Hanningfield Retirement Homes Limited

Hanningfield Retirement Home Limited

Inspection report

99 London Road
Sittingbourne
Kent
ME10 1NR

Tel: 01795479587

Date of inspection visit:
13 March 2018
14 March 2018

Date of publication:
11 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hanningfield Retirement Home is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hanningfield is registered to provide accommodation and personal care for a maximum of 39 people. The home specialises in providing care to older people, people who are frail and some people living with dementia. At the time of our inspection there were 38 people living in the service. Hanningfield is located in Sittingbourne and is arranged over two floors.

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

People were protected from abuse. Staff received regular safeguarding training, knew how to identify potential signs of abuse and knew how to report concerns. Risks to people and the environment were assessed and minimised. Risks associated with people's care had been identified and appropriate risk assessments were in place. There were sufficient numbers of staff to keep people safe and meet their needs. People received their medicines when they needed them from staff who had been trained and competency checked. People were protected by the prevention and control of infection. Accidents and incidents were reported by staff in line with the provider's policy, and the registered manager took steps to ensure that lessons were learned when things went wrong.

Staff received the training and skills they needed to meet people's needs. Staff were recruited safely. Staff didn't always feel confident in their roles as training was not always kept up to date. People's needs were assessed and their care was delivered in line with current legislation. People were supported to eat and drink enough to maintain a balanced diet. People told us they enjoyed their meals. Staff worked together across organisations to help deliver effective care, support and treatment. Staff were knowledgeable about the Mental Capacity Act, knew how to seek consent for care and knew the process to help those who lacked capacity to make decisions. People's needs were met by the adaptation, design and decoration of the service.

People were treated with kindness, respect and compassion. We saw staff listening to people, answering questions and taking an interest in what people were saying. People were supported to express their views and be actively involved in making decisions about their care and support. People's privacy, dignity and independence were respected and promoted.

People told us they were not always supported to take part in activities that interested or were appropriate to them. Activities provided by the volunteer were group based, and not always tailored to individual interests. We have made a recommendation about this. Other aspects of people's care was provided in a personalised way. People were encouraged to maintain relationships with those who mattered to them.

Family members and friends were welcomed into the service. People told us they were confident to raise complaints and concerns about the support they received. People were supported at the end of their life to have a comfortable, dignified and pain-free death. Staff worked closely with the palliative care team and the local hospice.

Governance systems were not always effective in ensuring that shortfalls in service delivery were identified and rectified. Audits had not been effective in identifying all of issues we identified at this inspection. The registered manager had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. Management encouraged transparency and honesty within the service. People, their families and staff were encouraged to be engaged and involved with the service. There were strong and growing links with the local community.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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 abuse.

Risks to people and the environment were assessed and minimised.

There were sufficient numbers of staff to keep people safe and meet their needs.

People were recruited safely.

People received their medicines when they needed them from staff who had been trained and competency checked.

People were protected by the prevention and control of infection.

Accidents and incidents were reported by staff in line with the provider's policy.

Is the service effective?

Good

The service was Effective.

People's needs were assessed and their care was delivered in line with current legislation.

Staff received the training and skills they needed to meet people's needs.

People were supported to eat and drink enough to maintain a balanced diet. People told us they enjoyed their meals.

Staff worked together across organisations to help deliver effective care, support and treatment.

Staff were knowledgeable about the Mental Capacity Act.

People's needs were met by the adaptation, design and decoration of the service.

Is the service caring?

Good

The service was Caring.

People were treated with kindness, respect and compassion.

People were supported to express their views and be actively involved in making decisions about their care and support.

People's privacy, dignity and independence were respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

People told us they were not always supported to take part in activities that interested or were appropriate to them.

Other aspects of people's care was provided in a personalised way.

People were encouraged to maintain relationships with those who mattered to them.

People told us they were confident to raise complaints and concerns about the support they received.

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Governance systems were not always effective in ensuring that shortfalls in service delivery were identified and rectified.

The registered manager had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff.

Management encouraged transparency and honesty within the service.

