explored for the person to use. Other assessments of risk and plans to manage these had not been review since 2015.

We brought this to the attention of the registered manager. They told us that they were aware that since becoming the registered Provider in December 2017, that records relating to people's care were in need of review. They had a plan in place to do this, and had prioritised those where the most changes had occurred since the last review, and where the highest levels of risk were. They were also looking to procure a new electronic system that stored people's care records, and identified where these were in need of review.

The registered manager kept a record of all accidents and incidents. This included where people became distressed or angry, and displayed behaviours that were considered as challenging. We saw that staff had recorded any potential triggers for this behaviour, and the impact of any interventions that they had tried. One relative told us that because of this, staff had arranged for their relative to receive support via their GP for a specialist in behaviour that may challenge. This demonstrated that systems were in place to learn from incidents and take actions to ensure people's safety.

People received their medicines safely. Medicines administration records (MAR's) were up to date with no gaps, however, on two occasions recently, staff had signed to confirm they had administered one person's medicine in the wrong section of the MAR. This meant that the MAR did not accurately reflect what time the person had received their medicines. We brought this to the registered manager's attention, who took action immediately to make it clearer on the MAR as to which section staff should complete.

Where people had not been administered their medicines, for example if they had been on leave and with relatives, this was made clear. People's records contained protocols for 'as required' (PRN) medicines. PRN protocols provided guidance on how staff should recognise if people required pain relief.

The registered manager ensured medicines were stored securely and in an organised manner. Staff carried

out daily checks of the temperatures of storage areas to ensure medicines were stored in line with the manufacturer's guidance. Staff carried out a daily count of medicines as well as a weekly audit. There was an annual visit from the pharmacy; the most recent visit had identified no concerns. Staff had been trained in how to administer medicines and the Provider assessed their competency every year. Staff were observed administering medicines to people and they did this in line with best practice. Staff checked who they were administering medicines to and followed guidance in care plans.

People were supported by staff that understood their roles in safeguarding them from abuse. One staff member told us that if they were concerned about something, "I would go and tell [registered manager] straight away, or I would go straight to the safeguarding team." Staff had received safeguarding training and this had been regularly updated. Staff were knowledgeable about the correct process for raising any potential safeguarding concerns that they may have.

We found the staffing level was appropriate to ensure that there were enough staff to meet people's needs safely. People's requests for assistance were responded to in timely manner. The registered manager assessed the needs of individuals living at the service to work out the required number of staff and this was reviewed regularly. The registered manager told us that they had recently completed the recruitment of a number of new staff. They shared with us their plans for growing the staff team at a rate that would ensure there was a core of experienced staff, before accepting any new placements of people using the service. This would also limit the impact of unfamiliar staff providing support to people. Staff were interacting with people throughout the day and were quick to respond if people became anxious and needed reassurance. Where people needed to go out on planned activities, staff were able to facilitate this, such as attending medical appointments, or visiting family members away from the service.

There were robust recruitment procedures in place to check that prospective care workers were of good character and suitable to work in the service. Staff employed at the service told us they had relevant pre-employment checks before they commenced work to check their suitability to work with people. These included two written references, proof of the person's identification, employment history and a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were protected against the spread of infection. The home environment was clean with no malodours. However, some areas of the home were in need of refurbishment and redecoration. The registered manager had an on-going plan of works to complete this. Since the change to a new registered Provider in December 2017, there had already been some investment in redecoration and new flooring in areas deemed to be of priority. The registered manager ensured that people using the service were fully involved in these plans. People were able to contribute their views to changes in communal areas, and take the lead in decisions made about their own bedrooms. We observed that people's bedrooms were free from clutter with clean linen and surfaces. The registered manager regularly checked infection control and cleanliness and staff had received training in this area.

The registered manager ensured the safety of the premises. Regular checks were carried out on the health and safety of the building and maintenance works were actioned where improvements were identified. The registered manager had plans in place for in the event of a fire and equipment in place to support staff. Staff were trained in fire safety and regular drills were conducted.

Is the service effective?

Our findings

People and their relatives told us that they felt staff were competent. They told us that staff were well trained, and knew how to support them. One person told us, "Staff are very good at their jobs."

