Alpine Lodge RCH Limited

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Inspection report

Alpine Lodge RCH Limited
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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

Overall summary

The inspection took place on 29 and 30 January 2015 and was unannounced.

Alpine Lodge is a residential home providing care, rehabilitation and support for up to 20 people with mental health needs. Some people are detained under the Mental Health Act and are under supervision in the community. Alpine Lodge has a registered 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 2008 and associated Regulations about how the service is run.

During the inspection people and staff appeared relaxed, there was a calm and pleasant atmosphere. Comments included; "I feel safe here and looked after"; "I'm happier here, staff are kind"; "Staff are very approachable and caring" and "The staff are nice."

Care records were individualised and gave people control. Staff responded quickly to people's change in

Summary of findings

needs. People were involved in identifying their needs and how they would like to be supported. People's preferences were sought and respected. "I've been to lots of places like this – the staff are by far the best, they care and they always have time to talk to me."

People's risks were managed well and monitored. People were promoted to live full and active lives and were supported to be a part of the local community. Activities were varied and reflected people's interests and individual hobbies.

People's medicines were managed safely. People received their medicines as prescribed and on time. People were supported to maintain good health through regular access to healthcare professionals, such as GPs, mental health professionals (CPNs) and social workers.

People told us they felt safe. Comments "Yes, they keep me safe"; "Staff are very good at keeping me safe. They give me suggestions for when I'm feeling bad, get me out, distract me."

People's human and legal rights were respected. Staff understood their role with regards to the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Applications were made and advice was sought to help protect people and respect their human rights. All staff had undertaken training on safeguarding adults from abuse. Staff displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff told us they felt confident any incidents or allegations would be fully investigated.

Staff described the management as very open, supportive and approachable. People told us the registered manager was a visible presence within the home. Staff talked positively about their jobs telling us they enjoyed their work and felt valued. The staff we met were caring, kind and compassionate.

Staff received a comprehensive induction programme. There were sufficient staff to meet people's needs. Staff were appropriately trained and had the correct skills to carry out their roles effectively. One staff member said "I was supported throughout my induction and have since been supported to do my NVQ."

There were effective quality assurance systems in place. Incidents were appropriately recorded, investigated and action taken to reduce the likelihood of reoccurrence. People knew how to raise a complaint if they had one. One person said "No complaints – I'd talk to staff if I had any." Feedback from people, friends, relatives and staff was encouraged and positive. Learning from incidents, feedback and inspections were used to help drive improvements and ensure positive progress was made in the delivery of care and support provided by the home.

We found the home was clean and uncluttered. Infection control policies and procedures were followed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were sufficient numbers of skilled and experienced staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse, and the service acted appropriately to protect people. People felt safe.

People's risks had been identified and managed appropriately. Assessments had been carried out in line with individual need to support and protect people.

People's medicines were administered safely and as prescribed.

The home was clean and hygienic.

Is the service effective?

Good

The service was effective. People received care and support that met their needs.

People's human and legal rights were respected. Staff had received appropriate training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to have their choices and preferences met by skilled staff.

People were supported to maintain a healthy diet.

People's health needs were met.

Is the service caring?

Good

The service was caring. People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Positive caring relationships had been formed between people and supportive staff.

People were informed and actively involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive. Care records were personalised and so met people's individual needs. Staff knew how people wanted to be supported.

Activities were meaningful and were planned in line with people's interests.

People's experiences and comments were taken into account to drive improvements to the service.

Is the service well-led?

Good

The service was well-led. There was an open, transparent culture. The management team were approachable and defined by a clear structure.

Staff were motivated to develop and provide quality care for people.

Quality assurance systems drove improvements and raised standards of care for people at the home.

Alpine Lodge RCH Limited

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 was undertaken by an inspector on the 29 and 30 January 2015 and was unannounced.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

Fifteen people were living at Alpine Lodge on the day of our inspection. We met 13 people who lived at Alpine Lodge and spoke with nine people who used the service. We spoke with the registered manager and four members of staff. We read 10 care records relating to people's individual care needs; four staff recruitment files and reviewed staff training records. We reviewed 15 records associated with the management of medicines. We looked at the quality audits undertaken by the service, which included 15 questionnaires completed by people who lived at Alpine Lodge, one questionnaire returned by a CPN, and thank you cards from people and their relatives.

