West Bay Housing Society Limited

Harbour House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 24 and 27 May 2016 and was unannounced. We last inspected Harbour House on the 24 June 2014 and found they were meeting all requirements.

Harbour House provides residential care without nursing for up to 35 older people. There are 30 rooms with the facility for two rooms to be shared by couples and one room is booked in advance for short stays. There were 32 people living at the service when we visited. The service's website states, "Harbour House is a purpose built residential home for active elderly people".

A registered manager was employed to manage the service. 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. The service is a not for profit organisation supported by a management committee to meet people's needs in line with the Quaker philosophy of care the central idea being that by living together in organised and caring environments, individuals' health, emotional and spiritual well-being can benefit hugely.

People told us they were safe and happy living at Harbour House and were looked after by staff who were kind and treated them with respect, compassion and understanding. All staff expressed a commitment to the values of providing only good care and to continue to improve the service.

People were in control of every aspect of their care. People's medicines were administered safely and they had their nutritional and health needs met. People could see other health professionals as required. People had risk assessments in place so they could live safely at the service. These were clearly linked to people's care plans and staff training to help ensure care met people's individual needs. People's care plans were written with them, were personalised and reflected how people wanted their care delivered. People's end of life needs were planned with them. People were supported to end their life with dignity and free of pain.

Staff knew how to keep people safe from harm and abuse. Staff were recruited safely and underwent training to ensure they were able to carry out their role effectively. Staff were trained to meet people's specific needs. Staff promoted people's rights to be involved in planning and consenting to their care. Where people were not able to consent to their care, staff followed the Mental Capacity Act 2005. This meant people's human rights were upheld. Staff maintained safe infection control practices.

Activities were provided to keep people physically and cognitively stimulated. People's faith and cultural needs were met.

There were clear systems of governance and leadership in place. The registered manager and management committee ensured there were systems in place to measure the quality of the service. People, relatives and staff were involved in giving feedback on the service. Everyone felt they were listened to and any

contribution they made was taken seriously. Regular audits made sure aspects of the service were running well. Where issues were noted, action was taken to put this right.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living at the service.

There were sufficient staff on duty to meet people's needs safely. Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

People had risk assessments in place to mitigate risks associated with living at the service.

Is the service effective?

Good

The service was effective.

People were cared for by staff trained to meet their needs.

People were assessed in line with the Mental Capacity Act 2005 as required. Staff always asked for people's consent and respected their response.

People's nutritional and hydration needs were met.

People had their health needs met.

Is the service caring?

Good

The service was caring.

People were cared for by staff who treated them with kindness and respect. People spoke highly of staff. Staff spoke about the people they were caring for with fondness.

People felt in control of their care and staff listened to them.

People said staff protected their dignity.

Staff sought people's advance choices and planned their end of life with them.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans in place to reflect their current needs.

Activities were provided to keep people physically, cognitively and socially active. People's religious needs were met.

People's concerns were picked up early and reviewed to resolve the issues involved.

Is the service well-led?

Good

The service was well-led.

People and staff said the service was well-led.

There was clear evidence of the management committee ensuring the quality of the service. The registered manager had audits in place to ensure the quality and safety of the service.

People and staff felt the registered manager was approachable. The registered manager had developed a culture which was open and inclusive.

People and staff said they could suggest new ideas. People were kept up to date on developments in the service and their opinion was sought and respected.

There were contracts in place to ensure the equipment and building were maintained.

Harbour House

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 the 24 and 27 May 2016 and was unannounced.

The inspection was completed by two inspectors and a specialist nurse advisor. The specialist nurse had experience in residential care of older people.

Before the inspection we reviewed the information we held on the service including notifications. Notifications are specific events registered persons are required to tell us about.

During the inspection we spoke with 10 people and two relatives. We reviewed the care of five people to check they were provided with their care as planned. We observed how staff and people interacted with people. We sat with people at lunch on both days and spoke with people.

We spoke to six staff and reviewed three staff files to check they had been recruited safely. We reviewed the training records for all staff. The registered manager supported the inspection and was available to answer our questions. On the second day we spoke with two members of the management committee.

During the inspection we spoke to two health and one social care practitioner. This included a link nurse who worked in the community, a CPN (mental health nurse) and a social worker.

Good

Is the service safe?

