Mr & Mrs S P Shirley

The Oasis (Copper Beeches)

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

Overall summary

The inspection took place on the 10 & 11 September 2015 and was unannounced.

The Oasis (Cooper Beeches) is a residential care home providing care and accommodation for up to 35 older people, some whom are living with dementia. On the day of the inspection 32 people were using the service.

The service had 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 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 were calm and relaxed; the environment was clean and clutter free. There was a happy, peaceful atmosphere. Comments from people, relatives and health professionals were exceptionally positive "From the first day I left Mum in your care I knew it was where she should be, everyone we met was so caring and friendly, always helpful and genuinely interested in Mum's health"; "When I phoned,

Summary of findings

nothing was too much trouble" and "Thank you from our hearts for the love and care shown…". People moved freely around the home and garden and enjoyed living in the home.

Care records were focused on people's needs and wishes and encouraged people to maintain their independence. Staff responded quickly to changes in people's needs. People and those who mattered to them were involved in identifying their needs and how they would like to be supported. People's preferences were sought and respected. People's life histories, disabilities and abilities were taken into account, communicated and recorded, so staff provided consistent personalised care, treatment and support.

People told us they felt safe and secure. People who were able to share their views told us they felt the home was safe "Nobody ever shouts at me and I don't hear anyone else being shouted at!" "Oh yes, happy and safe"; "Such an incredible improvement since he has been here." We saw staff were visible in the communal areas and responded promptly when people required assistance. Equipment to maintain people's safety was visible where needed for example grab rails in bathrooms and accessible call bells.

Staff were kind, thoughtful and compassionate. People, relatives and professionals were exceptionally positive about the quality of care and support people received. Supportive, kind and respectful relationships had been built between people, family members, professionals and staff. Staff took pride in their roles and the small extra things they did made people feel special and showed they cared.

There was an open, transparent culture where learning and reflection was encouraged. People's risks were monitored and managed well. Accidents and safeguarding concerns were managed promptly. There were effective quality assurance systems in place in all areas. Incidents related to people's behaviour or well-being were appropriately recorded and analysed. Audits were conducted in all areas, action points noted and areas improved where needed. Staff received good training and held lead roles in particular areas such as end of life care and infection control. Research was used to promote best practice in dementia and end of life care.

People were encouraged to live active lives and were supported to participate in community life where possible. Activities were meaningful and reflected people's interests and individual hobbies for example many enjoyed reading and maintaining their spirituality. People enjoyed activities within the home such as visits from a complimentary therapist, musicians, animal visits and external outings.

People had their medicines managed safely. People received their medicines as prescribed, received them on time and understood what they were for where possible. People were supported to maintain good health through regular visits with healthcare professionals, such as district nurses, GPs and mental health professionals.

People, friends, relatives and staff were encouraged to be involved in meetings held at the home and helped drive continuous improvements. Feedback we reviewed was excellent from families and health professionals. Complaints were investigated and responded to promptly. Listening to feedback helped ensure positive progress was made in the delivery of care and support provided by the home.

People and those who mattered to them told us the management team and staff always listened and were approachable. People told us they did not have any current concerns but any previous, minor feedback given to staff had been dealt with promptly and satisfactorily.

Staff understood their role with regards to ensuring people's human rights and legal rights were respected. For example, the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) were understood by staff. All staff had undertaken training on safeguarding adults from abuse; they 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 received a comprehensive induction programme and the Care Certificate had been implemented within the home. There were sufficient staff to meet people's needs. Staff were appropriately trained and had the correct skills to carry out their roles effectively. Training was used to enhance staff skills and the care people received.

Summary of findings

People's end of life wishes were known and specific details sought and recorded about how people wished to be cared for in their final days. Staff had completed the local hospice end of life care programme and acted as "champions" in this area. Good working relationships with health professional's ensured people's last days were dignified.

Staff described the management as open, very supportive and approachable. Staff talked positively about their jobs, understood their roles and felt valued.

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.