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 people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management of best interests decisions and assessments of people's mental capacity was not always undertaken in line within the framework of the MCA. In records that we reviewed, we found some decisions had been made for people without an assessment of their capacity being undertaken. This assessment is to determine whether they had the capacity to make the decision themselves, or consent to actions being taken on their behalf. For example, where people's medicines were being managed on their behalf, records did not identify that their consent had been sought to do so. Records did not show that an assessment of their capacity had been undertaken, and a decision taken in their best interests applied within the principles of the MCA.

We also saw that where lasting powers of attorney had been granted in relation to a person's welfare to a legal appointee, decisions related to this had not been approved by them. For example, one person had a treatment plan to manage a serious health condition, which was signed by a member of staff to consent to this treatment on their behalf. The member of staff did not have the legal authorisation to consent to this treatment on the person's behalf. The person who had been granted the legal authorisation to do this, had not been asked to sign the document. This meant that people were likely to receive treatment that they themselves or a legally appointed person had not consented to.

We discussed our concerns with the registered manager and found they had a limited understanding of the Mental Capacity Act and its application to people living at Holly Cottage. They did not fully understand the actions they were required to take to ensure when it had been identified that a person may be lacking in capacity to make decisions. They did not understand the process to undertake that assessment and any best interests decisions that may need to take place. Staff we spoke with also had very limited understanding of the principles of the MCA.

This was a breach of regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

People's weight and nutritional intake was monitored in line with their assessed level of risk and referrals had been made to the GP and dietician as needed. Risk assessments had been carried out to identify people at risk of malnutrition and dehydration, however these had not all been updated regularly. The registered manager was aware of this and in the process of reviewing these to ensure that they were still current. Staff monitored people's weights to make sure they remained as healthy as possible. When staff had a concern, they contacted health professionals, such as dieticians for advice and followed any guidance given. People who needed support to eat their meal were supported discreetly. Staff gave people time to eat at their own pace, and chatted to them during the meal.

People were supported to access healthcare professionals. Every person had their own 'Health Action Plan' that identified any medical conditions and any medicines that they were prescribed. Staff supported people to arrange and attend appointments and documented these. People's records also contained evidence of regular visits to the dentist, optician and GP. As we found with other documentation relating to people's care, these all required a review, in some cases this had not been undertaken for three years. The registered manager was aware of this and since becoming the registered Provider in December 2017, had begun to do this.

People's needs had been assessed before they moved into the home to ensure staff could provide the care they needed. The registered manager was clear about the types of support the service could offer, and that if they could not meet the assessed needs of a person, then they would not offer to provide support. The registered manager had recently purchased new pieces of technology that could promote people's independence, this included voice activated entertainments systems which were easier for some people to use than those operated via a remote control. People's support plans identified where they needed additional support to ensure they were not discriminated against, for example to meet their religious needs. For example, one person told us that they were supported to attend their local church.

Staff had the skills and experience they needed to meet people's needs effectively. There was a programme of on-going training available for all staff, which included, safeguarding, moving people, safe handling of medicines and health and safety. Staff training records showed that staff completed their training in a timely manner. The variety of training offered meant that staff were supported to have the correct knowledge to provide effective care to the people. All staff spoken with told us the training was beneficial to their role. Staff received regular updates of their training to ensure that they continued to support people safely.

Before starting work at the service, staff completed an induction programme. New staff shadowed more experienced staff to get to know people, their choices and their preferences. They went on to say experienced staff had supported them, which had been beneficial in getting to know the people living at the home. Staff were supported to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff received training and support specific to the needs of the people that they supported. Staff supported people with learning disabilities at Holly Cottage and all staff had received training in this. Staff were knowledgeable about the people that they supported and their individual needs. Staff had one to one supervision meetings where they discussed people's needs and any areas for training and development. The registered manager was available to support staff on a day-to-day basis. Staff told us that they felt supported and could approach them at any time.

We received positive feedback about the food provided at the home. One person told us, "The food is good, we get to tell staff what to put of the menu, if you don't like something then they make something different.

