Elmcare Limited

Cedar Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection visit took place on 8 July 2018 and was unannounced. The inspection was completed by one inspector. Cedar Lodge is a care service and has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Registering the Right Support CQC policy. This is the home's first inspection with us since they were reregistered under a new provider in February 2017.

Cedar Lodge is situated in a village near Chesterfield. It is a large building with accommodation on two floors. Each level has their own lounge space and access to outside spaces. Some bedroom had ensuite facilities, others were located near a communal bathroom. The home is registered for ten people and at the time of our inspection nine people were living in the home.

Cedar Lodge had a registered manager who supported two locations for the provider.
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 also had a deputy who provided support to the registered manager.

Professionals involved in people's care confirmed that the service was focused on individual's needs. The provider had been able to meet people's needs where other services had not been able to support the person in the same way.

People were able to make decisions and their own choices. When they had a long term illness guidance was obtained to follow best practice. Staff received training which was bespoke to each person's needs, this in turn provided clear relevant training for their role. Meals supported people nutritional requirements and innovative ways had been considered to promote good nutrition and dietary support.
Health care professionals had been regularly consulted to support people to achieve better outcomes for their health care and wellbeing. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.
People had been able to personalise their own space. The environment had been adapted to meet people's needs. The home was cleaned to a high standard and the risk of infection was prevented due to schedules and processes in place.

People felt they were safe from harm and there were clear processes in place for reporting and reflected on practice. Risk assessments had been completed and any risks reviewed to consider how these could be reduced. There was sufficient staff to meet people's needs and when required reviews had taken place.

Medicine was managed safely and reviews had taken place to consider the levels of medicine people received and how that impacted on their wellbeing. We had received notification about events and incidents relating to the home.

People told us and we saw that positive relationships had been established. Staff responded to people's needs in a timely way. Advocates were available to support people. Staff ensured people's dignity was respected.

Care plans contained detailed information about people's needs which included how they required information and how to support their cultural and sexuality needs. Activities were available which met people's interests and activity level. Complaints had been responded to.

People's views had been consulted and improvements and changes made. Professionals felt that the provider had people's needs and outcomes were the cornerstone of the service.
Audits had been used to make continuous changes to support peoples safety and life experience.

Partnerships had been established to make connections smoother and to support ongoing needs of people. This is both with health and social care professionals along with community links and the providers other locations.

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 were protected from the risk of harm and lessons had been learnt in connection with the reporting processes. Risk assessments had been completed and measures taken to reduce any reoccurrence of incidents or falls.

There was sufficient staff to support people's needs. Medicine was managed safely. People were protected from the risk of infections.

Is the service effective?

Outstanding

The service was extremely effective

Staff had received skills to support people's individual needs. Training was ongoing and was developed in recognition of each person's needs. This enabled staff to deliver the most effective service.

People's rights were protected. Staff acted in accordance with the Mental Capacity Act 2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly and people were supported in the least restrictive way possible.

People's healthcare had been developed to provide them with a better quality of life. The provider worked with a range of internal and external healthcare professionals.

People were supported to have their dietary needs met. They were encouraged to make choices and had an opportunity to develop independence in this area.

The environment had been considered for people's needs and there was an opportunity for people to personalise their own space.

Is the service caring?

Good

The service was caring

People were encouraged to make choices about their day and supported to ensure these happened.

Staff knew people well and positive caring relationships had been established. Advocates were available to support people's decisions.

Care was provided in a responsive and respectful way to ensure people retained their dignity.

Is the service responsive?

Good

The service was responsive

People had detailed care plans which provide staff with the information needed to ensure the care provided met their individual needs.

Activities were provided and things of interest made available.

Complaints had been responded to.

Is the service well-led?

Good

The service was extremely well led

Everyone without exception felt the needs of people were at the centre of the home. The atmosphere was open and people felt at home.

People's views had been considered and these drove improvements and changes. Audits had been to consider peoples changes or to reduce the identified risks. Governance systems were embedded and all staff understood their responsibilities to contribute to them.

Partnerships had been developed and strong relationships had been established with professionals. The registered manager understood their requirements in relation to the regulations.

Cedar Lodge

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.

This inspection took place on 8 July 2018 and was unannounced. The inspection was completed by one inspector. This was the home's first inspection with this provider.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us at the inspection visit.

We were not able to speak with all the people who use the service. This was due to some people who did not communicate verbally, so we observed how the staff interacted with these people in communal areas. We did speak with five people who used the service who were able to tell us their experience of their life in the home.