People, their families and staff were encouraged to be engaged and involved with the service.

There were strong and growing links with the local community.

Hanningfield Retirement Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered persons continued to meet 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.

We used information the registered persons 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. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 13 and 14 March 2018 and the inspection was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

During the inspection we spoke with six people who lived in the service and with three relatives. We also spoke with three members of a care staff and the chef. In addition, we met with the registered manager and the registered provider. We also observed care that was provided in communal areas and looked at the care records for three people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, we 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 speak with us.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe at Hanningfield. One person said, "I feel safe living here they are very good." A relative told us, "I wouldn't have her anywhere else. I have peace of mind knowing she's being looked after safely."

People were protected from abuse. Staff received regular safeguarding training, knew how to identify potential signs of abuse and knew how to report concerns. A staff member told us, "We have safeguarding training which helped us understand what abuse is. If I ever saw anything I'd report it and I know it would be treated seriously." The registered manager knew to report concerns to the local authority when necessary, and records showed they had informed the Care Quality Commission when concerns had been raised. Staff understood the service's whistleblowing policy and told us they would be confident in using it if the need arose.

Risks to people and the environment were assessed and minimised. Risks associated with people's care had been identified and risk assessments were in place covering areas such as moving and handling and falls. Positive risk taking was encouraged and guidance was provided to staff in order to help keep people safe. Staff were aware that each person had a personal emergency evacuation plan (PEEP) in place which provided them with guidance on how to support people in the event of a fire. Records for one person showed they needed to be accompanied when outside as there was a risk they would leave the assembly point, but the section which recorded how staff were to support them in an emergency was left blank. This meant the person might be at risk during an evacuation of the building. We brought this to the attention of the registered manager who completed the assessment fully before the end of the inspection. Other people's PEEPs were completed accurately.

The provider had ensured that the environment was safe for people. There were up-to-date safety and maintenance certificates for gas appliances, moving and handling equipment and legionella. Weekly health and safety hazard checks of rooms and communal areas were completed. Hazards were identified such as "main light not working" and "wardrobe handle came off". Any action taken was recorded such as "put in a new bulb". The service had recently received a fire inspection where there were a number of areas identified which required replacement or improvement such as carrying out a new fire risk assessment and replacing fire door alarm systems. Records showed all areas of improvement had been either completed or were planned to be.

There were sufficient numbers of staff to keep people safe and meet their needs. The registered manager used a dependency tool to assess the needs of people living at the service, and used this information to determine staffing levels. The registered manager told us they did not use agency staff. All staff were permanent employees meaning people were supported by staff they knew well at all times. During our inspection we saw there were enough staff on duty. Call bells were responded to promptly and staff told us they had enough time with people. People who used the service said there were enough staff to support them, with one person telling us, "All the staff are good, they help me whenever I want it." Staff were recruited safely. During our inspection we looked at three staff files and saw the service was following its

recruitment policy. This included keeping records of application forms and interviews; photographic identification; employment history and reference checks from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks identified if prospective staff had a criminal record or were barred from working with people that need care and support. These measures helped ensure that they were suitable people to be employed at the service.

People received their medicines safely. When people moved into the service their ability to manage their own medicines was assessed and recorded in their care file. One person had been assessed to manage some of their own medicines and had been supported safely to do this. When required, other people were supported with their medicines by staff who had received training from the local pharmacy. Most people's medicines were dispensed from blister packs provided directly from the local pharmacy. If people needed 'as and when' medication such as paracetamol, these were stored safely and details were recorded accurately in the medication records. The records had photographs of the people being supported which helped reduce the risk of mistakes. Medicines were stored safely. Staff used locked medicine trolleys and we saw staff locking the trolleys when they were carrying out the medicine round. Other medicines were kept in a locked room. The room and fridge temperatures were monitored to ensure medicines were kept at the correct temperature. The service had close relationships with local GPs who visited on a weekly basis, or as and when needed. Records showed medication reviews took place appropriately. Some people had anticipatory medicines which staff could give to people if they displayed symptoms of a known illness such as a urine infection. This was managed in conjunction with the community matron, who drew up an anticipatory care plan for people, giving staff guidance on how much medicine to give. We noticed one care plan was overdue a review, and some medicine stored was past it's use by date. We brought this to the attention of the registered manager who took immediate steps to dispose of the medicine. Staff were able to describe the cross-checking procedure when giving people this medicine, which assured us that nobody was at risk of receiving this medicine without the date being checked. When moving between services, such as when people went into hospital or when people left the service following a respite stay, staff provided them with up-to-date information about their medication.