Our findings

People felt safe living at Harbour House. People felt comfortable speaking with staff and told us staff would address any concerns they had about their safety. One person said, "It's very nice here, very relaxed. I never worry; the staff will keep me safe. I don't need a lot of help but it makes me feel reassured to know people are about to support me when I need it." A relative said, "I am reassured that mum is well looked after."

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would listen to people or notice if people's physical presentation or emotions changed, as that may be a sign something was wrong. Staff would pass on concerns to the registered manager and. All staff felt action would be taken in respect of this. Staff said they would speak to external agencies if they felt issues were not being addressed.

Harbour House applied the Quaker philosophy in that, "People will live in a safe and comfortable environment, where they are treated with respect and equality, irrespective of their needs and backgrounds and in an environment of trust and familiarity". We observed in how staff spoke with people and read in people's records how this philosophy was applied. Everyone, regardless of who they were treated as equal to each other. People were encouraged to be tolerant of and understand each other.

Risk assessments were in place to support people to live safely at the service. People had risk assessments completed which were up to date. People were always involved in identifying their own risks and in reviewing their own risk assessments. One person said, "I feel encouraged to do what I like, they have helped me make decisions about where I want to live and supported me in the choices I have made." Staff told us how they took time to get to know people to mitigate the risks people faced. All risk assessments were clearly linked to people's care plans and the registered manager's review of staffing and staff training.

We saw some risk assessing by staff had not always been drawn together in a dedicated risk assessment which could then be reviewed. For example, one person had a detailed care plan in place in respect of their possibility of choking due to their rushing to eat their food. The care plan detailed how this had been discussed with the person and showed the person chose all their food at lunch to be soft so they could swallow quickly. All staff were aware of the risk and how it was to be managed, however, there was no choking risk assessment in place. This meant the risk was not being reviewed to help ensure it was being managed well. Once discussed with the registered manager, the risk assessment was put in place by the registered manager and linked with the care plan. People with specific health needs, such as diabetes, or taking medicines such as blood thinning drugs also did not have risk assessments in place. This was resolved by the last day of the inspection and shared with staff to ensure they understood the risks and their role in meeting them.

Personal Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to ensure people were kept safe in the event of a fire or other emergencies. Due to its location close to the sea the service had a clear plan in place of what to do in the event of flooding and extreme weather. The plan had been drawn up with the support of the Environment Agency. Risk assessments were in place to help

ensure people were safe when moving around the inside and outside of the building. By risk assessing the inside of the building the registered manager had identified the dining room layout made it difficult to meet people's needs, so plans had been agreed to redesign the area to make movement by people and staff safer.

There were sufficient staff to meet people's needs safely. The registered manager had systems which were flexible to ensure staffing levels were maintained at a safe level in line with people's needs. The registered manager advised staffing was above expected levels as they recognised staff were to provide care to the individual first and the task second. This made if possible, they felt, to respond immediately to people's needs in a personalised manner. People told us there were enough staff. Staff also confirmed there were enough staff for them to meet people's needs safely.

Staff were recruited safely. The registered manager ensured staff had the necessary checks in place to work with vulnerable people before new staff started in their role. All prospective staff completed an application and interview. New staff underwent a probationary period to ensure they continued to be suitable to carry out their role. A small number of known agency staff were sometimes used. The registered manager ensured their checks were up to date and in place before agreeing they could work at the service.

People's medicines were administered safely. All people were given the opportunity to manage all or aspects of their medicines if that was their wish. There were risk assessments and care plans in place to support this to be safe. One person said, "Although people can and do look after their own medicine's I don't. I feel a lot safer letting the staff give me my medicines because sometimes I forget if I have or have not taken them, this arrangements suits me." Everyone we spoke with told us their medicines were administered on time and as they would like. Medicines were managed, stored, given to people as prescribed and disposed of safely. Medicine storage rooms and fridge temperatures were monitored daily and a record kept to ensure the temperature was in the correct range. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Medicines Administration Records (MARs) were all in place and had been correctly completed. Clear direction was given to staff on the precise area prescribed creams should be placed and how often. Staff kept a clear record to show creams were administered as prescribed

Staff followed good infection control practices. We observed hand washing facilities were available for staff around the service. Staff were provided with gloves and aprons. Staff were trained to follow good infection control techniques. One person said, "The home is very clean, the staff clean my room every day and then once a week they give it a good going over moving things around and thoroughly cleaning." Following an outbreak of the Norovirus in the service, the registered manager worked closely with health protection staff. A detailed analysis of events had taken place to ensure any learning could be put into action to prevent a similar issue from happening in the future. The service's infection control policy and procedures had also been reviewed and updated. People and staff were informed of the learning so everyone could be better protected in the future. We also saw the laundry was a high risk area as the dirty and clean areas were in close proximity to each other. The registered manager reviewed this straight away with staff and with people who washed their own laundry, to reduce the likelihood of risks occurring.