During the inspection we spoke with the cook, the domestic, three staff members, a senior member of the care team, the training lead for the provider, the deputy and the registered manager. After the inspection we spoke with a relative by telephone, a social care professional and the GP. Their comments have been included in the report.

We looked at the care records for three people. We checked that the care they received matched the information in their records. We also looked at a range of information to consider how the home ensured the quality of the service; these included audits relating to, infection control, fall and incidents and other aspects of the home. We also reviewed complaints and feedback information to see how people's views had been responded to.

Good

Is the service safe?

Our findings

People were supported to be safe from abuse or harm, which they told us and we observed. One person said, "I feel safe living here and I am a lot happier than where I lived before." Relatives we spoke with said, "I can tell [name] trusts the staff so they must feel safe." Staff had received training in safeguarding and were able to discuss with us the different types of abuse and how they report any concerns. One staff member said, "People are safe here, we always check for potential risks." We saw information relating to safeguarding was available on the notice board in the reception of the home which was in an easy read format and was also discussed in meetings with people. The registered manager had raised safeguards when they had any concerns, and worked with the local authority to address these and shared any learning with the staff team.

The provider had also shared learning from previous safeguards from their other locations. This included the reporting process. The registered manager told us they had not always reported safeguards directly to the authorised local authority, however they had always reported to the linked social worker and taken direct action. This process had been changed so that it directly followed the safeguarding protocol and we saw safeguards had been reported in line with this.

Some people expressed themselves with behaviours which could cause themselves or others harm. We saw detailed plans were in place which reflected the potential behaviour, any possible triggers and how to de-escalate the situation when it occurred. One staff member said, "The plan talks about triggers, I know not to crowd them and to follow the steps on the guidance." All the staff we spoke with could share with us how they supported people to manage their behaviours or periods of anxiety.

There were measures in place to support people in case of an emergency. Each person had an emergency evacuation plan which was specific to them and the support they required. These were accessible within the care plans and in the emergency 'grab bag' located at the exit. There was also an 'accident and emergency' sheet which was used to support people if they required medical support, for example if the needed to attend hospital.

Risk assessments had been completed for all aspects of the environment and for people's life activities. Measures had been taken to reduce the risks, for example, one person had bed rails to ensure they were safe when in bed as they were at risk of falling. The person was able to consent to the use of the bed rails and told us, 'They make me feel safe at night'.

We saw when people had fallen measures were taken to reduce the risk of reoccurrence. For example, one person had fallen and broken a bone. Staff reflected on this incident and could not understand how the person had fallen and why this fall had resulted in a broken bone. They obtained support from the GP and the person had a bone density scan. This revealed the person was lacking in vitamin D, which would affect the strength of the bones. We saw the person now received a supplement, in addition they had been referred to the falls team for any further guidance.

There was sufficient staff to support people's needs. We saw that when people required one to one support this was provided by staff who were familiar with the person. This ensured consistency in the way they were supported. People told us when they required support staff they were always available to assist them. One person said, "Staff help me out, they are all lovely."

Staff we spoke with all felt there were enough staff. One staff member said, "We are a good team, we work together and cover when needed so people get consistency." People's care was on a commissioned basis. The registered manager was aware of the need to review people's needs on a regular basis and this was done with the commissioners. When people's needs had changed the level of support was discussed and amended so that the staffing levels were able to meet these needs.

We saw that checks had been carried out to ensure that the staff who worked at the home were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place.

People were supported with their medicines. We saw that the time of the medicine was in line with people's needs. For example, one person required their medicine at 8:00am each morning. They told us, "They are always on time, never miss." Another person said, "My medicine is always on time and if I am in pain, they have pain killers to help me." We reviewed the medicines management and saw that stock was regulated and maintained. When people required medicine on an as required basis there was a protocol in place. When people required medicine for their anxiety, this was only used as part of a planned approach. We reviewed the usage and noted that this medicine was rarely used, supporting the approach described. We saw that medicine reviews had taken place, we have reported on this in the 'Effective' domain. This meant people's medicine would be prescribed in a safe way.

The home was clean and hygienic which reduced the risk of infection. We saw there were cleaning schedules in place and staff used protective equipment like gloves and aprons when they provided personal care or served food. We saw that the new furniture which had been purchased had been treated with a protective coating. The domestic staff member told us, "It makes a real difference as its easier to clear up any spillages." The home had a five-star rating from the Food Standards Agency, which is the highest award given. The food hygiene rating reflects the standards of food hygiene found by the local authority.