As part of the inspection we observed the interactions between people and staff, discussed people's care needs with staff and pathway tracked two new admissions. Pathway tracking is where we follow a person's route through the service and capture information about how they receive care and treatment.

We looked around the premises and environment to ensure it was clean and safe for people.

Good

Is the service safe?

Our findings

People told us they felt safe living at Alpine Lodge. Comments included "I feel safe here and looked after"; "Yes, they keep me safe"; "Staff are very good at keeping me safe. They give me suggestions for when I'm feeling bad, get me out, distract me."

People were protected by staff who knew how to recognise signs of possible abuse. Staff were confident reported signs of suspected abuse would be taken seriously and the situation would be investigated thoroughly. For example, in a recent safeguarding issue at the home, staff had raised a concern which was responded to quickly. Staff followed the correct procedures and notified the registered manager, the relevant authorities and plans were immediately put in place to reduce the risk of a reoccurrence.

All staff understood their roles to protect vulnerable people and received training in safeguarding. Staff explained their role was keep people safe and they did this by reading people's care plans and being aware of people's risks and vulnerabilities. Staff gave us an example of how they would use a body map to record any unexplained bruises, notify the registered manager, local authority and police if the need arose. Policies related to safeguarding were accessible to staff in the absence of the registered manager.

Risks were assessed and well managed to keep people safe. Staff had a good knowledge and understanding of each individual. They knew how to reduce environmental stress and anticipate situations which might trigger people to become anxious and/or agitated. For example, one person at the home could, at times, become agitated due to their mental health needs and respond to external stimuli. Staff were observant to their changing moods and used distraction techniques and de-escalation to reduce the possibility of this behaviour affecting others at the home. This approach minimised incidents and protected people.

Staff were observant of people's own communication styles which might indicate they were troubled or showing signs which might suggest a relapse of their mental health. Risk assessments detailed people's individual early warning signs for staff to observe. Staff shared concerns and relevant information through handovers and documenting changes in people's daily records. Discussions were then held with staff and plans were put in place to minimise any potential risk to people and staff. For example, one person sometimes thought others were going in their room. At these times two staff cleaned their room. At night there were only two staff on duty. If there were concerns about people's safety at night, staff remained together and aware of each other's movements within the home. This helped ensure the safety of people and staff and reduced the likelihood of an incident.

Any potential bullying, harassment, or acts of aggression between people was promptly dealt with and the police notified if required. Incidents were discussed with the people concerned after the event. Ways to live together and overcome personal relationship clashes within the house were considered and people encouraged to take personal responsibility for their behaviour in the home. Learning to interact with others was essential to people's social development within the home. Staff however were mindful of the risks when people did not get along or misinterpreted others actions or words.

The registered manager informed us that new admissions to the home were carefully considered to ensure the mix of people in the house remained as stable and safe as possible. Previous care plans and risk assessments were obtained prior to admission to help ensure risks had been considered. Where possible people were encouraged to visit as part of the admission process.

Many people at the home had previously been detained under the Mental Health Act. Some people had previous criminal convictions and restrictions placed on their movements to ensure they were supervised and safe in the community. People's mental health needs sometimes made them vulnerable to others in the community. Their care plans and risk assessments clearly reflected the conditions people were required to adhere to. Staff were conscious of the restrictions in place by law but ensured, as far as possible, people's freedom was not inhibited and they were supported to reach their personal goals. There were clear policies in place such as the missing person protocol if people did not return in a specified time frame. These informed staff of the actions they needed to take in the event of a breach of any the conditions which applied to some people. We saw these were followed in practice and we were notified of these events.

People were supported by suitable staff. Safe recruitment practices were in place and organised records showed

Good

Is the service safe?

appropriate checks were undertaken before staff began work. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. We saw from the staff records that any areas of concern relating to staff had been promptly followed up by the registered manager.

People told us there were enough staff to meet their needs and keep them safe. Staff also confirmed sufficient staff were on duty. Staff turnover was low and this provided continuity for people. The registered manager advised the staffing levels were flexible depending on people's needs and activities on specific days. Most days there were four to five staff on duty including the registered manager. Senior management were on call and able to cover in the case of sickness or an unplanned absence. We observed staff had time to sit and talk with people throughout the day and supported them to attend health care appointments. Staff carried out their work in an unhurried and calm manner.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Staff received medicine training and they were observed for competency in administration by the registered manager. Medicines were locked away appropriately. People's medicine administration records (MARs) were fully completed and any changes or additions were signed by two staff with supporting prescriptions.

