Agincourt Care Home Limited

Agincourt Care Home

Inspection report

116 Dorchester Road
Weymouth
Dorset
DT4 7LG

Tel: 01305777999
Website: www.agincare-homes.com

Date of inspection visit:
29 October 2018
30 October 2018

Date of publication:
19 December 2018

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

Agincourt Care Home is residential care home registered to provide care for up to 31 people in a residential area of Weymouth. At the time of our inspection there were 29 older people living in the home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Systems and processes were in place to maintain people's safety and protect them from avoidable harm.

Where management spot checks or feedback had shown staff needed to improve their practice evidence showed they had been given coaching.

Staff had a good understanding of how to safeguard people from abuse and knew what signs to look for and how to raise a concern. The home had robust recruitment processes to ensure that people were supported by staff who were suitable to work with vulnerable adults. Medicines were managed safely. Staff were confident with this task and had regular observations to check their competency. The home conducted audits to ensure there was learning from incidents or issues and the chances of them reoccurring was reduced.

People's needs and choices were assessed with their involvement. This included listening to them and noting aspects of their lives that were important to them and made them unique. This diversity was acknowledged, respected and supported. Reviews of the support people required were completed and included evidence that they were included in these discussions. People were supported by staff that had received training that gave them the skills and confidence to meet their specific needs.

People were supported to have a balanced and varied diet. People were supported to maintain their health and wellbeing. This included support to attend routine appointments or with visits from health and social care professionals. Improvements were being made to the home environment to make it more dementia friendly.

Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people living there particularly when they lacked capacity to make certain decisions affecting their life. The MCA 2005 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Records showed that people who required these safeguards had them in place and, where conditions were attached, they were being met.

People were supported by kind and caring staff who supported them to express their individuality and celebrate what they had done so far in their life. People were given the time and support they needed to express their views and wishes. Staff understood the importance of helping people to maintain their privacy and dignity. People were encouraged to maintain contact with their relatives and friends.

People received personalised care and support that was reflective of their current and emerging needs. People were supported to participate in a wide range of activities both in the home and local community. Staff recognised the importance of supporting people and their wider family when they required end of life care.

There was a positive culture at the home where everybody's views were considered. Staff and relatives thought highly of the management at the home. Team meetings were well attended and demonstrated wide ranging discussions and shared learning. People and their relatives had the opportunity to feedback through annual surveys with this used to inform improvement planning. Local nursing teams had provided staff training in dementia care and best practice in managing challenging behaviours.

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.

Systems and processes in place protected people from avoidable harm.

People were supported by staff with a good understanding of how to safeguard them from abuse.

There were enough staff to meet people's needs and respond flexibly.

Medicines were managed safely.

The home was visibly clean but needs to ensure that malodours are eliminated or minimised to maintain people's health and dignity.

The home used logs of accidents, incidents and near misses to help ensure lessons were learned and the chances of them happening again were reduced.

Is the service effective?

Good

The service was effective.

People were supported to have a varied and balanced diet.

People had their needs assessed to support their move to the home.

Staff had received appropriate training to help them meet people's specific needs.

People at the home benefited from regular visits from GPs, district nurses and a community psychiatric nurse.

People were supported to access health care services as and when they needed them.

Staff understood the principles of the Mental Capacity Act 2005

(MCA 2005) and how it applied to the people living there.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were given the time and support they needed to express their views and wishes about the care and treatment they received.

People were supported by staff who understood the importance of maintaining people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support.

Complaints were logged, acknowledged and investigated.

Staff supported people and their wider family when they required end of life care.

Is the service well-led?

Good

The service was well-led.

There was a positive culture at the home where everybody's views were considered.

Staff felt valued and rewarded.

Surveys were conducted with feedback used to improve the service.

The home had established and maintained partnerships with other agencies and organisations such as local hospice nurses and colleges.