Outstanding ☆

Is the service effective?

Our findings

The provider and registered manager were aware of the importance of adhering to the 'Building the right support' which was introduced in October 2015. This sets out the importance of valuing people's choice, promotion of independence and inclusion. The registered manager recognised these as fundamental in providing a good service and a good life for people. This was reflected in the provider recognising the need for any new training which was in relation to national best practice.

When people moved from other services there was a planned and coordinated approach, in line with national guidance. We reviewed one person's transition. This person had limited understanding of the changes and they were unable to express themselves verbally. To support them they were provided with visits to the home and regular staff to initiate consistency. During the transition, health and social care professionals were consulted along with relatives to work together. A health care professional told us, "The staff team act positively in asking questions and looking for solutions. They watched the person and take their lead from them. This showed real professionalism." A relative said, "[Name] settled in really quickly, whatever they are doing it's positive. The move has been a good one for them."

People's support and outcomes had been improved by staff receiving training which was bespoke to people's needs. For example, training in relation to dysphasia, this had been identified through an analysis of information. We saw that care plans reflected any specific guidance identified and how the meal experience had been improved for this person. The cook ensured food was prepared in line with these guidance which meant the person would receive the nutritional elements to maintain a healthy diet without any impact on the persons long term condition. Other elements from the training reflected techniques in helping reduce the persons anxiety.

Training had been tailored around the individual to provide a person centred approach so that the training linked to each person's needs. The training lead for the provider told us, "We look at each person and map out what training staff will require to enable them to support them." For example, one person had recently been diagnosed with early stage dementia. Staff had all received training in this area. However, additional external training was to be provided to give more guidance so the support could be focused on the person's continuous changing needs.

Creative ways had been used to ensure people felt included when they received their meal. Guidance identified when people required a specific diet which needed to be pureed. The cook had received training not only in the nutritional content of the pureed diet, but also in the requirement of the specific condition. Health care professionals had been consulted and the guidance from them was in a separate folder. It was documented the person would become upset if their food looked different to other peoples within the home. To avoid behaviours being triggered by visual presences of the food, the cook pureed the items individually and remoulded them into the shape of the meal on the menu. For example, a hot dog or vegetable shape. The cook added their own notes to the information in relation to likes and dislikes and any techniques. This meant the person would enjoy their meal and avoid the potential of any anxiety related behaviours.

We saw best practice had been implemented following a link with professionals from other health care specialists. These professionals recognised the positive approach which had been taken by the registered manager in supporting people. The professionals then offered to deliver specific training in this area. Staff received training in 'positive distraction' techniques. We saw the learning from this training had been used to develop people's behaviour plans. The registered manager told us that physical intervention was rare as staff were skilled in de-escalation and distraction techniques. We saw that all staff had received training in both restraint and distraction techniques. One staff member told us, "It's good to have the training so that when a situation occurs you know how to deal with it and know how to do it properly. However, I have not needed to use it as we use distraction techniques and these work." This meant that people were protected from the use of avoidable restraint. A health care professional said, "When people are supported here, it's like a positive lifestyle change, like an open door. They really do change people's lives."

Staff reflected on the effective induction period in ensuring they had the skills to support and maintain the values established within the home. We spoke with staff who had been newly appointed, they were able to tell us about their induction and the support they had received. Some of the courses were on a computer, staff were given access to a computer and/or supported with this training. One staff member said, "I was shown how to do a course only yesterday, they really support you." The provider had introduced 'buddies' in different areas to provide staff with the opportunities to obtain peer support in different areas. For example, understanding behaviours or dignity.

We spoke with the training lead for the provider. They told us, all new staff received training in the Care Certificate over a three-day period. The Care Certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high-quality care. One person said, "All training is really good, it covers the things you need to know. I like that, we review information and get refreshers too or new training."

Following the three day training staff received moving and handling training, along with in-house shadowing and support. Staff told us, "We have time to read all the care plans, this enables us to be familiar with any allergies, personal preferences and how to manage any individual situations." Staff were observed to ensure they had absorbed the training and were able to reflect it in their practice. Staff told us this was done in a proactive way to recognise competence and knowledge which was integral to providing high quality care and support.