People were protected from harm. Staff had a good understanding of how to recognise and report any signs of abuse, and the service acted appropriately to protect people.

People received their medicines safely. Staff managed medicines consistently and safely. Medicine was stored and disposed of correctly and accurate records were kept for most medicines.

The environment was clean and hygienic.

Is the service effective?

Good

The service was effective. People received care and support that met their needs and reflected their individual choices and preferences.

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 maintain a healthy balanced diet.

Is the service caring?

Good

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

Positive caring relationships had been formed between people and staff.

People and those who were important to them were informed and actively involved in decisions about their care and support.

Staff were committed to providing outstanding end of life care which was compassionate and thoughtful.

Is the service responsive?

Good

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

Care plans were personalised and reflected people's strengths, needs and preferences. Activities were meaningful, enjoyable and planned in line with people's interests.

People's opinions mattered and they knew how to raise concerns.

Is the service well-led?

Good

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

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

Summary of findings

Quality assurance systems drove improvements and raised standards of care.

Good communication was encouraged. People, relatives and staff were enabled to make suggestions about what mattered to them.

The Oasis (Copper Beeches)

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 We our regulatory functions. This inspection checked 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 unannounced inspection took place on 10 & 11 September 2015.

The inspection was undertaken by one adult social care inspector and an expert by experience. The expert by experience was a lay person with experience of caring for an older person. 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. We also reviewed information we had received from health and social care professionals and the local authority.

During the inspection we spoke with four people who lived at The Oasis (Cooper Beeches). We spoke with three visiting relatives, the registered manager and six members of staff. We reviewed health professional feedback. We observed the care people received, participated in the staff handover and pathway tracked four people who lived at the home. Pathway tracking is where we follow a person's route through the service and capture information about how they receive care and treatment. We also looked around the premises and observed how staff interacted with people throughout the inspection.

We looked at four records related to people's individual care needs and people's records related to the administration of their medicines. We viewed four staff recruitment files, training records for staff and records associated with the management of the service including quality assurance audits, staff meeting minutes, complaints and compliments and maintenance records.

Good

Is the service safe?

Our findings

People told us they felt safe "Nobody ever shouts at me and I don't hear anyone else being shouted at!" and "Oh yes, happy and safe."

People were protected by staff who knew how to recognise signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Training records showed that staff completed safeguarding training regularly and staff accurately talked us through the action they would take if they identified potential abuse had taken place. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately by the service. Staff told us safeguarding issues were discussed regularly within team. The safeguarding policy detailed the different types of abuse and how the service protected people.

Staff told us they kept people safe by "Knowing people well, we know their mobility, who can manage the stairs; we ensure drinks aren't too hot, their diet is correct; ensure floors aren't slippery."

People's needs were considered and met in the event of an emergency situation such as a fire. People had personal evacuation plans in place. These plans helped to ensure people's individual needs were known to staff and to emergency services, so they could be supported and evacuated from the building in the correct way. Staff at the home had participated in fire training and we saw evidence of regular fire drills in place. Regular health and safety checks had been undertaken and equipment such as the hoists were regularly serviced ensuring they were safe and fit for purpose. Most routine maintenance was carried out by the maintenance man, staff recorded broken items / faults promptly and these were quickly repaired.

Staff told us they made sure people had the equipment they needed around them such as their call bells and mobility aids to encourage their use. We observed people's calls bells were within their reach and people told us staff came quickly when they used them. Where people had been identified as a risk of falls pressure mats were in place to alert staff when they were trying to walk. Regular checks occurred on everyday equipment such as wheelchairs ensuring footplates, tyres and brakes were all in good condition and working well.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. The recruitment process ensured staff had the values the home wanted.

Staff, people and relatives told us there were sufficient numbers of staff on duty to keep people safe. Recruitment was in progress to fill current vacancies; two staff were due to start in October 2015. Permanent staff were supplemented by a "bank staff" team where possible, these were staff who knew the service and people and agency was also used. Most agency staff in use were familiar with the service and people to ensure consistency and continuity of care was maintained. The registered manager had worked closely with the Department of Work and Pensions to support young people to gain employment in the care sector and apprenticeships.