The summer food is different to the winter food, we have salads more in the summer." People were able to choose where they wanted to eat their meals, this made meal times a social experience. Mealtimes were flexible to people's schedules and wishes, with meals being freshly prepared at various times over the lunch period, depending on when people wanted to eat. The main meal and puddings were served separately and people were able to eat at the pace that suited them. Choices of drinks were offered throughout the meal.

Weekly menus were planned and rotated monthly and included people's favourite choices. The daily menu was displayed on a notice board. People could choose where they wished to eat; some ate in their rooms, others in the dining areas. The meals looked appetising, and all meals were prepared daily from fresh ingredients. We observed that refreshments and snacks were offered throughout the day. Where people were known not to like the main choice of meal on offer that day, they had been provided with a choice of alternatives.

People were involved with the refurbishment and redecoration decoration of the premises. They told us about choosing the colour of their bedroom and that they were consulted on changes to communal areas. The design and layout of the premises and garden was appropriate to meet people's needs.

Is the service caring?

Our findings

People and their relatives told us that they found the staff to be caring. A person we spoke with told us, "Staff give me all the care I need." Another person said, "I get well looked after, staff are nice to you." One relative told us, "The staff are excellent, very caring." A staff member we spoke to said, "I love working here, it's so homely, like one big family."

We observed pleasant caring interactions between people and staff. Staff were observed sitting with people and engaging in activities throughout the day. People looked comfortable in the presence of staff and responded positively to interactions with them.

People were supported by staff that knew them well. All staff that we spoke with displayed a good knowledge of people's backgrounds and their preferences. Care records contained information about people's backgrounds and choices and staff were knowledgeable about these. For example, one person enjoyed looking after their pet fish, and staff had ensured that they received the support to do this. Staff also paid compliments to the person about how pretty the fish tank was looking. Each person had an allocated keyworker. A keyworker is a member of staff who works closely with a person, getting to know their needs and choices so that they can oversee their care and reviews. We noted that many staff had worked at the home for a long time and had to know the people that they supported well.

People were supported to maintain important relationships. People's care plans showed involvement of relatives and plans were in place for them to maintain regular contact. Care plans contained details of these relationships and how they wished to maintain contact. Relatives told us that they had good communication with staff and that this had improved since the new provider came into place. Relatives views were documented at reviews and relatives told us they were encouraged to visit whenever they wished. The service also had a minibus for the use of people living at the home, and was used to facilitate trips for people to visit family.

People were routinely involved in their care. Assessments and reviews took into account any specific religious or cultural needs people may have so that these could be identified and met. Staff identified ways to encourage people to develop skills and confidence. People's schedules included support to access the local community, which people said was an important part of their routine. One person told us that they were supported to access a local gym, which enabled them to work towards improving their health.

Care was provided in a way that promoted people's privacy and dignity. Staff carried out personal care discreetly in people's rooms. Where we wished to discuss people's needs, we noted that staff were mindful to ensure discussions took place where they could not be heard. This showed a commitment to people's confidentiality. Staff were able to tell us how they provided care to people in a way that respected their privacy. They gave us examples about how they would do this, such as knocking on people's bedrooms doors, or checking with them first before providing support. We saw in minutes of staff meetings that managers at the home regularly facilitated discussion about how staff should promote peoples privacy and dignity, for example when supporting them to get dressed.

Is the service responsive?

Our findings

Since becoming the registered manager and director of the Provider in December 2017, they had created a development and action plan. This plan was to ensure that the existing records and systems in place at the home met the requirements of the regulations governed by the Care Quality Commission. The Providers plan also identified areas for development at the service to the fabric and decoration of the buildings. Checks and audits were carried out within the service to monitor quality and to identify how the service could be improved. This included checks of people's care plans including risk assessment and consent records. Audits covered areas such as infection control, health and safety and medicines.

However, we saw that the audits did not identify the issues we found during the inspection. People's care plans had not been updated in the 4 months that the Provider had been running the home. We identified in our inspection that the dates of the last reviews of some people's care plans had not been completed since 2015, for example, where there had been a significant change in a person's mobility. The audits had also not identified where documentation relating to peoples' capacity to consent , had not been completed within the legal framework of the Mental capacity Act 2005. When we discussed this with the registered manager, we found that they did not have an adequate understanding of the MCA and their responsibilities to ensure that legal requirements were met.