Agincourt Care Home

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 comprehensive inspection took place on 29 and 30 October 2018. The first day was unannounced with the second day announced. The inspection team included two inspectors and an Expert by Experience. The Expert by Experience was present on day one only. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of caring for older people and people with dementia.

In planning the inspection, we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we contacted the local authority safeguarding and quality improvement teams for their views on the home.

During the inspection we spoke with six people using the service and six relatives. We also spoke with the registered manager, operations director, operations manager, maintenance person and four care staff.

We looked at four people's care plans and observed whether they were supported in line with their assessed needs. This is called pathway tracking. We also looked at records relating to the management of the home including staff rotas, medicine administration records, meeting minutes and the recruitment information for three staff. During the inspection we spoke to a visiting community health professional.

We carried out general observations and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People's risks were managed which helped to protect them from avoidable harm. People told us that they felt safe, for example telling us, "I feel safe and secure here."

We observed that one person who was at increased risk of falls did not have their alarm mat near them when sat in their room. When we spoke with the registered manager about this they explained that the person was known to kick their mat away from where they were sat. This behaviour was noted in the person's care plan. Staff reduced risks to this person by carrying out hourly checks. The person had also been supported to move to a room closer to the office to enable these regular observations. On day two of the inspection the alarm mat was next to the person's chair.

We observed that one person who was at increased risk of falls did not have their alarm mat near them when sat in their room. When we spoke with the registered manager about this they explained that the person was known to kick their mat away from where they were sat. This behaviour was noted in the person's care plan. Staff reduced risks to this person by carrying out hourly checks. The person had also been supported to move to a room closer to the office to enable these regular observations. On day two of the inspection the alarm mat was next to the person's chair.

We observed one person expressing that a cup of tea was too hot for them to drink. The staff member supporting them immediately went to add more milk, so it was at a temperature comfortable for the person to drink safely.

People's risk of skin pressure damage was well managed, for example air mattress were at settings recommended in their care plans. However, on one occasion a person who was assessed as needing a pressure relieving cushion was sat in the lounge without this piece of equipment. The cushion was in their bedroom. When we mentioned this to staff it was immediately retrieved and put in place on the person's chair.

Equipment and the home environment were regularly checked to ensure they were in good working order and did not present a risk to the people living there and staff. This included hoists, pressure relieving equipment and fire safety systems. People had individual Personal Emergency Evacuations Plans (PEEP). These guided staff on the most appropriate way to support them to get out of the home safely in the event of an emergency such as a fire or flooding.

People were supported by staff with a good understanding of how to safeguard them and how to raise concerns either internally or externally if they suspected harm or abuse. Staff told us that they got on well as a team and that they had not experienced bullying or discrimination from any colleagues.

The provider had responded appropriately to concerns raised. For example, concerns about staff conduct were fully investigated and had resulted in increased monitoring by the management. The local authority safeguarding team were continuing to consider the allegations at the time of this inspection. Staff told us

that they knew how to whistle blow and would have no hesitation in doing so if the need arose. The home had established two whistleblowing leads so that staff could easily access support and guidance in this area. One staff member said, "If I had a whistleblowing issue and the whistle blowing leads could not resolve it I would speak to the management, head office, safeguarding or CQC."

There were enough staff to meet people's needs. A dependency tool was used monthly to ensure that staffing levels continued to match the needs of the people living there. Staff were not rushed and were observed spending meaningful time with people.

The home had robust recruitment practices in place which meant people were supported by staff suitable to work with people who could be considered vulnerable. Staff did not support people until criminal background checks had been completed with the Disclosure and Barring Service (DBS).

Medicines were managed safely. People received them on time and as prescribed. Staff that were responsible for the administration of medicines were all trained and had had their competency assessed. We observed one staff member waiting until a person was fully awake before offering them their medication. The temperatures of the room and fridge where medicines were stored were recorded and were within the acceptable range. Medicines that required stricter control measures by law were stored correctly in a separate cupboard and records kept in line with relevant legislation.