People were protected by the prevention and control of infection. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. Staff were aware of the infection control policy, and they received training during their induction with yearly online updates afterwards. Staff had access to personal protective equipment (PPE) such as aprons and gloves, and alcohol gels were seen throughout the building, We saw staff using this equipment when supporting people in the service. We found the service to be clean and tidy. Equipment such as hoists and wheelchairs were in good condition and were clean. One relative told us "When mum moved in she had a new carpet and curtains." People's rooms were deep cleaned every six weeks which included washing curtains, carpets and skirting boards.

Accidents and incidents were reported by staff in line with the provider's policy, and the registered manager took steps to ensure that lessons were learned when things went wrong. Records showed the registered manager kept a log of when people had an accident, such as a fall. They recorded the reasons for the fall, and action taken such as making a referral to a health professional. They then reviewed this information to look for patterns which would help prevent further accidents in the future.

Good

Is the service effective?

Our findings

People and their relatives told us their needs were met and staff were skilled in carrying out their roles. One person told us, "They're good at what they do. They know how to look after me." Another said, "The food is good, I've had everything I've ever wanted." A relative said, "The staff seem knowledgeable. I spend a lot of time here and they're confident."

People's needs were assessed and their care was delivered in line with current legislation. The registered manager carried out a pre-admission assessment before a person moved into the service. This assessment took place in the person's home, at a hospital or in another care home. The assessment took into account their physical and emotional needs, such as their disabilities, the support they needed with communication, their personal histories and their likes and dislikes. People's relatives were invited to the assessments if the person wished, and the registered manager told us how they would refer to external advocacy if the person wanted support. People's protected characteristics such as their religion and disability were recorded. Care was delivered taking preferences into account. Staff received training on discrimination during their induction.
Staff received the training and skills they needed to meet people's needs. Each new member of staff completed an induction, which included completing the Care Certificate. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff told us they thought the induction equipped them with the skills to carry out their role. One staff member said, "I went through the induction with the manager. Then I had some time shadowing staff so I could see how things were done." Staff also received on-going training which included Health and safety, fire training and moving and handling. However, not all staff felt confident in their roles as training was not always kept up to date. We spoke to one staff member who told us they needed to carry out basic life support on one person but did not feel confident to do so as they had not received training for a number of years. We looked at records which showed formal basic life support training was provided to staff more than four years prior to the inspection. Nationally recognised guidance suggests it is good practice to complete a refresher session on basic life support annually. We raised these concerns with the registered manager, who told us they had identified the shortfall in training and had arranged for a senior staff member to be trained to provide practical training to all staff. Although the senior staff member had been trained, basic life support training had not been delivered at the time of the inspection. The registered manager arranged for all staff to receive refresher training before the inspection came to an end. Staff who attended the course confirmed they felt confident to provide basic life support to people in future if required.

People were supported to eat and drink enough to maintain a balanced diet. When needed, staff weighed people so any significant changes could be brought to the attention of health professionals. Special dietary requirements were met by staff who followed guidance from the Speech and Language Therapy (SaLT) team. For example, some people were at risk of choking when drinking, so needed their drinks to be thickened. Information was recorded in the kitchen about how to thicken food for each person, and to what consistency. Information on allergies was recorded in a person's care plan and made readily available to kitchen staff. People had a choice of what to eat at mealtimes, and the chef sought feedback from people

when drawing up the menu. One person told us they liked to eat a mixed grill, and the chef showed us this had been incorporated into the menu. People told us they enjoyed their meals. Snacks were available for people outside of mealtimes. One person said, "We have crisps and bananas, you can help yourself." We saw staff offering people biscuits to have with their tea, including to those who preferred to remain in their bedrooms during the day.