Staff were visible throughout our inspection and conducted their work in a calm, unhurried manner. People told us staff were there when they needed them. We saw in the staff meeting minutes staff discussed staffing levels and the registered manager informed us these were continually reviewed dependent upon people's needs.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Medicine administration records were mostly accurate and fully completed. There were photographs in place for each person requiring medicines, a list of staff signatures and people's allergies were noted. We feedback to the manager some handwritten entries were not signed by two staff. MARs were colour coded dependent on the different times medicines were required. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. People had signed to consent to staff administering their medicine. Where people had trouble with tablets due to swallowing difficulties, liquid medicine had been arranged for them. Some people had health conditions which meant they were unable to put their medicine in their mouth themselves; their care plan detailed how staff should administer their medicine. The service had a good relationship with their pharmacy and people's prescriptions were obtained promptly for example when antibiotics were required. The service had learned from medicine errors which had previously occurred and now

Good

Is the service safe?

wore brightly coloured tabards to reduce the likelihood of being disturbed by people during the medicine round. Controlled drugs were kept safely and clear records kept. Regular medicine audits and feedback to staff helped to ensure consistency of recording for skin creams and an improved system for alerting the chemist of people's warfarin blood results.

People's needs with regards to administration of medicines had been met in line with the MCA. The MCA states that if a person lacks the capacity to make a particular decision, then whoever is making that decision must do so in their best interests. For example, some people were unable to consent to their medicine. People's doctors had been involved in these decisions. This showed the correct legal process had been followed.

People were supported to take everyday risks to enhance their independence and enable them to feel in control where possible. For example those people who liked to wash independently but needed some staff support to reach areas such as their backs, were supported.

Risk assessments highlighted individual risks related to people's diet, skin care and mobility. Those who were at risk of developing sore skin had special equipment in place to reduce the likelihood of their skin breaking down, for example cushions to sit on and special mattresses. Personal care plans highlighted checking people's skin vigilantly; using prescribed skin creams when needed and helping people maintain their mobility.

People were kept safe by a clean environment. All areas we visited were clean and hygienic. Protective clothing such as gloves and aprons 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 were able to explain the action they would take to protect people in the event of an infection control outbreak such as a sickness bug. Regular audits had identified areas for improvement which had been implemented for example better cleaning of corners, waste bins being externally cleaned and rooms were being upgraded to have paper towels for visitors and visiting professionals.

Good

Is the service effective?

Our findings

People felt supported by knowledgeable, skilled staff who effectively met their needs. They told us "Yes, staff are well-trained."

Staff undertook a four week induction programme at the start of their employment at the home. A mentor was allocated and there was regular observation and feedback of the new starter's progress. The registered manager made sure staff had completed an introduction to the home and the daily procedures, understood the philosophy and values the service aspired too. Staff had time to read people's care plans and get to know people. The Care Certificate induction was in place and the registered manager had completed assessor training to be able to support people through this induction. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life to promote consistency amongst staff and high quality care. Staff were required to attend appropriate training to help ensure they had the right skills and knowledge to effectively meet people's needs before they were permitted to support people. New staff shadowed experienced members of the team until both parties felt confident they could carry out their role competently. Ongoing training such as dementia training, first aid, moving and handling, skin care, diet and nutrition, communication skills and food hygiene supported staff's continued learning and was updated when required. Staff said "I've just had some handling training yesterday. I respect the manager so much and she encourages me in my work."

Staff felt supported by a regular system of supervision and appraisal which considered their role, training and future development. Comments included "I have regular supervision from the manager and owner. They're really good" and "We have supervision every three months; it's helpful. Also informal support is ongoing; my annual appraisal is due next week." Observation of practice and discussion of staff was held and feedback into staff supervision. In addition to formal one to one meetings staff also felt they could approach the registered manager and deputy informally to discuss any issues at any time. Staff competency was continually observed in areas such as hand washing, moving and transferring people and communication. If any issues were identified, additional training and support was provided for staff to help them to become competent. Staff found the management team supportive "Doors always open, […] is approachable and helpful." The registered manager and deputy manager regularly worked alongside staff to encourage and maintain good practice.