Medicine Administration Records (MAR) were completed and audited appropriately. Topical creams charts included clear instructions for staff to apply these correctly. There was sufficient stock of people's prescribed creams and those listed on people's charts matched those in their rooms. Where people were prescribed medicines that they only needed to take occasionally, guidance was in place for staff to follow to ensure those medicines were administered in a consistent way.

Although the home was visibly clean there was an unpleasant smell throughout the home on day one. This had the potential to impact on people's dignity. The registered manager told us that this had been identified as a trending issue within complaints they had received. The home had then included this as an area for improvement within their business plan. On day two the malodour was not present. The management told us that this was because they had washed the radiators alongside the regular application of a chemical treatment to the carpets and deep cleaning by an external company. The operations director told us they planned to replace the older carpets within the home between March and July 2019. The home should ensure that all attempts are made to eliminate or minimise malodours to maintain the dignity of the people who live there.

The home had a procedure in place to log accidents, incidents or near misses. Where this had been done, the information was analysed by management to identify contributory factors and trends. This helped to reduce the chance of them happening again. However, on one occasion an accident and incident form had not been submitted at the time a person had become agitated. For example, after it was identified that more people were having falls in the evenings the provider had new LED lighting fitted in the corridors and people most at risk were supplied with night lights for their rooms. One relative said, "[The staff] have rung me if [relative] has had a fall and they get the medics out." Two other relatives told us, "[Relative] had a little fall earlier this year and they let me know straight away.

Good

Is the service effective?

Our findings

People were supported to have a balanced diet. People's meal time experience reflected their likes and dislikes and demonstrated that staff knew them well. People's food was served from a trolley in the centre of the dining room. This gave people the opportunity to smell and see the food before making a choice of what they wanted. Where people required specialist equipment to help them to eat and drink independently, for example a two-handled beaker or adapted cutlery, this was provided. The cook spoke with people each day to ask what they would like to eat and drink. Where required picture cards were used to support people in making these choices. People were then reminded what they had chosen and could change their mind and have something else if they preferred.

Although food was covered when being taken from the kitchen to the dining rooms, or people's rooms, one person did not have their food plated up and served to them for approximately 30 minutes. During this time their food had the opportunity to go cold. We asked a carer if the meal they were about to serve this person was warm. It wasn't so they were asked by the deputy manager to reheat it in the microwave. The management and kitchen team have agreed that the kitchen will hold back meals for those people requiring assistance or dining elsewhere or in their private rooms until the main dining rooms have been served. This will help avoid a reoccurrence of a meal being at a temperature that could affect a person's enjoyment of their meal.

People had their needs assessed to support their move to the home. This included their care needs, life history, and achievements. Religious, faith based and spiritual needs were recorded where these had been expressed or previously known.

Staff had received appropriate training to help them meet people's specific needs. They told us that the training had helped them to feel confident and competent in their roles. Records confirmed that staff had received training in areas including: tissue viability and wound care, behaviours that challenge and dementia awareness. One staff member said the dementia training had helped them "relate to people and families" with this condition. Staff had completed an induction programme which involved shadow shifts with more experienced members of staff.

Competency checks were undertaken to help ensure that staff practice remained up to date and met current best practice. These checks covered areas such as medication, personal care and assistance with meals. One staff member's record showed that they had 'showed politeness and respect at all times.' Another staff member had been assessed as 'demonstrating a caring manner.'

Supervision was held regularly with staff telling us that they could raise anything at these sessions. Supervision was structured with discussion areas which included MCA 2005, professional boundaries, infection control and good record keeping. Development opportunities were offered and followed up. A relative expressed, "The staff I have met seem very good." Another relative told us, "I think the staff are wonderful."

People at the home benefited from regular visits from GPs, district nurses and a community psychiatric nurse. Examples were shared with us in regards good partnership working with health professionals. One of the professionals told us, "They have the skills and experience to manage people with complex needs. Hats off to [the registered manager] and her staff. They are pro-active and are good at amending care plans to reflect people's changing needs."