Staff worked together across organisations to help deliver effective care, support and treatment. The care plans we reviewed showed information from the local authority, GP and continuing health care professionals was obtained to ensure the person's needs and wishes were fully known and included. Feedback from health professionals we spoke with was positive. One nurse told us, "This is the best home we work with, the referrals they make are appropriate and they follow always our guidance." People were supported to live healthier lives by receiving on-going healthcare support. Records showed that people had received all of the help they needed to see their doctor and other healthcare professionals such as the district nurse, continence team, chiropodist, optician and audiologist. People told us they had access to medical treatment in a timely manner, with one person telling us, "The doctor comes quickly when he is called."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are 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 were being met. Staff were knowledgeable about the MCA, knew how to seek consent for care and knew the process to help those who lacked capacity to make decisions. Staff would ensure the least restrictive practice was used where possible. Records showed a DoLS application was made for one person, and a plan was put in place to keep them safe. When appropriate staff would make best interest decisions involving health professionals, family members and others involved in the person's care. Where people had a lasting power of attorney, these were complied with. A lasting power of attorney is a legal document which names an attorney who can make decisions on another person's behalf.

People's needs were met by the adaptation, design and decoration of the service. Some of the communal areas were in need of decoration, and records showed the registered provider had a plan to renovate the property, including replacing carpets, some of which had been completed prior to the inspection. However, people told us they found the accommodation comfortable to live in. One relative said, "The décor might not be up there with the best, but you can't fault the caring nature of staff and that means more to mum than the carpet." The environment did not present a risk to those living there, and where staff or people identified an issue it was fixed promptly by maintenance staff. For example, a staff member noticed some carpet was loose by the lift, which might present a risk to people using a walking frame. Records showed this was fixed the day it was reported. People were involved in making decisions about how their bedrooms were decorated and were encouraged to bring their own furniture when they moved into the service. People told us this helped them feel more at home.

Good

Is the service caring?

Our findings

People and their relatives told us they found staff caring and treated them kindly. One person told us, "I had a bad time last night, I was hot and sweating. The staff kindly came in and changed my sheets for me and gave me a clean nightie." Another said, "I mostly like all the staff, they look after me well." A relative told us, "The care here is excellent. My mum wouldn't be here today if it wasn't for the staff here."

People were treated with kindness, respect and compassion. During our inspection we watched how people and staff interacted with each other. There was a homely feel to the service and there were frequent and friendly interactions between staff and people and their visitors. Staff were able to describe people's likes, dislikes and routines. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We saw staff listening to people, answering questions and taking an interest in what people were saying. Staff spoke discreetly to people about any personal care issues. On one occasion we observed staff asking one person discreetly if they would like to go to the toilet. They went down to the person's level and whispered to them. Another time we saw a staff member supporting a person with their nebuliser. They explained what it was for and waited patiently until the person was ready to use it.

People were supported to express their views and be actively involved in making decisions about their care and support. Most people had family or friends to support them express their preferences. Each person's care plan was reviewed on a monthly basis, and people and their relatives were able to contribute to the reviews. Relatives told us communication from staff and the registered manager was good, with one telling us, "If anything changes they always let me know. And if mum has an appointment and I can't go, they'll take her to it. "

People's privacy, dignity and independence were respected and promoted. People were able to speak to their relatives in the privacy of their room if that was their wish, and there were no restrictions to visiting times for family members and friends. Staff were able to give examples of how they maintained and protected people's privacy and dignity whilst providing support. One staff member told us, "I'll always close the door to the bathroom and close the curtains when supporting people with personal care." Staff were mindful not to intrude into people's private space and people told us that staff respected their privacy. One person said, "Yes they always knock on the door before coming in." However another person commented, "They have just taken the locks off the doors for fire safety and the man who puts the pictures up just knocks and then comes in, sometimes I am on the toilet I liked the privacy of a lock." We raised this concern with the registered manager, who confirmed that the fire safety officer had suggested all locks were removed from bedroom doors. As a result of the feedback we received during our inspection, the registered manager told us they would consult with each person and that if requested suitable locks would be installed. We also noted that people's post was kept in pigeon holes in the main reception area of the service. Most of the letters were unopened but we saw an open letter from a health professional for one person living at the service. The pigeon holes presented a risk that people's personal information might be accessible to others within the home. We raised this concern with the registered manager, who arranged for the pigeon holes to be immediately removed, and for post to be stored in locked cupboards in people's rooms. Other information was stored confidentially. Care records were locked away when not being used by staff, and