Staff communicated effectively within the team and shared information through regular, daily handovers. We attended one handover and essential information and discussion was held regarding people's health needs. This supported staff to have the relevant information they required to support people. Healthcare professionals confirmed communication was good within the team.

People when appropriate were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection to make sure their safety is protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS applications had been appropriately made. The registered manager was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body. Feedback we reviewed from one DoLS assessor said "Fantastic."

People's capacity was regularly assessed by staff. 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. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. A staff member told us they gave people time and encouraged people to make simple day to day decisions. For example, what a person liked to drink or wear and what they wanted for lunch. However, when it came to more complex decisions the relevant professionals were involved. This process helped to ensure actions were carried out in line with legislation and in the person's best interests. The MCA states, if a person lacks the mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf, must do this in the person's best interests.

People confirmed and records evidenced consent was sought through verbal, nonverbal and written means for example if people were unable to verbally communicate staff were observant of their body language. People had been asked the frequency people wished to be checked at

night and if they were happy for staff to take their photograph. Staff ensured people were able to make an informed choice and understood what was being planned. Care plans gave clear guidance for staff to ensure explanations were provided to people about their care and treatment and their views respected.

People were involved in decisions about what they would like to eat and drink. Regular meetings were held and people were asked what they would like to eat that week and the menu was developed from people's preferences. Staff told us the kitchen assistant asked people for their choices in the morning and where they would like to sit. Feedback had been acted upon and the supper meals were now larger to ensure people had ample food before retiring to bed. The chef had developed a winter and summer menu with people's favourite dishes and was always happy to provide alternatives. Some people told us they felt spoilt by the chef who gave them extra helpings of their favourite meals.

There were two meal sittings in different areas of the service. One was for people who required staff support; this was to preserve their dignity if they needed staff assistance. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy, balanced diet. For example some people had diabetes but liked sugary foods. Staff supported them to make an informed choice so they were aware of the potential risks of sweet foods. Staff we spoke with knew people's favourite foods and the chef confirmed he was always promptly informed of people's dietary needs and showed us this information.

During lunch people were relaxed and told us they had sufficient choice. Ample portions of Hungarian goulash were enjoyed by those who requested this meal, other enjoyed sandwiches. There was juice, water and hot drinks available for people depending on their preference. We observed people having a leisurely lunch at their pace.

Those who needed staff support to eat were given time. Staff made eye contact, used touch and spoke encouraging words to keep people engaged and alert during their meal. We observed staff offering people a choice of drinks when they asked and their preferences were respected. People said "Yes, the food is very good." Staff commented "X does the ordering, always enough food" and "Ample choices, always seasonal fruit; presentation is nice; meat so tender."

People's care records highlighted where risks with eating and drinking had been identified. Those who had dietary needs had food and / or fluid charts were in place. If advice was needed, a dietician was involved or a referral to Speech and Language Team (SLT) had been made. Their advice for example for the person to have a pureed diet was followed. Care records noted health conditions such as diabetes or if the person was of a low weight. Staff were mindful of those at risk of weight loss and monitored their food and fluid intake closely. Staff confirmed if they were concerned about weight loss / gain they would discuss people's care with their GP.

Staff communicated effectively to share information about people, their health needs and any appointments they had such as dentist appointments or GP visits. People had access to a range of community healthcare professionals to support their health needs and received ongoing healthcare support. For example opticians, dentists and chiropodists. Staff promptly sought advice when people were not well for example if they had a suspected urine infection. Staff were mindful of each individual's behaviours and mannerisms which might indicate they were not well or in pain. We spoke to a visiting professional from the district nursing team who confirmed communication was good and they were called promptly when needed and appropriately. Comments we reviewed from mental health professionals were also positive about communication within the service.