People were supported to access health care services as and when they needed them. Health professional visits were recorded which detailed the reason for the visit and outcome. These were readily available to staff. Recent health visits had included a speech and language therapist, a GP, and a hospice nurse. A relative told us, "They know if [relative] is not well and they would tell me. They called a GP once when [relative] had a bad cold and let me know."

The home was set out across two floors with a working lift supporting access to the first floor. There were handrails along each corridor to support people who felt unsteady or were at increased risk of falls. Although the layout and age of the building made it a challenge to significantly change or modify it to meet people's increasing needs, improvements and ongoing changes were being made to make the home environment more dementia friendly. The registered manager had replaced some of the pictures on the walls with sensory materials which would help to stimulate and engage the people living with dementia. New lighting in the corridors had been put in to help those with a sensory impairment. Almost half of the doors to people's rooms were of a design that imitated that of a front door with a rolling programme to replace the remainder. One person told us this made them feel like it was their home. Signage and the layout of the home helped people orientate to time and place. The home had purchased new lounge chairs for the ground floor which was part of a planned update to maintain its homely atmosphere.

The registered manager told us that they were currently considering suitable replacement signage for the communal bathrooms and toilets to make them more recognisable to people. People were consulted about changes to the décor within the home. For example, the colour of one of the upstairs bathrooms had been chosen at a resident's meeting. One person said, "I think the colour is excellent."

People on the ground floor had direct access to the enclosed garden using patio doors in their rooms. This led to a covered seating area with individual tables and chairs for people and visitors to sit out and relax. There was a pond across the lawn which was fenced and netted for safety. Photos showed that garden parties were held here in the summer.

Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people living there particularly when they lacked capacity to make certain decisions affecting their life. One staff member said, "The MCA is always drummed into our heads." The MCA 2005 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. Where people had been assessed as lacking capacity best interest's decision meetings had been held with involvement from people's relatives and relevant health professionals.

The home kept a record of people who had representatives that could act on their behalf when they lacked capacity. Records showed that these people were involved in decisions affecting the person and only signed to give consent within the correct scope of the legal authority they held.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. One person had conditions on their DoLS authorisation and records confirmed that staff were meeting these.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who supported them to express their individuality and celebrate what they had done in their lives. Bedrooms were personalised with items that were important to people such as photographs and ornaments. We saw that these acted as reference points for communication between people, staff and visitors. One person was an avid fan of a particular popstar and had been helped to decorate their room to reflect this. Another person had been a keen underwater diver and had a port hole decoration outside their room and, until recently, had enjoyed exploring the sea using a virtual reality headset. These examples demonstrated the extent to which the staff respected what people enjoyed and the interests they had developed during their lives.

Relative comments included, "The staff are very pleasant and we can have a laugh", "They treat [relative] very well. They are caring" and, "needs attention and [relative] is always attended to. They interact with [relative], reassure [relative] and always tell [relative] what they are doing." Comments from people included, "They are very pleasant to me. I have no worries here so I am quite happy", "I like the staff. They are very kind to me and caring."

People were given the time and support they needed to express their views and wishes about the care and treatment they received. A relative said, "They understand [relative] absolutely and they speak to me about [relative's] condition. The staff are like a second family." Another relative reiterated this when telling us, "[Relative lived here for two years. I find the care very good. They are like part of the family." A staff member told us that some people were more inclined to convey their acceptance or refusal of the support being offered using non-verbal signals and that staff had developed the skills to recognise these such as a smile or a turn of the head. Staff knew people well and had developed ways to tailor their support to meet people's individual needs. For example, one staff member told about a person who became much calmer when offered and supported with a bath in the afternoon.