computers were password protected so they could only be accessed by authorised staff.

Requires Improvement

Is the service responsive?

Our findings

Some people said care staff provided them with all the assistance they needed. One person said, "Everything is fine, I'm quite happy here." Another said, "It's very good, there's nothing to complain about." However, we did not always find the service was responsive to people's needs.

A range of activities were available for people who lived at the service. These included monthly visits from a local musician, and regular visits from the Salvation Army and children from a local primary school. The service did not employ an activities coordinator but a volunteer visited the service every Monday, Wednesday and Friday. On other days people were supported by the registered provider and other members of staff to take part in activities such as armchair–based exercises. People were able to choose their own daily newspaper. Some feedback from people and their relatives was positive. One relative told us, "I find the staff very accommodating." However, other people told us they were not always supported to take part in activities that interested or were appropriate to them. There were large televisions in each lounge which were on throughout the visit. One television was playing a chat show, and a resident commented, "This is not very appropriate". Another resident in the afternoon commented "I'm fed up with this DVD, it has been playing forever." We spoke to the registered provider about these comments, who said staff tried to make sure most people in the communal areas were happy with what was being shown on the television. They also supplied televisions in each person's bedroom so people had the opportunity to watch individual programmes when they wished. Activities provided by the volunteer were group based, and not always tailored to individual interests. When we spoke to people about how they would like to spend their time, they came up with suggestions which had not always been explored by staff. One person suggested, "Film nights would be a good idea." Another person said, "I'm a knitter but I don't knit here. I might knit if there were a group of us." On the second day of the inspection we saw the volunteer playing a game of hangman with a small group of people. However, one person who had not joined in said, "I used to go out with Age Concern, I miss going over to the Isle of Sheppey to sit on the beach and watch the ships." The registered provider told us they used to support this person to go on outings but the person had declined further trips out. One person who spent time in their room said, "I watch the television and listen to talking books. The staff come in and have a chat but they are always on edge." However, feedback we received from people about how they were supported by other staff members was positive.

We recommend the registered provider review the activities programme to ensure it meets the needs and preferences of all those living at the service.

Other aspects of people's care was provided in a personalised way. People were involved in the writing of their care plans, and family members or other advocates were involved if people wished. Care plans were person centred and took into account people's individual preferences in most areas. For example, people were asked if they would prefer to be supported by a male or female member of staff, and the rota showed both male and female staff were on shift each day. People's personal histories were recorded and we found staff to be knowledgeable about the people they supported. The care plans were being reviewed each month to ensure they reflected people's changing needs. Other records confirmed people were receiving support in line with their care plan. Some of the care records we saw were in a format that could help people

understand the information held about them. For example, each section of the care plan had a coloured picture indicating what the section covered. The complaints policy was available in a large print format. Older people who have sensory adaptive needs and people who live with dementia often benefit from having information given to them through multi-media tools such as graphics and colours so that it is easier to understand.

People were encouraged to maintain relationships with those who mattered to them. Family members and friends were welcomed into the service and one relative told us, "It's like a home from home for me." Where people had existing relationships such as with churches, they were encouraged to continue them when they moved into the service.