We saw detailed information about people's medicines in their care plans. This gave staff guidance on when "as required" (PRN) medicine may be needed. For example to help soothe someone if they were agitated. The medicine policy supported safe administration of medicines and regular audits were undertaken to monitor this area of people's care.

People were protected from the possibility of infection as staff followed clear infection control policies and practices. We spoke to the registered manager about improving one area of infection control and reducing the risk of cross contamination by providing hand wash and paper towels in the communal bathrooms. The home was observed to be clean and tidy. Staff undertook responsibility for the cleaning alongside people in the home where possible. There were daily checklists for bedrooms that required cleaning. Protective clothing such as gloves were readily available throughout the home to reduce the risk of cross infection and hand gel was visible in the communal areas for people and staff to use. Staff explained how they had managed a recent case of diarrhoea and vomiting at the home through ensuring the use of protective clothing and trying to minimise the person's contact with others in the home.

Good

Is the service effective?

Our findings

People said staff were well-trained and able to meet their individual needs. Staff were supported at the start of their employment by a thorough induction to the home, information about the people who lived at the house, and the philosophy of the home. The induction included essential training to support staff working with people in the service. This included understanding safeguarding, mental capacity, communication skills, mental health conditions and physical health problems. Also all staff underwent training in infection control, first aid and fire safety. Staff were supported to attend higher qualifications in care. We saw most staff held a national vocational qualification in care (NVQ). One staff member told us "I was supported throughout my induction and have since been supported to do my NVQ." The registered manager held an NVQ in leadership. Other staff confirmed the training they received gave a good grounding for working at the home. A senior staff member informed us they had recently completed a "team leading" course which had increased their confidence in this area and meant they were now taking on more responsibilities to support the management team.

All staff confirmed they were supported to carry out their roles fully. Staff were supported by regular one to ones and an annual appraisal. Regular competency checks were conducted by the registered manager to ensure the standard of care provided remained high and staff had the necessary skills and knowledge to carry out their roles effectively. Comments from two staff said: "I enjoy working here, it's a nice little home" and "We discuss things and work together to sort things out." Staff confirmed, if there was an incident at the home, one to one time was offered to talk through the incident which had occurred.

People's consent to their care and treatment was sought. As part of people's admission, consent was sought to share information as required with health and social care professionals involved in their care and people were asked for their consent in relation to medicine management. People were assessed in line with the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) as required. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. DoLS provides legal protection for vulnerable people who are, or may become, deprived of their liberty.

When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. No one at the home was subject to a DoLS authorisation.

The registered manager was aware of the recent changes to the law regarding DoLS and had a good knowledge of their responsibilities under the legislation. Staff showed a good understanding of the main principles of the MCA. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Daily notes evidenced where consent had been sought and choice had been given. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf and understood the role of advocates in supporting people to make informed decisions. For example, we spoke with staff about one person who had wanted to move to a different part of the country. The staff arranged for health and social care professionals to conduct an assessment of their capacity. A "best interests" meeting was held with the relevant people involved in their care. This helped decide if the move would be in their best interests as the person lacked capacity to make an informed decision about the move and weigh up the benefits and risks involved. The decision was clearly recorded to inform staff. In addition, staff were proactive in identifying those who may not have capacity to manage their finances and we saw the relevant social care professionals had been contacted for advice.

Some people were detained under the Mental Health Act 1983. Staff understood the need to obtain consent and involve people in decision making, where possible, regardless of their legal status. Staff understood the difference between lawful and unlawful practice and ensured any restrictions in place were minimal. Staff were mindful of the restrictions related to people's care and treatment but as far as they were able to, gave people freedom of choice and movement for them to live as independently as possible.

People had their nutritional needs met. The staff involved people in deciding the menu and food. Meals were spaced throughout the day at set times. The mealtime routine helped people have structure to their days although there was flexibility depending on people's activities and plans.

Food was home-cooked and people shared meals in a dining room. Although everyone was invited to eat together in the kitchen; some people chose to eat at a different time

Good

Is the service effective?

and staff supported people's preferences and needs where this was required. For example, one person didn't like to eat with others; we saw they were able to eat after people had left the dining area. People told us a late snack was available before bedtime and a bowl of fruit was available in one of the lounges for people to enjoy.