We saw how some staff required more specific support in relation to their own learning style or cultural background. For example where English was not their first language, knowledge papers had been translated to further support their understanding. When some training required a test or timeframe for completion we saw additional time had been arranged. One staff member told us, "Some courses are more difficult and if you need help it is available you just have to ask." This demonstrated that staff received training in a format to support their learning and which focused on the needs of the people they were supporting.

Information was included in each person's care plan regarding their individual abilities and illnesses. Some people had uncommon conditions and we saw there was printed information about these conditions to provide staff with the opportunity to understand the impact that had on the person. Any practices or care was delivered in line with current legislation to ensure best practice care was embedded across the home. For example, in respect of diabetes and other dietary requirements.

There was a strong emphasis in place on the dietary needs of people and the importance this had on ensuing people's wellbeing. We saw how choices had been promoted. One person said, "The food is

fantastic, you always get a choice." People told us they had been consulted on the menu and were able to view the menu as it was displayed. One person said, "I get to add my favourite food. If I don't like what's on the menu I can have an alternative." We saw on the day of the inspection the cook discussing the evening meal with one person recognising the menu choice for that day was something that person did not like. They discussed alternatives and that was prepared for the person. The cook had reflected on how they could obtain people's views who were not able to express them verbally. They told us, "You can tell by the persons facial expressions or if they don't want to eat it. I then note that for future menu planning." We saw people were encouraged to go into the kitchen with support and offered visual options in relation to drinks or snacks.

The GP told us how one person's health had been dramatically improved following their move to the home. One person was identified as requiring a specific diet, through the staff diligence in adhering to the diet the person no longer requires any medicine to support their condition as it is now regulated by diet. The GP said, "This is completely down to the improved diet and active nutritional support." This demonstrated that people's nutritional needs were being catered for, monitored and managed.

Positive health care outcomes had been experienced leading to improved quality of life. We saw how the staff had questioned the use of specialist footwear with one person's consultant. It had been noted the person mobilised well without the need for these. The consultant agreed for the staff to try a standard pair of shoes, this was a success and the consultant has now discharged the person. The person is now able to wear and shop for a range of footwear of their choice.

The registered manager had worked in conjunction with the GP in considering new initiatives in relation to medicines management and stopping over medication of people (STOMP) with psychotropic medicines. This is a national project involving many different organisations which help to stop the over use of these medicines. We saw how this initiative had been used to improve the health care needs of people. People received a review and some medicines were reduced on a planned basis and staff observed any reactions. The GP said, "This campaign has really worked to reduce the medicine for people, it's a real success." The reduction in medicine had shown real improvements in the person's behaviour and awareness of their surroundings, enabling them to be more involved in the home's social aspects.

People's health care had been monitored, to support their wellbeing and ongoing health needs. One person required regular support from the dentist and a specialist toothpaste. The person told us, "I get my toothpaste from the chemist and staff always ensure I have it on time." They added, "They always make my appointments." One person told us how staff had responded to an ongoing health need. The person was experiencing headaches on a regular basis, the staff obtained medical support and they now received regular medicine. However, the medicine had an impact on another element of the person's health so further guidance was obtained. The person told us they were included in all their decisions and discussions about the medicine and any possible side effects.

The registered manager had ensured that all people had access to information that enabled them to understand their care needs and the health services available to them and this ensured people were not unduly discriminated against. For example, accessible 'easy-read' documentation was in place in relation to what people should expect from the service. This demonstrated that people were at the centre of decision making when their health care needs were considered.

The new providers had invested in making adaptations and changes to the environment. People had been integral to these decisions in relation to colour choices, and people were encouraged to personalise their own rooms. All the people we spoke with shared how they had been able to add items of interest to their

rooms. Other aspects of the environment had reflected individual's needs. For example, a communal bathroom had been refitted to remove the bath which was replaced with a walk-in shower. This was to support people who were unable to use the bath. One person told us, "With the shower I am able to be more independent, I still need staff support, but I can do more for myself." For those who still wished to use a bath, one was retained in the other communal bathroom.