Although the registered manager and Provider had implemented changes and made improvements to the physical appearance of the service, they had not identified and prioritised the assessment of risks to people, and ensuring the meeting of legal requirements were completed. The Provider and Registered manager were required to make further improvements to the quality monitoring process to ensure that they had a clear overview of practice within the service.

People and their relatives told us that they felt the home was well-led. One relative told us, "It was always run ok before, but since [registered manager] took over, overall it's been a much better home."

Providers are required to notify CQC of important events such as allegations of abuse, deaths or serious injuries. There had been very few notifiable incidents at the home and CQC had been notified where appropriate. The registered manager demonstrated a good understanding of when to send notifications to CQC when we spoke with them. It is a legal requirement that a Provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the Provider had clearly displayed the last assessed rating, given when the home was run by another Provider, at the entrance to the home.

Staff told us that they felt supported by the registered manager. One staff member told us, "The manager is supportive and approachable." The registered manager had worked at the home in a different position for the previous Provider. This meant that they knew the service and people who lived their very well. When we asked in detail about people's specific needs, they demonstrated a strong understanding of these. During the inspection, we observed the registered manager interacting with staff and people and was accessible

throughout the day.

Regular meetings were held with people who used the service to ensure the registered manager made themselves accountable to the people involved in running the service. Minutes we reviewed demonstrated these meetings were an opportunity to openly discuss, a wide range of topics, from safeguarding and complaints to activities and menus.

Staff benefitted from regular meetings that involved them in decisions about the home. Staff told us they had regular team meetings and records showed that these took place regularly. Minutes of meetings documented that staff frequently made suggestions to identify improvements at the home. There were regular meetings to enable good communication between staff. Staff completed a communication book and had a daily handover meeting. These ensured that important messages about people's care, health or activities were delivered to the staff working with that person.

People who used the service and staff confirmed they were able to raise queries or suggestions in a welcoming, inclusive atmosphere. Good community links were in place, particularly with a local village hall, where people who used the service attended a range of activities. The registered manager had ensured the service had not become isolated but remained a part of the community, to the benefit of people who used the service.

The registered manager and Provider had a vision for the service and an on-going plan to continually improve including plans to modernise the service for the future. The registered manager also regularly attended local meetings with registered managers from other services in the local area to share and learn best practice.

Is the service well-led?

Our findings

Since becoming the registered manager and director of the Provider in December 2017, they had created a development and action plan. This plan was to ensure that the existing records and systems in place at the home met the requirements of the regulations governed by the Care Quality Commission. The Providers plan also identified areas for development at the service to the fabric and decoration of the buildings. Checks and audits were carried out within the service to monitor quality and to identify how the service could be improved. This included checks of people's care plans including risk assessment and consent records. Audits covered areas such as infection control, health and safety and medicines.

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Although the registered manager and Provider had implemented changes and made improvements to the physical appearance of the service, they had not identified and prioritised the assessment of risks to people, and ensuring the meeting of legal requirements were completed. The Provider and Registered manager were required to make further improvements to the quality monitoring process to ensure that they had a clear overview of practice within the service.

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throughout the day.

Regular meetings were held with people who used the service to ensure the registered manager made themselves accountable to the people involved in running the service. Minutes we reviewed demonstrated these meetings were an opportunity to openly discuss, a wide range of topics, from safeguarding and complaints to activities and menus.

Staff benefitted from regular meetings that involved them in decisions about the home. Staff told us they had regular team meetings and records showed that these took place regularly. Minutes of meetings documented that staff frequently made suggestions to identify improvements at the home. There were regular meetings to enable good communication between staff. Staff completed a communication book and had a daily handover meeting. These ensured that important messages about people's care, health or activities were delivered to the staff working with that person.

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The registered manager and Provider had a vision for the service and an on-going plan to continually improve including plans to modernise the service for the future. The registered manager also regularly attended local meetings with registered managers from other services in the local area to share and learn best practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The registered manager and staff did not fully understand or follow the principles of the Mental capacity Act 2005. Where decisions had been made for people, this had not always been done within the best interests framework, and by staff that were not legally able to do so.</p>