Good

Is the service caring?

Our findings

People, relatives and professionals were exceptionally positive about the quality of care and support people received. Supportive, kind and respectful relationships had been built between people, family members, professionals and staff. Comments included "Mum couldn't have had better care than what she received with you and your staff"; "From the first day I left Mum in your care I knew it was where she should be, everyone we met was so caring and friendly, always helpful and genuinely interested in Mum's health"; "When I phoned, nothing was too much trouble" and "Thank you from our hearts for the love and care shown…"

The registered manager shared with us "I'm a people person, caring by nature – passionate about people's rights, seeing people happy, that brings me joy as a manager...I care about my staff too." We were informed the goal of the registered provider was to create "A home away from home." The homely atmosphere was evident.

People told us their privacy and dignity was respected and relatives confirmed this. People had coloured doors with front door knockers so their rooms were like a front door would be and created a "home from home" feeling. Staff always knocked before entering people's rooms. Staff were conscious of protecting people's dignity and privacy when providing personal care. They ensured curtains were closed and people were covered up. Staff meeting minutes showed there were discussions about good personal care and ensuring people's hair and nails were done if they wished. Respecting people's dignity, choice and privacy was part of the home's philosophy of care. Staff shared "We promote their independence, give them choices, know what they like to wear" and "I like to promote independence, privacy and dignity." The service managers attended the local Dignity in Care meetings to ensure good practice. The philosophy of the home was to promote people living with dignity and respect, choice and control. Staff explained how they demonstrated care "It comes from within, appropriate use of touch, knowing the client, we sit with them, hold their hands and try to accommodate what they are asking for. We make time to sit and chat, take them out into the garden."

People's individual choices were respected; people dressed, ate and partook in activities of their liking and individualised care was central to the home's philosophy.

There were private areas of the home where relatives could be comfortable and have a private conversation during their visit. Relatives told us "I'm always made to feel welcome." Relatives felt they were kept informed of any changes and involved in care planning where appropriate.

People were able to choose whether they wanted gender specific staff for their personal care and told us this was respected. Staff spoke to people kindly and in a gentle, polite manner and in ways they would like to be spoken to. All interactions we observed were courteous, gentle and kind. We observed staff patiently supporting people, for example as one person guided them around the home with no particular destination in mind. Staff were patient and both looked at ease. Staff knew those people who enjoyed joking with staff and were polite and courteous with those who preferred a more formal conversation. We observed one staff member being spoken to in an unkind way by someone with health needs; they did not respond but moved away and asked a colleague to take over. Staff understood how people's dementia could affect them and that each person was unique.

People and those who mattered to them were encouraged to express their views and be actively involved in decisions about their care and aspects of the service. The registered manager involved relatives unable to visit regularly by telephone or email. Regular feedback was sought from people in a format they could understand. For example those unable to read had pictorial questionnaires they could complete.

Care plans and reviews occurred with people and their families so their views about how they wished to receive care were known. Advocacy services were involved where appropriate to support people's views to be heard if they did not have capacity.

Staff were able to adapt their communication styles dependent on people's needs. For example if people were resistant to personal care during the morning, different approaches were used to support the person to wash, for example trying at different times of day when the person was in a different mood and more receptive. If people were confused or disorientated staff knew to speak calmly, clearly, repeat information and alter their approach so they were understood. These details were included in people's care plans which all staff had signed to indicate their reading.

Good

Is the service caring?

People's end of life wishes were known and specific details sought and recorded about how people wished to be cared for in their final days. Staff had completed the local hospice end of life care programme, advanced care planning training and the registered manager acted as a "champion" in this area. All staff had received training in providing a dignified death to enhance their care in this area and adhered to the "Gold Standards Framework" for end of life care which is a training programme to ensure excellent care for people nearing the end of their life. A resource file related to end of life care was available and sharing of information about people's end of life wishes occurred through handover and staff meetings. The registered manager attended the local End of Life meetings where best practice was discussed. People's wishes were asked and known, for example whether the person wanted any to be in hospital or stay at the home, whether they wanted any specific music, candles or flowers. Staff attended people's funerals following their death and gave family comfort.