There was a range of rooms to enabled choice along with maximising space. The home had been decorated to a high standard and provided a range of spaces for people. There were two lounges which allowed for a choice of space or television programme. One lounge had direct access to the outside garden space. We saw how spaces had been considered in meeting people's wishes for privacy when meeting professionals and family. For example, a downstairs room in the home had originally been used to support one person who required a separate activity space, this was no longer required due to the person choosing to integrate with other people in the home. This room was to be redecorated and changed to a meeting space to provide the opportunity for a private meeting place.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

People were supported to make decisions and direct their own lives and when required the legal framework of the MCA was implemented. For example, in relation to a medical examination we saw where the person lacked capacity a best interest meeting had been completed. The meeting involved the GP and relatives to consider the if the examination should take place and if so the impact on the person. The relative told us, "[Name] is unable to tell us their wishes. Everyone involved in the meeting had [name's] best interest at heart and we're working towards that." Consideration was made in relation to the person's medical history and lifestyle. All decisions were documented and when the person could be involved in the process they were. The GP said, "The staff involve people and never make a decision without them."

People we spoke with told us they were supported to make choices, they were provided with information to enable informed choice and we saw staff respected people's decisions. One person said, "I am able to make my own decisions. Staff listen to me, I make my own choices." Some people we spoke with told us they had given their consent to the staff for medicines and financial support. This had been clearly recorded in the care plans.

Staff we spoke with had a comprehensive understanding about decisions and the MCA. One staff member said, "We give people options and that can look different for each person. When more complex decisions are needed, we involve professionals so that we can be sure that all aspects have been considered."

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 Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met. When people required a referral, this had been made to the relevant local authority and we saw the registered manager kept a record which was reviewed monthly.

Care plans contained specific information about any restrictions which were also linked to risk assessments. When a person had a DoLS which had been authorised by the local authority we saw that any conditions had been or were being met. The management team were committed to ensuring that people were

supported in the least restrictive way possible. The registered manager reviewed any restrictions to ensure they were still necessary.

Some people from the service were involved in partnership working on the 'Health Action board,' as an advocate for others. This enabled them to have a voice in wider decisions about services which were being provided. One person had also received support from the partnership as the service were able to provide direct advocacy support. Independent advocacy is a way to help people have a stronger voice and to have as much control as possible over their own lives.

Good

Is the service caring?

Our findings

People we spoke with and observed had established positive relationships with the staff. One person said, "We have a bit of fun here." All the people we spoke with related to the kind and fun-loving nature of the staff. We saw staff responded to people on a one on one basis giving people time and respect with their request or general chatter. A staff member said, "I get on well with people here. We have warm friendly banter." They added, "I like the fact that people feel comfortable to have that banter. It creates a great rapport between people."

People were encouraged to maintain control over their lives. They had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. There was information about advocacy displayed in communal areas of the service, which were displayed in an easy read format. Some people had a link with an advocacy service. The registered manager was aware of the importance of advocates and had encouraged people to use them especially when the decisions were of a delicate personal nature.

People's religious and spiritual needs were recognised and embraced. People could access the local church. One person told us, that they attended each week and travelled by taxi. If other people expressed spiritual needs the registered manager provide the necessary support to ensure they could access this need.

Relatives told us they felt welcomed and relaxed at the home. One relative told us, "If I have any questions they are always answered." They also told us that the staff ensure that their relative is ready when they arrive to collect them for a day out or overnight staff. They mentioned that even at short notice things were organised.

Peoples dignity was respected. One person told us, "The staff are kind and thoughtful." Another person mentioned about the responsiveness of staff, they told us, "When I press the call bell system the staff come. Staff care." We saw that staff responded to people when they requested support. Before staff entered people's rooms they knocked and waited to be invited in. This was also observed when people used the bathroom.

The requirements in relation to data protection had been considered. Where computers were in use these had been password protected. People's information and personal details were stored in locked cabinets and access was restricted on a need to know basis.

Good

Is the service responsive?

Our findings

The registered manager made sure that when people moved to the home all the relevant information was obtained. They worked with family and the previous service to transfer information which would support the staff in meeting the individual's needs. Following the transition of one person a relative said, "They have considered all my concerns and taken action to make the changes needed." They added, "I have been involved in the care plan and any support the home has required in getting to know [name]."

The care plans were comprehensive and contained details about the persons preferences, history and current care needs. One staff member said, "The care plans reflect people really well and they are well set out so easy to follow."

The plans included how information was provided. The Accessible Information Standards (AIS). The AIS is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. We saw that a range of methods were used to support people. These include the use of easy read documents, Makaton sign language and visual promotes to aid people with understanding.

People's cultural and diverse needs had been considered. Assessment of people's diverse needs were in relation to the protected characteristics under the Equality Act 2010. People's diversity and sexuality was considered and identified people's personal preferences and how they wanted to be supported. This included information about how people expressed their sexuality.