People were supported by staff who understood the importance of maintaining people's privacy and dignity. One person said, "They knock on my door and they encourage me to do things for myself." A relative told us that when a GP had visited the home and seen their relative in the lounge, staff had supported their privacy by putting a screen around them. Another relative said, "The staff are compassionate. They support [relative's] dignity and close the curtains when [relative] is changing."

People were encouraged to maintain contact with their relatives and friends. This included regular visits and, if they were able, the use of a private telephone. The numerous lounges around the home meant that people could meet privately with visitors in areas other than their bedrooms.

Good

Is the service responsive?

Our findings

People received personalised care and support that was reflective of their current and emerging needs. There was an emphasis on personalised care and spot checks supported this approach. This included the promotion and provision of good oral care with management conducting checks to ensure that this happened. Staff had a good understanding of different people's oral health care needs and had been given written guidance to support this. This helped to embed the importance of helping people maintain their oral health and dignity where they could not do this themselves.

Care plans detailed people's communication needs and anything that would impact on their ability to interact with others. This included whether people had a sight, hearing and/or cognitive impairment that required a personalised and sensitive approach from staff and visiting professionals.

Where people's needs had changed they, staff familiar to them, relatives and health professionals were involved in reviewing the care or treatment required to maintain their health and well-being. One relative told us, "[Relative] has improved since [they] came in here" and, "If we are concerned they listen and keep us posted. If they feel [relative] is going downhill they let us know."

People were supported to participate in a wide range of activities both in the home and local community. These had included an interactive singing and dressing up session with people from a popular TV talent show, pet therapy, a farm trip and planting in the garden. There was a good rapport between people and staff. We observed staff using a tablet device to show people photos and pictures in the lounge and on a 1:1 basis in people's rooms. This encouraged interaction and reminiscence. This was further encouraged via a large font daily reminiscence newspaper specially developed to provide stimulation, interest and fun articles for older people and those living with dementia. Staff read this to people who were unable to read it themselves. The newspaper acted as a way for people, staff and relatives to engage with each other.

Relatives were made to feel welcome and were encouraged to visit and take part in activities. One person's care plan noted that they 'love visits from their [relative] who brings along the dog.'

The home recognised that people had different interests and actively supported them to pursue those. For example, male residents had been supported on a 'male only' visit to a local D-Day museum where they dressed up in army uniforms and enjoyed a pint of beer. One person's relative told us, "They do [relative's] hair and it always looks nice." Residents and staff had created greetings cards which they were selling to raise funds for a new minibus. Upcoming events were advertised in both lounges so that people and their relatives could plan ahead. Previous events were recalled in colour booklets that the provider had produced and made available to people around the home. A sense of community had been maintained by the establishment of visits from the provider's sister homes with a plan to extend the invitation to other provider's homes in the area.

The home kept a record of compliments it had received. Recent examples included: 'Everyone has commented on how well [name] is looking, and they mentioned how happy they were with you all there at

Agincourt', 'Thank you so much for all the care, comfort and kindness you gave to [relative] and the help I had from you all' and, 'Just a short note to formally thank you all for your help with my [relative] for the last years of their life.'

All complaints were logged, acknowledged and investigated. The handling of complaints was audited monthly and an action plan put together. Actions to resolve issues included the management meeting with the complainant to discuss the outcome of internal investigations. Where the home was found to be at fault an apology was provided to the person concerned or their relatives, if acting on their behalf. When patterns and themes had been identified, for example with regards odours within the home and the décor, these had been added to the provider's business plan to ensure that actions were scheduled to resolve the issues. Relative comments included, "I know the people in charge and I would know who to complain to but I haven't had to", "I have never had to complain" and, "I would get in touch with the manager if I needed to complain but I have never needed to."

Staff understood the importance of supporting people and their wider family when they required end of life care. Staff had received training in end of life care. People's future wishes were discussed and recorded with their relative's involvement where they had given consent. People had end of life medicines available for when they needed them. Staff followed advice from relevant health professionals to be 'mindful of comfort' and people's dignity as this time.