Staff encouraged people to consider healthy eating options for their health and weight. One to one discussions were held with people who had specific dietary needs to help educate them and prompt them to make healthy choices. For example, some people were overweight, others were at risk of diabetes and one person could neglect their diet when unwell. Staff considered these people's needs by encouraging people to choose low sugar foods if they were diabetic and discussing healthy eating options for people overweight. Staff told us another person had previously been overweight and they attended weight watchers regularly. One person was a vegetarian and staff respected this decision and offered vegetarian meal choices. We saw another person required soft foods to reduce their risk of choking. Their risk assessment detailed offering foods which weren't crispy and staff were aware of their dietary needs. Staff balanced people's right to choose what they ate (which was sometimes not healthy and nutritious) with encouraging them to make good food choices for their well-being.

Some people had previous eating difficulties related to their mental health. Staff were mindful of this and monitored people's weight with their consent. Where there was concern, staff discreetly observed people to ensure they maintained an adequate food and fluid intake.

There was a large locked kitchen and a smaller kitchen where people could make hot drinks after lunch. At other times staff would make people a drink. Risk assessments supported the restrictions in place in the large kitchen and the smaller kitchen area.

People told us they had their health needs met. Staff ensured a change in people's physical and mental health needs were recognised and responded to quickly. People accessed a range of healthcare in the community. For example everyone was registered with a dentist, GP and optician. Regular checks and health screening were encouraged to support people's health such as screening for prostate cancer and diabetes. Additional health checks and vaccinations were offered to people such as the flu jab. Most people had capacity and were able to discuss these health appointments with staff and decide whether to attend. Where people had refused, staff had documented this.

Prompt referrals were made to relevant healthcare services quickly when changes to people's mental health or wellbeing had been identified. Detailed notes evidenced where a health care professional's advice was sought. For example when staff noticed a person deteriorating and becoming more agitated, the mental health team had been contacted and a review requested. The person was supported by the mental health crisis team to prevent hospital admission. Individual relapse signs were known by staff. For example if a person decided to stop taking their medicine, staff were aware to seek advice quickly from people's mental health professionals. Other care records indicated people were visited by the health and social care professionals involved in monitoring their health and placements.

The house was suitable to meet the range of needs people had. Although there were communal areas such as the dining room, there were quiet spaces where people could relax, see visitors, play a game or read a newspaper. The main lounge had a large area where people could watch television or engage in art work together. People had access to their bedrooms at all times if they wished to be alone. Each bedroom had a lock on it to protect people's belongings and for their privacy. Where people were able to, they held their own keys to maintain their privacy. Fire retardant furnishings were in place for those who did not follow the home's "no smoking" guidance. An accessible outside area with tables, benches and barbeque facilities provided people with the opportunity to enjoy the garden.

Good

Is the service caring?

Our findings

People who were able to share their views told us they felt listened too, cared for and they mattered. People told us "Staff are kind"; "Staff are very approachable and caring"; "The staff are nice."

Comments we reviewed in cards the home received included "Thank you for the care and support you gave me when I stayed here"; and a relative had written "Thank you for everything you have done for my mum. What a wonderful place you are!" A CPN commented in one of the questionnaires we saw, the home was "Caring and professional."

Staff described the fondness they had of the residents and the service's ethos. Staff said: "We view this as people's home"; "We sit and talk to people about their interests" and "We listen to them, if they want to chat we give them time and understanding." Other staff explained their role as helping to give people opportunities in line with their abilities and personal history; helping people to maintain what was important to them.

The staff showed concern for people's welfare at Alpine Lodge. Discreet conversations took place with people who were worried about something, and we observed staff offering reassurance to people concerned about upcoming appointments and changes in their lives. Conversations were relaxed and friendly. We observed a staff value base that was non-judgemental and compassionate.

People's needs in terms of their mental health, race, religion and beliefs were understood and supported by staff in a professional way. Staff were knowledgeable about all the people at the home and able to tell us about people's routines and background histories. Staff told us they had time to sit and talk with people, listen to their concerns, and get to know their likes and dislikes. They encouraged people to pursue their hobbies and interests. For example one person liked the theatre and dance and they had been involved in a local pantomime. Another person liked football and playing this sport was arranged for them. People's personal histories were known to all staff and this enabled staff to offer a caring, individualised approach. Staff celebrated people's special occasions such as birthdays which made them feel they mattered. People were asked what type of cake they liked and were involved in the baking and decorating if they wished to be.