There was an "end of life" noticeboard to support people to think about this area of care and a system was in place to monitor where each person was with their planning. For example red indicated people were end of life and the home ensured they had everything in place such as pain relief. Health professionals confirmed end of life care was thoughtful and compassionate and palliative care specialist advice sought when needed. Staff talked with us about how they would provide personal care and described talking to the person to explain what they were doing at each stage, involving where appropriate their family and supporting them to join in if they wished. Staff shared a recent example of supporting someone in their final hours. The person had been discharged from hospital to die at the home, staff stayed beyond their hours to ensure they were comfortable to the end. Support for the family was provided and the staff ensured the person was in their favourite dress before she left the home. Staff gave another example of when one person had died and they had no family. They planned and coordinated the funeral ensuring the person was in their best suit, hat and had their hankie. An end of life audit was in place to ensure each person was monitored and their individual plans were in place.

Staff knew the people they cared for. They were able to tell us about individuals' likes and dislikes, which matched what people told us and what was recorded in individual's care records. Staff knew who liked to wake early, how people liked their tea, who liked to maintain their faith and they supported people to maintain these choices. Staff went the extra mile to ensure people had their choices for example the cook would often go and get additional ingredients to cook someone their favourite dish.

Staff showed concern for people's well-being in a meaningful way and spoke about them in a caring way. The registered manager told us improving the quality of life for people at the home was central to all they did. For example one staff member had taken the lead for hearing loss. Their role involved supporting people with hearing aids to attend appointments and replace old or lost hearing aids. The support people had been given in this area meant people who were previously reluctant to wear their hearing aids now did which improved their quality of life. People could now hear well so they were able to contribute to their care planning and have conversations with other people and staff. Other staff showed their kindness by supporting people in their own time to escort people to appointments or bring in cookies to enjoy a cup of tea and biscuit with people that did not have visitors. One staff member brought their dog in to play with someone who was not able to have their own.

Staff took time to listen to people and ensure they understood what mattered to them. Through walk rounds of the home, resident's meetings, the surveys which were conducted and concerns raised, the things which were important to people were noted and where possible the staff made sure they met people's wishes.

All staff we met took pride in their roles and the small extra things they did made people feel special and showed they cared. Special occasions such as birthdays and Christmas were celebrated. Staff were also cared for and their contribution valued. Birthdays were remembered with cards and flowers, new births celebrated with baby showers and chocolates were brought in for staff meetings.

Good

Is the service responsive?

Our findings

People's individual needs were assessed prior to admission and a more in depth care plan was developed as they settled into the home. Health and social care professionals, family and friends were involved in this process to ensure the home could meet people's needs. Staff took time to get to know people so they knew how people liked to be supported. Friends and family were encouraged to be a part of the assessment and care planning process where appropriate.

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 they wished to receive their care. Personalised care plans described how they wished to be cared for, their life histories, what people's favourite food and drinks were and what hobbies and activities people enjoyed. For example, one person liked to wear trousers rather than skirts and this was respected. Where people's dementia affected their orientation, care records documented the importance of providing simple information, easy instructions and reassurance.

People's changes in care needs were discussed daily in staff handovers. For example, where nutritional supplements or new medicines had commenced all staff were made aware; where people had been unsettled at night, information regarding what had helped them to relax was shared.

People, who were able, were involved in planning their own care and making decisions about how their needs were met. Residents' meetings and regular staff contact occurred to involve people in their care and discussions about activities and plans for the home. For example, People were encouraged to share the meals they wanted included on the menu. People engaged in a variety of activities of their choice and an activities coordinator worked three days a week. For example, people enjoyed having their nails painted by the beautician, visiting musicians, a visit to the local museum, church visits and animals such as donkeys and owls coming to the home. Soft music played in the main lounge after lunch when people relaxed. A further room was available with books, an old style radio and dressing up clothes. An additional garden room provided a quieter area for people to enjoy. We saw people engaged in puzzles and one relative commented, "My husband has been encouraged to help doing a jigsaw which I'm surprised he likes." The garden had seen recent improvements and the home had come second in a flowers competition. The new sensory garden had a secure area for people to walk, a mosaic people had made and a water feature.