Good

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager understood their responsibilities under the MCA. They had attended training and ensured all staff were trained in the MCA and associated Deprivation of Liberty Safeguards (DoLS). Staff understood that all people were assumed to have capacity first and foremost. This was displayed in staff areas to remind staff of how important this was. Currently, everyone living at the service had the ability to consent to their care and treatment. The emphasis was on supporting people to remain cognitively active and able to consent for as long as they could. Extra support would be used, such as special equipment or different ways to communicate, before assuming people could not consent. Staff ensured people's ability to consent was under review and people would be reassessed if needed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager advised they currently did not require anyone to have a DoLS assessment. People were observed to have the freedom to come and go from the service as they wanted to. People were also able to purchase mobile scooters or be assessed for the equipment required to achieve independence. For people who needed staff support this was provided when they wanted it so they were not limited in their freedom.

People told us staff always asked for their consent before commencing any care tasks. We observed staff always asked for people's consent and gave them time to respond at their own pace. This included administering medicines and at lunch, for example staff offered to come back later because the person did not want the support at the time.

People had their nutritional needs met in a personalised way. The kitchen staff knew people well and went out of their way to buy special food people liked. For example, one person wanted only organic food so this was provided. People were encouraged to be independent in eating with the right equipment provided for them to do this. In addition, to set meal times and drinks rounds, people were encouraged to eat and drink where and when they would like. Fridges were available with snacks on each floor which people could access as needed.

People's likes and dislike were sought from them or from getting to know people. People's special dietary needs were catered for. One person said, "The food is good here and lots of options. I am a vegetarian and the chef will talk with me about new things they are thinking of introducing to ensure its ok." Everyone we spoke with spoke very highly of the food and its quality. One person said there was always plenty to eat in

fact, "too much" so they had to ask staff for less on their plate. Another person said, "The food is good, there is enough snacks and drinks; I am a bit too well looked after". People contributed ideas to the menu. For example, people wanted a better choice of bread so all local bakers were asked to submit samples for tasting. The baker with the highest score was then chosen.

People had access to fluid when required. People were independent in drinking. People had recently asked for fresh coffee to be provided so this was made available after lunch with pots of cream and chocolates to accompany it. Given the warm weather during the inspection, people were encouraged to have regular fluid intake to keep them hydrated.

When needed, the amount people ate and drank was carefully recorded and monitored. Any concerns were acted on immediately. For example, people who were losing weight or were observed by staff to struggle to eat certain foods were referred with consent for assessments with dieticians and speech and language team. Guidance given was discussed with the person and then followed to support the individual to improve.

People had their healthcare needs met in a personalised manner. All decisions about people's health and treatment was discussed with them to ensure they understood what was being planned. People said they could see their GP and other healthcare staff as they desired. People added that this was always achieved without any delay. Records detailed people saw their GP, specialist nurses, optician and dentist as necessary. People also had regular assessments with their GP or a link nurse practitioner who visited the home every Tuesday. Health professionals recorded their visit in people's records which meant any advice was first hand. Any advice from professionals was linked to their care plan to ensure continuity of care and treatment. A staff member said, "[People's health needs] are followed up, if you mention that you think a district nurse or GP is required then it's organised." All the professionals spoke highly of how the service met people's health welfare needs.

Staff told us they felt trained to carry out their role effectively. The registered manager had systems in place to ensure all staff were trained in the areas identified by the provider as mandatory subjects. This included first aid; fire safety; manual handling; safeguarding vulnerable adults; infection control and food safety. Staff were trained in areas to meet specific needs of people living at the service. For example, identifying the signs of possible dementia. One staff member said, "There's lots and lots of training, the registered manager is very hot on training."

Staff were also being supported to gain qualifications in health and social care. Staff had regular supervision, appraisals and checks of their competency to ensure they continued to be effective in their role. Additional supervision was offered for any staff who required it. All staff who carried out supervision as part of their role were trained in effective supervision techniques.