When invited, staff had attended people's funeral services and had helped marked the passing of a person with no immediate family by reading a poem at their service that recognised their love for countryside and outdoor pursuits. They had also located a distant relative using a genealogy solicitor to establish where the person would most likely have wanted their ashes spread.

Good

Is the service well-led?

Our findings

Monthly audits and spot checks covered areas which included care plans, staff files, medicines, and nutrition and hydration. The latter audit helped ensure that when people did not eat or drink amounts that had been recommended to maintain their health, timely corrective action was taken which included referral to relevant health professionals.

Where management spot checks or feedback had shown staff needed to improve their practice evidence showed they had been given coaching. When their practice had improved the action plan was signed off by management and the staff member.

There was a positive culture at the home where everybody's views were considered. The registered manager expressed, "I get staff on the same page by encouraging them to share their ideas and bring them to team meetings. I'm a nurturing manager." One staff member said, "It's a good team and a friendly home. I enjoy my job." Two other staff members told us, "It's really nice here…All the staff get on well" and, "They are very nice here. Everyone is lovely and very welcoming. It's like being part of a big family." The registered manager said they were most proud of "allowing residents to be who they want to be. We all have our own quirks; little ways and we should be respectful and mindful of these. We shouldn't take away these things as this is what makes [he residents individuals."

Staff and relatives thought highly of the management at the home and told us they promoted an open-door policy. Comments from staff included, "You get a lot of support from the management…If I have any concerns I know I can walk into the office" and, "I feel really supported by [the registered manager]. You can go and see them at any time." Relatives comments included, "I would say the manager is very competent", "I find [the registered manager] approachable as I can talk to [title]" and, "The registered manager and deputy manager are really nice people and visible."

Staff told us that they felt valued and rewarded. One said the registered manager "tells me all the time I do a good job." The home motivated staff by awarding recognition to an 'employee of the month.' The recent winner had been praised for their 'outstanding commitment, dedication and overall approach.' Staff were provided with the opportunities to develop whether that be via gaining academic qualifications or taking on one of the 'champion' roles that had been introduced. These roles served to motivate the staff and reinforced the importance of particular areas of practice such as upholding people's dignity.

The registered manager demonstrated a robust understanding of their role and of CQC requirements including the type of events or incidents that we need to be informed of such as when a person using the service passes away and where the Duty of Candour applies. This is when a provider is required to act in an open and transparent way by writing to a person, or the person or body who has the legal authority to act on their behalf, and apologise when a suspected or actual reportable incident has occurred with a person's care or treatment. They must provide an account of how it happened, investigate the incident and provide all reasonable support in relation to the incident.

Team meetings were well attended and demonstrated wide ranging discussions took place on areas such as pressure care, meal choices and dignity. Information was shared with staff to ensure that standards were maintained and people received care that reflected their individual needs.

The registered manager maintained and developed their skills by attending regular training at the provider's head office and quarterly managers training days. They told us they received support in their role from the operations director and regular supervision and appraisal from the operations manager.

People and their relatives had the opportunity to feedback through annual surveys. The peoples' survey had included questions about choice and control, meals and activities. People had fedback that they were either satisfied with the quality of the service with some people stating that it exceeded their expectations. The relatives' survey asked question that included their views on the cleanliness and presentation of the home, whether they were invited to attend the residents' and relatives' meetings which are advertised in the home's newsletter and whether they were made to feel welcome. The results of the surveys were analysed and used to inform the provider's business plan and prioritise areas for improvement. This information was shared with staff so that all knew where improvements were required and could help achieve these.

The service had established and maintained good working relationships with other agencies to provide good care and treatment to people living there. For example, links with hospice nurses had ensured that people living with cancer had support from staff knowledgeable about the condition and how it affected them. A health professional told us, "They only contact us if they need help. The registered manager is very good at helping her staff support the residents some of whom have very complex needs." The home had also developed partnerships with local schools and colleges to encourage health and social care students to undertake placements there.