People told us they were confident to raise complaints and concerns about the support they received. The complaints procedure was displayed around the home which encouraged people to raise any concerns to the manager or registered provider. There was a suggestions box at the entrance of the service where people could leave comments anonymously. People were also asked whether they wanted to raise any complaints during residents' meetings which were held monthly. Three complaints had been recorded within the last year, all of which had been investigated thoroughly by the registered manager to the satisfaction of the complainant.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. People were asked about their wishes at the initial assessment if it was appropriate, and this information was held in an advanced care plan which staff had access to. This included if the person wanted to remain in the service or be admitted into hospital. The registered manager arranged for the service to hold anticipatory medicines. These can be used at short notice under a doctor's guidance to manage pain so that a person can be helped to be comfortable. Staff worked closely with the palliative care team and the local hospice. The hospice provided training to staff on how to support people to have a dignified death. We noted that staff had supported relatives at this difficult time. This included making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance. The registered manager had links with a local counselling group who could offer support to staff or relatives following the death of someone in the service.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff told us they thought the service was well led. One relative told us, "Communication with the manager is good. It seems well run." A person living in the service said, "The owners are here every day, always offering biscuits around. We enjoy having them around." A staff member said, "I love coming to work. They've given me back my love for caring again." However, we did not always find the service to be well led.

Governance systems were not always effective in ensuring that shortfalls in service delivery were identified and rectified. The registered provider had ensured the continuous improvement of parts of the service by carrying out regular quality audits. A range of audits were carried out each month to check on the safety and quality of the service including audits of the environment, observations of staff moving and handling techniques and audits of some care records. However, these had not been effective in identifying all of issues we identified at this inspection including emergency risk assessments, training and the provision of activities. We spoke to the registered manager about these concerns, and following the inspection were sent a more detailed quality assurance procedure which the registered manager hoped would address the concerns we had. We will be checking this procedure is effective and has been embedded within the service at our next inspection.
A failure to effectively monitor the service to identify shortfalls and to make improvements is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

There was a registered manager employed at the service and they had an oversight of and reviewed the daily culture in the service, including the attitudes, values and behaviour of staff. They told us they spent the majority of their time in the service, observing practice and speaking to people. The registered provider also had a 'hands on' approach, visiting the service daily and interacting with people and their relatives. One staff member said, "Management help out if we need it. The owners are brilliant and the residents really like them." During our inspection we saw the registered provider supporting staff when hoisting one person, as well as helping with lunch and sitting chatting to people. All staff shared a vision for the service, which was described by the registered manager as "being responsible, committed and caring." The registered manager was complimentary about the conscientious and dedicated attitude of staff. They told us, "In the recent snow I knew everyone would make it in, no matter how difficult it was for them. Even staff who weren't on the rota wanted to come in to help."

Management encouraged transparency and honesty within the service. One staff member said "If I wasn't happy about something I know I could speak up and the manager would listen to me." Where there were incidents, outcomes of any investigations were shared with families in line with the registered manager's Duty of Candour responsibilities. The Duty of Candour is to be open and honest when untoward events occurred. One relative told us, "The manager is easy to talk to. I've not really had any issues, but if I did I know they'd be open and honest with me." Management had the skills and experience to carry out their role. The registered manager and registered provider had qualifications relevant to their roles, and had subscribed to a number of professional websites in order to receive up to date information about legal requirements that related to the running of the service. They were also a member of Kent Integrated Care

Alliance and Skills for Care Registered Managers Network and shared knowledge gained at staff meetings. The registered manager and registered provider were aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

People, their families and staff were encouraged to be engaged and involved with the service. There were regular resident and relative meetings. In one recent staff meeting staff were given reminders about the importance of clear recording in daily records, an update of the recent fire inspection and details about forthcoming training. A recent resident and relative survey was carried out, and records showed the one issue identified was rectified. Feedback was generally positive, with one person commenting, "Staff and residents and everything is wonderful about the home." People were encouraged to provide feedback on care home websites which provide information to the public on people's experience of the service. The feedback we saw was positive.

There were strong and growing links with the local community. The registered manager had good relationships with the local authority, hospice, GPs and other health professionals. Staff were proactive in engaging more widely within the community. This included building and maintaining relationships with local schools and churches.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have systems or processes in place to assess, monitor and improve all aspects of the service. Regulation 17(1)(a)