New staff underwent an induction when they started to work at the service. New staff shadowed other experienced staff. While they were completing this, they were extra to the staff on the rota so they had time to learn their role fully. The progress was reviewed with new staff to offer any support and advice as required. The service had introduced the Care Certificate. The Care Certificate had been introduced to train all staff new to care to nationally agreed level. The registered manager had a small number of known agency staff to fill in for absent staff. The registered manager ensured agency staff training was up to date and had been checked as competent to work with people at Harbour House. Agency staff had a dedicated induction and information folder they were requested to read and sign so they could work as effectively as all staff.

Good

Is the service caring?

Our findings

The atmosphere in the service was calm and people were observed to be happy in the company of staff. People were encouraged to support each other and people were observed chatting easily with each other. Lunchtime for example, was a sociable occasion where friendships were rekindled. We observed staff supported people throughout our time at the service with kindness, respect and in the person's own time. Discreet support was offered as necessary such as at lunch time to support someone to cut up their food.

People and staff spoke highly of each other and with affection. One person said, "I have been happy here since day one; there is lots of laughter." Another person said, "I have a lot of friends here, it's a happy place. We look after each other. I go for walks; sometimes my friends join me if the weather is nice."

A relative who had written to the registered manager had said, "My first impressions of Harbour House were outstanding; I was happy. My impressions when moving dad in were equally so; I was happy and probably a little surprised. I can stop worrying and just enjoy the fact dad is sorted". Another relative wrote, "My visits leave me with a sense of calm, contentment and overarching happiness; Harbour House is 'a little piece of paradise'…seeing dad blossom in his twilight days."

People were in control of every aspect of their care and treatment. Staff were there to support and help people make any decisions about their future but the final decision was always the person's and this was respected. For example, one person had come for a short stay to see if they wanted to live at the service permanently. The person told us how the staff spent time discussing their future with them. They added staff had supported them to decide they did not want to live at Harbour House yet. Instead, staff helped them to organise help coming to them when they went home. They added, "It's very nice here, staff are so kind and relaxed, there is lots of laughter" and, they felt reassured having discussed their future through with staff.

Another person said, "I have a good sort of life here" and, "[Staff] look after me well. I go out when they have the time. I choose when I get up and go to bed. I choose what to do with my time and choose when I want support. They (the staff) are always here when I need them; sometimes I have to wait but never for long."

Positive and caring relationships between staff and people were observed throughout the Inspection. There appeared to be a genuine warmth and spontaneous response during interactions. For example, one person and a staff member had pet names for each other that caused laughter to all involved.

Staff demonstrated respect and positive regard for the people they were caring for. For example, people were addressed by their preferred name or title when being spoken to and when staff were discussing people without them being present. One staff member said, "I make sure I give them dignity when I'm doing personal care, I make sure the door is shut for privacy, I involve them in their care and give them choices, we look after people as long as possible. I never come to work miserable."

Staff were quick to pick up if someone was becoming upset and acted promptly to support the person and work together as a team to respond to any needs. For example, a person was becoming anxious because

their husband had not arrived, so they spoke with staff. The staff listened and reassured them they would find out if there were any problems. The staff returned shortly afterward and told the person they had phoned their husband who had been delayed. They also offered to get a mobile phone so that they could talk to him directly which the person declined. This reassured the person who appeared less anxious. Another person was given reassurance by staff in line with their care plan to keep them settled; all staff recognised the person could become anxious in certain circumstances and had worked with the person on how they wanted staff to handle this. Discreet support was the person's preferred option and staff were heard greeting them by name and asking if they needed staff help or if they would like to go for a walk together. In this way the person's needs were met as they liked.

People told us their relatives were also welcomed with offers of refreshments. Families were encouraged to attend for special celebrations such as national events and people's birthdays. Sunday lunch was described as a special time when people and their families ate together. Extra tables had needed to be brought in to accommodate this as it had become very popular.

People's end of life was planned with them in advance. People and their relatives were encouraged to plan how they wanted their loved ones end of life met in a personalised manner. People who wanted to die at Harbour House were supported by a staff team trained to meet people and their relative's needs. One staff member said in relation to caring for people at this time, "I give choices, lots of talking, not assuming what they want. One lady who was end of life care wanted to stay here; we cared for her until the end of her life, with the help of the district nurse. We turned her regularly, carried out oral hygiene and supplied her with a hospital-type bed. She was pain free". A relative wrote on the passing of their loved one, "Thank you for her tailor-made care and attention which was given with kindness and compassion. I feel she could not have had better care."