Staff showed concern for people's wellbeing in a meaningful way whilst supporting people to become more independent and reach their goals. For example, one person was due to move to less supported living; staff supported them to attend the meetings related to this whilst listening to their worries and concerns regarding the move. The person told us: "I've been to lots of places like this – the staff are by far the best, they care and they always have time to talk to me." They told us they were involved in planning their care and setting their own goals. For example their goal for the week we inspected was to go swimming with staff, to get through a difficult meeting and not to go back to bed during the day. Staff were supporting them with these goals.

People told us their views and choices were respected by staff. One person said that sometimes it felt as if professionals were making decisions about their life, whereas staff at Alpine Lodge helped them to express their own views and make their own choices and decisions.

People's independence was encouraged where possible. For example, although staff cleaned the home, if people were able to tidy their own rooms and make their beds this was encouraged. For those able to take more responsibility for aspects of their lives, this was supported, for example managing their own medicines. Most people were independent with their personal care needs but staff were mindful some people needed prompting and encouragement to wash regularly, brush their teeth and change their clothes. Other people were independent regarding how they wished to spend their time but staff understood some people lacked motivation to engage in activities and support and encouragement were needed.

People's personal and private information and health care records were kept safely and their confidentiality protected. People's privacy was maintained by staff. People were able to lock their rooms and hold their own keys if they wanted. Respecting people's dignity was paramount, for example staff supported one person with their personal care. They knew how the person liked to be showered, respected their preferred routine and always ensured they had their dressing gown. Their care plan specified particular needs the person had and the times when they would require additional support and prompting from staff.

We were told by people that friends and family were welcomed and encouraged to visit. The home had areas where people could see relatives and friends in the

Good

Is the service caring?

company of others or privately if they wished. People were supported to maintain relationships with friends outside of the home and told us they met friends for coffee in cafes nearby. Where friendships created concern and people were vulnerable, these relationships were documented, monitored and reflected in people's care plans as necessary.

Good

Is the service responsive?

Our findings

People were supported by staff to have their needs assessed. We pathway tracked two people who had recently moved to Alpine Lodge. Both people had complex mental health needs. Prior to their admission relevant information was obtained from the health and social care professionals involved in their care.

Care records contained detailed information about people's health and social care needs. They were written using the person's preferred name and reflected how the individual wished to receive their care. People had personalised care records which detailed their likes and dislikes, their daily routine and their preferences. For example one person liked to visit the hairdresser regularly and this was arranged for them; another person liked boxing and football and staff supported them to engage in these activities.

Where possible people were involved in planning their own care and making decisions about how their needs were met. For example, one person talked to us about how they were being supported to consider their move onto more independent living. Staff were helping them to consider how they would be able to continue to attend their hobbies from their new home and supporting them to manage aspects of their own care in preparation for the move. Some people had individualised recovery plans such as WRAP (Wellness Recovery Action Plan). In most cases care records reflected what staff had shared with us about people and what people told us about their lives. Each care record highlighted people that mattered to the person. They contained essential information about people's backgrounds and their needs.

Staff had a good understanding of people's background, their likes and dislikes. Staff confirmed what was written in people's care plans about their routine. For example, despite the home having a no smoking policy within the home, one person continued to smoke in their bedroom. Staff were conscious of the risks this presented and fire retardant furnishing had been used to minimise the risk of fire. The other person enjoyed singing and drama and staff had supported them to engage in the local theatre and they had participated in the Christmas pantomime.

Staff regularly assessed and reviewed people's health. This information was shared with the staff team in handover and in daily records. Staff confirmed handovers were thorough and care records were accessible so they had up to date information. Daily records were personalised and not task-orientated. People were central to how the days were planned and organised. Staff understood people's diverse needs and adjusted their approach accordingly. People who required or preferred gender specific staff to support their needs and activities were known by all staff and supported by staff they had good relationships with. The registered manager made prompt referrals to the relevant health and social care professionals when needed and followed these up to ensure people received the care and support they needed promptly. For example one person appeared sedated on their medicine. The mental health team were notified and an appointment made for the doctor to review their medicines.