Things were available to provide opportunities for people to embrace their areas of interest or to learn a new skill. Activities covered a range of things which were focused on each person's individual needs. Some people preferred to stay at the home and have staff support to access games, music or just one to one time. Other people enjoyed going out to clubs, the pub or local community activities. One person said, "I am happy here and don't get lonely anymore." One staff member we spoke with told us how they could be spontaneous. They said, "Last week we went to the local outdoor concert and then the following day we packed up a picnic and went to the park. People enjoy doing things." This showed that people received support in areas of interest to them.

The provider had a complaints policy which was available to people on the notice board in an easy read format. We saw that when complaints had been received they followed the policy guidelines and a timely response and written correspondence. This included an apology and the outcome of the complaint. The registered manager was also considering how they could report and monitor non- formal complaints.

At the time of this inspection the provider was not supporting people with end of life care, so therefore we have not reported on this. Those people who were able had been given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives. We saw these plans were in place and included personal reflections like a favourite song to be played at the funeral and were the person wished their ashes to be placed or scattered.

Good

Is the service well-led?

Our findings

There was a registered manager in post. People, relatives and professionals, without exception reported the service was well led. We saw that everyone involved in the running of the home had an opportunity to contribute to the person-centred nature of the home. One person told us, "I love it here and I am so glad I came to stay at this home." There was a homely atmosphere which had been enhanced by the recent refurbishments. One staff member said, "It's a pleasure to work here." We saw through a range of feedback and meetings that people's views were shared and responded to.

The home had received a certificate in relation to the dignity award in March 2017. It stated, 'Promise to provide people who need care and support with high quality services.' Health care professionals and the GP both confirmed this statement was true to what was provided. The health care professional said, "Staff are welcome professionals who respect people." The GP commented, "There are no issues here, staff are responsive. It's a pleasure to visit." The dignity award had been renewed in April 2018. Staff and people had completed a balloon launch on Mother's Day, a dignity tree had been created and was on display. One person told me, "We made that, it was a nice thing to do." Other events involved a planned coffee morning where coasters had been made with the strap line, 'A cup of coffee shared with a friend is happiness tasted and time well spent.' The registered manager said, "Respect is integrated into the structure within the home."

Staff felt supported by the manager and provider. One staff member said, "All management are easy to talk to, I feel totally supported." We saw that supervisions and impromptu meetings had been made available for staff to receive support for their role. The registered manager also received support from the provider and they felt confident in their team. This included the deputy. the staff team who provided the support and the dedication of the cook and domestic support. Other support was available, for example, the home was moving to an electronic medicines management system. Technical support was available and staff had been given the training and time to understand the new system before it was implemented.

People's views had been considered in relation to improvements and any changes linked to the home. People had been involved in the recruitment process when new staff attended interviews. We saw that the person's views had been recorded as part of the process and used as part of the decision making in confirming new appointments.

We reviewed the satisfaction questionnaire which had been produced in an easy read format. All the people reflected that they felt happy at the home. Comments from the questionnaires reflected this, 'Staff do help me with my choices, they listen to me.' And, 'I help with my care plans and get to say about what I want.' Relatives had also been asked their views, again the responses were positive with comments like. 'I am always included in the care planning and invited to meetings.' And, 'When [name] requested a room move this was supported.' This showed that the provider had taken the time to ask people's views and when required acted on any changes.

The registered manager had established links with a range of partners. These were both health and social

care professionals along with social links within the local community. These links enable the staff to be responsive to people's needs and the contacts were in place. We saw where professionals had responded to a questionnaire the comments reflected the relationship which had been established. 'Excellent service, staff very helpful' and 'I have seen a big improvement since [name] moved to this home.' When needed new links were established. We saw that people had accessed a range of holiday opportunities with people who they had established a connect with from the providers other locations.

Audits had been completed to support the running of the home. For example, when people had fallen we saw action had taken place to review the risk assessments and measures put in place to reduce the risks. A mapping exercise had identified a correlation between a person's behaviour and their pain relief in connection to their female cycle. After several months there was a clear pattern which in conjunction with health professionals could be addressed with an anticipated pain management plan. A health care professional said, "They look to find what the issue is and provide the solution. They don't just accept the behaviour as being okay." This showed that audits were used to drive improvements to support positive outcomes for people.

The registered manager was aware of their registration with us and ensured that notifications had been completed to reflect accidents or events. This is so we can see what action the provider had taken.