People and staff had recently lost a member of staff who had died suddenly following a short illness. People and staff were supported (and this was ongoing) to cope with this by the management team and management committee. It was evident this had been hard for all involved but what was clear was the support people and staff were to each other. The management committee took a pastoral role and gave emotional support to people and staff. All involved were encouraged to speak about how they were feeling and time was given over to ensure the necessary support was provided. This has been written in the report at the request of all involved

Good

Is the service responsive?

Our findings

The service had one room put aside for short stays. We identified on the first day of the inspection that people on short stay did not have a care plan and all their needs had not been risk assessed. The person we reviewed had a detailed initial assessment in place and a risk assessment to assess they could administer their own medicines safely. However, a care plan had not been developed, which meant staff did not have the information required to know how to support this person. We discussed this with the registered manager and deputy manager. They decided the best way forward was to review the care planning process for all people new to the service. They put in place a seven day initial care plan and risk assessment process which would be applied to everyone. This was then something which could be built on as staff got to know the person better. After the seventh day, regardless of their length of stay, a full care plan would be developed. A new person had arrived the night before our second day at the service and we saw a seven day care plan and risk assessments had been put in place. The information was taken from the initial assessment and first conversations with the person. This meant staff had the information available to support this person as they desired.

People enquiring about staying at the service could visit beforehand and stay for meals or activities. People could also stay in the short stay room. A relative told us, "When we came to look around we were accompanied by someone who lived here. We sat and talked with them, without staff, and spoke about what it was like to live at the home. This felt like they had nothing to hide. "

People had personalised care plans in place. The care planning process reflected the service's Quaker philosophy of care in that independence was promoted and everyone should be treated as individuals. Every person's plan of care was therefore designed around people's requirements and preferences. People had choice in all aspects of their daily routine. All care plans were designed with the person and reviewed regularly with them as well. Every effort was made by staff to meet their choices and requirements. For example, one person struggled to manage living in close proximity with others when they first moved in. This was identified and documented by staff. When a self-contained unit became available they were happy to be move to that room. With ongoing support they had managed well and been happy with the additional space and privacy they now had. Their care plan continued to be updated and reviewed with them and their family, particularly at present, due to deterioration in their physical health, and an increase in their health care needs. When we spoke with this person they had nothing but praise for the staff and how they met their needs.

When people asked staff a question or wanted their attention the staff responded promptly, listened carefully and took action or gave the information requested. One person said, "The staff encourage me to choose what I want. They are helping me decide what I need (by way of support) and have told me about care plans. They have sorted out doctor appointments and we have talked about the future and what support needs I may have." A relative told us about their mum's care, "Staff know how to look after her, they are attentive. When they were staying in their room the staff recognised this and talked about the risk of isolation with her and the family. They gently encouraged her to join others at mealtimes. Mum has benefited from this support as now she is more sociable and enjoying her life more".

We observed people could come and go as they pleased. All surfaces around and entrances to the home were level or ramped, so people could use their wheelchair, mobility scooter, walking stick or frame to move around the local area. Where people needed staff support to do this, this was provided. One person was worried they would not be able to do this every day as normal as the family member who came each day was going on holiday. Staff reassured them and told them this was already planned in and they would be going out as normal. One person said, "I tell staff when I go out so they know where I am." Another person told us they had a bus pass and could get the bus as desired.

People were provided with a range of activities to remain physically and cognitively stimulated. These were planned in advance but there were also ad hoc sessions to respond to what people wanted to do. The service employed a staff member to co-ordinate activity sessions. While we were at the service there was a sewing group and a poetry reading session. All activities were well attended and people told us they looked forward to them. Ad hoc sessions included supporting someone to do a jigsaw and sitting and chatting to people to see how their day was. People had newspapers ordered for them daily if they wanted them. A person said, "I have lots of choice about what I want to do. There are activities; some I join in with some I don't". A relative said, "They have lots of choice here."

People's religious and cultural needs were met. This included food being specially prepared if needed. Those who lived at the service and were Quakers had a quiet room provided to meet the requirements of their faith. All people of any faith were welcomed and had their needs met. A local Quaker group supported people or sat and chatted with people if people wanted this.