Care was consistent and co-ordinated. We saw in people's records regular reviews were held for people with their relevant health and social care professionals. Staff supported people to attend hospital appointments to share verbal information with hospital staff and provide reassurance to people during this process. People were encouraged and supported to maintain links with the community to help ensure they were not socially isolated or restricted due to their disabilities. Activities were organised according to people's choices, interests and needs. Staff were creative in considering ideas to support people's recovery and build their self-esteem. Some people liked to go to the garden centre or into the local town for coffee, others enjoyed the weekly "breakfast club" and bowling with staff. Those who were more independent engaged in activities such as theatre groups and baking. Some people had support staff from external agencies to support them in engaging with community activities.

Alpine Lodge had a policy and procedure in place for dealing with any concerns or complaints. This was made available to people, their friends and their families. The policy was clearly displayed within the service user handbook and in people's contract. People knew who to contact if they needed to raise a concern or make a complaint. People, who had raised concerns, had their issues dealt with straight away. One person said "No complaints – I'd talk to staff if I had any."

Staff confirmed any concerns made directly to them were communicated to the registered manager and were dealt with and actioned without delay. There were no written

Good

Is the service responsive?

complaints received by the service for us to review. The registered manager told us people were encouraged to raise concerns through informal discussions and questionnaires. These were used for people to share their views and experiences of the care they received. The registered manager frequently took the time to engage with people on a one to one basis, this enabled people to share any concerns they may have.

We reviewed questionnaires people and professionals had completed, all were positive. When issues were raised these were followed up in staff meetings. For example, a healthcare professional visiting a person had met them in a communal area and had not known there was a private room where they could have visited the person. At the next staff meeting the registered manager reminded staff to show visiting professionals to the private room.

Good

Is the service well-led?

Our findings

Alpine Lodge RCH Limited is owned by a company of the same name. The registered manager and deputy manager took an active role within the running of the home and had good knowledge of the staff and the people who used the service. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations. Staff comments included; "Things here run smoothly, we discuss things and work together to sort any issues out"; "The registered manager is really good, doesn't just sit in an office all day."

The registered manager promoted an open culture. The registered manager informed us the philosophy of the home was to treat people as individuals and respect individuality. They felt good communication and being clear with staff about expectations enabled the service to run smoothly. The registered manager told us "Residents and staff can come to me. I'm easy going, a good listener, I say it as it is." Staff felt supported, listened to and felt the management was visible within the home on a daily basis.

Staff told us "The culture is positive, genuinely caring." The home had an up to date whistle-blowers policy and defined how staff that raised concerns would be protected. Staff confirmed they felt protected and were encouraged to raise concerns. They informed us the management dealt with any issues quickly.

Staff told us they were happy in their work, were motivated by the management team and understood what was expected of them. Some staff had worked at the home for many years, staff turnover was low and staff felt valued by the on-going training and supportive environment.

People, relatives and professionals views and feedback on the service was sought to encourage improvement within the home. The provider encouraged people to voice their opinion and they felt listened to when they did. Questionnaires were completed by people who lived in the home and any responses of concern followed up and staff informed of people's feedback during staff meetings.

Staff meetings were held to provide an opportunity for open communication and enable decisions and any issues arising within the home to be discussed. Conversations were held about the people living at the home and training updates given such as fire safety. Staff told us the registered manager encouraged and supported them to question practice and consider ideas for improvement. For example, additional cleaning checks took place following staff stating one daily check was not sufficient in monitoring the cleanliness of the bathrooms.

Information was used to aid learning and drive quality across the service. Daily handovers, staff supervision, staff competency checks and staff meetings were seen as an opportunity to reflect on current practice and challenge existing procedures. For example, following a recent visit by the pharmacy, improved medicine audits had been developed for use within the home to improve the monitoring of medicines. External inspections were seen as helpful to "have a different pair of eyes" on the home to identify where possible changes could be made.

There was an effective quality assurance system in place. The registered manager was open to ideas for improvement and kept up to date with changing practice and legislation such as the new Care Certificate for staff. Feedback was accepted to drive continuous improvement within the service.

Audits were carried out in line with policies and procedures for example there were cleaning schedules and daily checks, audits of people's money and environmental and maintenance checks. Areas of concern had been identified and changes made so that quality of care was not compromised. Maintenance issues were quickly dealt with, for example we saw mould spores had been reported in one person's bedroom. These were promptly treated and decoration of the area planned.

We reviewed the business plan and spoke with the registered manager about plans for the future. The registered manager hoped to finish the garden landscaping in the summer. Depending on occupancy levels the registered manager was keen to continue with internal décor improvements, consider a dedicated activities worker, and look at increased physical activity to improve people's health.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.