People told us they were able to maintain relationships with those who mattered to them. Several relatives and friends visited during our inspection. Relatives confirmed they were able to visit when they wished and often enjoyed a meal at the service.

The provider had a policy and procedure in place for dealing with any concerns or complaints. This was made available to people, their families and professionals. The policy was clearly displayed in the home. People, family and health and social care professionals knew who to contact if they needed to raise a concern or make a complaint but told us they had no complaints "I've got no complaints but if I had I would tell my carer." We reviewed the few concerns and complaints which had been made to the service. All were taken seriously, investigated, feedback provided and where needed, action taken to address any shortfalls in care or service delivery. Staff, people and relatives all told us people were encouraged to raise concerns informally or formally with any staff, through residents' forums, questionnaires or the suggestion box.

Good

Is the service well-led?

Our findings

People, friends and family, healthcare professionals and staff described the management of the home to be approachable, open and supportive. Everyone described the service as personalised and well-led. People, relatives and health professionals had confidence in the leadership team and felt the values and ethos of the home was inclusive and empowering. Feedback regarding the registered manager included "A good manager, always there to talk to, very hands on, always know's what is going on; wonderful memory, remembers everything."

People, relatives and staff were involved in developing the service. Meetings were regularly held with people and their families and satisfaction surveys conducted which encouraged people to be involved and raise ideas that could be implemented into practice for example the new sensory garden. The manager conducted daily walk rounds and anything which was mentioned by people was noted and action taken. Plans for the future included involving relatives and visitors in reviewing the environment.

The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The service had notified the CQC of all significant events which had occurred in line with their legal obligations. The registered manager had an "open door" policy, was visible and ensured all staff understood people came first. They told us this style of leadership encouraged and sustained good practice. Achievements included the new sensory garden area, attending the End of Life accreditation and a positive review from the local authority quality team. The home were now working towards their Dementia Quality Mark (DQM) review. This is a local award for good practice in dementia care, and the training which had been completed in end of life care and mattering.

Staff were motivated, hardworking and enthusiastic. They shared the philosophy of the management team to put people first. Staff meetings were used to share good practice, discuss concerns and provide feedback to staff where improvements were required. All staff told us they enjoyed their job, were happy and it was a good place to work. The service inspired staff to provide a quality service. Staff understood what was expected of them in their roles and were motivated to provide and maintain a high standard of care. Staff were involved in identifying areas for improvement and their lead roles empowered them to strive for best practice and share this with colleagues.

Health and social care professionals who had involvement in the service, confirmed to us communication was good and the service was well led. They told us the staff worked alongside them, were open and honest about what they could and could not do, followed advice and provided good support.

There were effective quality assurance systems in place to drive continuous improvement of the service. The management carried out regular reviews which assessed the home's standards against the CQC regulations and guidance. Staff had engaged in discussions which helped them understand the new CQC methodology and what was meant by Safe, Effective, Caring, Responsive and Well-Led. Information following safeguarding investigations and complaints was used to aid learning and drive improvements across the service. Daily handovers, supervision, meetings and audits were used to reflect on standard practice and challenge current procedures.

The registered manager felt supported by the registered provider. Their goals were to create a positive culture of inclusivity, empowerment and involvement where people mattered and were their priority. The registered manger understood their responsibilities to deliver what was required of them. For example, maintaining occupancy levels, staff competency and a high standard of care.

Plans for the future included a sun room to increase people's Vitamin D levels and help reduce osteoporosis, consider all aspects of holistic health to improve people's well-being and a new lift so there was greater choice of rooms for people with mobility needs.

This section is primarily information for the provider

Action we have told the provider to take

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