The service had a complaints process in place. People knew who to complain to if needed. No formal complaints had been received since the last inspection. The registered manager explained they looked to pick up on any issues people had so they did not escalate to a formal investigation. However, she also explained how they then reviewed the concerns to check it was not an issue for others. Any learning was applied across the service. If the concern came from a group of people, then everyone was asked if it was something they were concerned about too. A majority opinion was then sought so application of the learning resolved the issue for as many people as possible. Staff then checked with people to ensure all were happy with the outcome.

Good

Is the service well-led?

Our findings

Harbour House was owned and run by West Bay Housing Society Limited. This was their only service. The service was run on a not for profit basis in line with the Quaker philosophy of care ; the central theme being that by living together in organised and caring environments, individuals' health, emotional and spiritual well-being can benefit hugely. A management committee oversaw the running of the service. There was a nominated individual (NI) in place. The NI is appointed to account for the service at the provider level. The NI was also the chair of the management committee. The service was managed by a registered manager who was supported by a deputy manager and administrator. The Committee members and the registered manager met formally once a month to review performance, to consider strategic issues and formulate policy.

The management committee members we spoke with (which were the NI and vice-chair) explained that leadership and governance were important while maintaining their Quaker identity. Records of committee meetings, and the verbal accounts of the two members of the committee, demonstrated the committee maintained an oversight role of the service and finances. They explained as well as the formal monthly committee meetings, members visited the service and spoke with people to ensure people were happy with the service that was being provided. Committee members also attended staff meetings and staff were also encouraged to contact committee members if they had any concerns.

People, staff and relatives told us they felt the culture of the service was very positive and built on putting people's needs first and empowering them to be in control of the service, their care and how they wanted staff to meet their needs. They added there was no sense that completing tasks was the most important factor. One staff member said, "The registered manager would rather staff take people out for a walk around the bay than do the laundry; laundry can be done at night". People and the staff felt the service was run well. People identified the registered manager as being in charge and explained they saw her often and that they thought she was approachable. We observed the registered manager often sat with people and asked how they were or just sat sharing time with people.

Staff had regular opportunities to contribute new ideas on how the service was run. These were through regular staff meetings and informal opportunities to speak to the registered manager or deputy. They told us any ideas would be looked at carefully. Staff spoke highly of the management of the service. Comments from staff included, "The management's brilliant. Everything is well organised; they are very supportive. If you've got a problem we can speak to them; the office door is always open", "Very often, the registered manager and deputy will be at the hand overs; they know what's happening. They are very accommodating to changing shifts and you are able to go to them with personal problems" and, "It's a nice, happy place to be; we work well as a team."

People told us their opinion was sought over a range of proposed changes. One person said, "We have residents' meeting where we are told of future plans for the home. We have been able to tell the management what we want and changes are made. For example, we found it hard to get around some of the furniture and so it was moved". Another person told us how they had all been involved in choosing the

dining room chairs. They told us a range of material samples had been sent by different companies and they had chosen the preferred option with a majority vote. Another person in the service wanted them to be a recycling home so this was introduced and it was with the person and staff working together that this was achieved. People were also keen to tell us how they were involved in the planning of the new dining room.

The registered manager had a number of audits in place to ensure the quality of the service. This included an infection control audit, audit of medicines, care plan audit and audit of falls. These were completed at regular intervals and action was always seen to be taken as required. The registered manager advised learning which needed to be applied to the service as a whole was then put in place. Staff were informed of the outcome of audits to improve practice. People and professionals linked with the service were regularly asked for their view of the service via questionnaires. The results of these were then analysed and any learning applied to the running of the service.

The registered manager had notified the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. The registered manager kept relevant agencies informed of incidents and significant events as they occurred. This demonstrated openness and transparency and they sought additional support if needed to help reduce the likelihood of recurrence.

The registered manager had introduced a policy in respect of the Duty of Candour (DoC) and understood their responsibilities. The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong. We saw the DoC had been applied following a recent medicines error. The person was advised of the error and told what would happen next. The registered manager apologised in person and in a letter. The person was kept informed of the outcome of an investigation and checked to ensure they were happy with the outcome. Their GP was advised and able to advice on any medical concerns.

The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that for legionella and of fire safety equipment took place.