Donnington House Care Home Limited

Donnington House Care Home

Inspection report

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Date of inspection visit:
14 November 2016

Date of publication:
06 December 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 14 November 2016 and was unannounced.

Donnington House Care Home is run by a registered charity and provides accommodation for up to 28 older people, some of whom are living with dementia and who need support with their nursing and personal care needs. On the day of our inspection there were 26 people living at the home. The home is a large property, spread over two floors, situated in Chichester. There are two communal lounges, a dining room and well maintained gardens.

The management team consisted of a board of trustees, a registered manager, two deputy managers and a business 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.

People had access to activities on certain days and records and photographs showed that people had enjoyed visits from external entertainers. However, observations showed that people spent their day with very little stimulation or interaction from staff, other than when being supported with their basic care needs. This is an area of practice that requires improvement.

People were protected from harm and abuse. There were good levels of appropriately skilled and experienced staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. People's freedom was not unnecessarily restricted and they were able to take risks in accordance with risk assessments that had been devised and implemented. People told us that they felt safe, one person told us, "I feel safe. I leave the curtains open at night and the windows open during the day. I always feel safe, there's always someone around". Another person told us, "I feel very safe because of the way they look after us". People received their medicines from registered nurses, they had these on time and according to their preferences. There were safe systems in place for the storage, administration and disposal of medicines.

People were asked their consent before being supported and staff had a good awareness of legislative requirements with regard to making decisions on behalf of people who lacked capacity. One member of staff told us, "Some people without mental capacity have to have decisions made for them in their best interests. There is a process around this which is part of the Mental Capacity Act". Another member of staff told us, "We always assume people have capacity unless we are sure they don't". Care plans documented people's needs and wishes in relation to their social, emotional and health needs and these were reviewed and updated regularly to ensure that they were current.

Staff worked in accordance with people's wishes and people were treated with respect and dignity. It was apparent that staff knew people's needs and preferences well. Positive relationships had developed

amongst people living at the home as well as with staff. One person told us, "The staff are very jolly. I can't choose between them". Another person told us, "They are very good indeed, no complaints there, very, very caring staff. We have a laugh". One member of staff told us, "I would place any of my relatives here if they needed to go into a home. People are treated with such respect".

People's health needs were assessed and met by registered nurses who made referrals to external healthcare professionals when required. People's privacy and dignity was respected and maintained, observations showed staff using privacy screens when supporting people in communal areas to move and position. People had a positive dining experience and told us that they were happy with the quantity, quality and choice of food. One person told us, "The meals are very good".

The registered manager welcomed and encouraged feedback and used this to drive improvement and change. There were rigorous quality assurance processes in place to enable the registered manager to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. People, relatives and staff were complimentary about the leadership and management of the home. One member of staff told us, "This is by far the best run home I've ever worked in. I'd heard about it before I came here. I'm so happy to work here". Another member of staff told us, "The manager and the team are great".

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 home was safe.

Good levels of staffing ensured people's safety. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People received their medicines on time, these were dispensed by registered nurses and there were safe systems in place for the storage, administration and disposal of medicines.

People's freedom was not unnecessarily restricted. There were risk assessments in place to ensure people's safety and people were able to take risks to promote their independence and quality of life. The home was clean, systems were in place to reduce the spread of infection.

Is the service effective?

Good

The home was effective.

People were asked their consent before being supported. The registered manager was aware of the legislative requirements in relation to gaining consent for people who might lack capacity and was in the process of seeking advice in relation to this.

People were happy with the food provided. They were able to choose what they had to eat and drink and had a positive dining experience.
People were cared for by staff that had received training and had the skills to meet their needs. People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. This extended to people when they were at the end of their lives and people received good end of life care.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

Activities were provided to people on certain days, however, there was a lack of stimulation and interaction with people.

People received care that was in accordance with their needs and preferences and people were involved in their care.

There were mechanisms in place to enable people and their relatives to comment and complain about the care people received.

Is the service well-led?

Good

The home was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Donnington House 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.

The inspection took place on 14 November 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked the registered manager to complete a Provider Information Return (PIR). This is a form that asks the registered manager to give some key information about the home, what the home does well and improvements they planned to make. Prior to the inspection we looked at previous inspection reports and notifications that had been submitted. A notification is information about important events which the registered manager is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with eleven people, four relatives and eight members of staff. We reviewed a range of records about people's care and how the service was managed. These included the care records for eight people, medicine administration record (MAR) sheets, three staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We spent time observing care and support in the communal lounge and dining room during the day. We also spent time observing the lunchtime experience of people and the administration of medicines.

The service was last inspected in August 2014 and no areas of concern were noted.

Good

Is the service safe?

Our findings

People told us that they felt safe and were able to talk to staff if they had any concerns. One person told us "I always feel safe, there is always someone around". Another person told us, "I feel very safe because of the way they look after us".

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks were completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

There were good levels of staffing to meet people's needs. Due to the increased number of nursing places within the home and an increase in people's nursing needs, the registered manager had increased the staffing levels to ensure people's needs were met. For example, they had increased the number of care staff during the morning and afternoon shifts and had also introduced a twilight shift so that an additional carer worked during the busier periods of the day. In addition to care staff the registered manager had increased the number of registered nurses on a shift. Another registered nurse now worked alongside the other and offered support and practical assistance to meet people's increased nursing needs. On the day of the inspection an additional member of care staff worked during the afternoon so that they were able to support a person to attend a medical appointment. This demonstrated that the staffing levels were flexible and responsive to people's needs. People, relatives and staff felt that there were sufficient staff on duty to meet people's needs and that when people required assistance staff responded in a timely manner and our observations confirmed this. One person told us, "They come quickly". One member of staff told us, "I don't think I've ever worked anywhere with more staff and I've been in care for a long time. There are four nurses and seven carers on today. Sometimes it's even eight". Another member of staff told us, "I think it's a priority for the managers and the people running the home. You can't give good care if you don't have enough staff". A third member of staff told us, "There's no question of them allowing poor care to happen. That's why there are so many staff".

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. One member of staff told us, "I would let social services know if a manager didn't do something about abuse". Another member of staff told us, "I know that if we see or hear something abusive we have to act". There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace.

Suitable measures had been taken to ensure that people were safe and their freedom unrestricted. People were supported to undertake positive risks, we observed people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Risk assessments recognised

people's physical and clinical needs as well as environmental hazards and were reviewed regularly. Staff confirmed that they found risk assessments and information within people's care plans useful as it provided them with guidance about how to support people in a safe manner. Observations showed that staff were aware of risk assessments and worked in accordance with them. For example, care records for one person stated that the person needed to be supported by staff and that a stand-aid hoist should be used. Observations showed staff assisting the person to transfer from their armchair to a wheelchair using the recommended hoist.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. There were regular checks to ensure fire safety and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of a fire. Accidents and incidents were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices, they wore protective clothing and equipment, maintained hand hygiene and disposed of waste in appropriate clinical waste receptacles.

People were assisted to take their medicines by registered nurses. Safe procedures were followed when medicines were being dispensed and administered and people's consent was gained before being supported. Observations showed one member of staff assisting a person to take their medicine on a spoon, as that was the person's preferred way of taking their medicines. People confirmed that if they experienced pain staff offered them pain relief and records confirmed that this had been provided. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People told us that they were happy with the support received.

Good

Is the service effective?

Our findings

People were cared for by staff that had the relevant experience, knowledge and skills to meet their needs. People and relatives confirmed that they felt staff were competent, well trained and efficient. When asked about the experience and competence of staff, one relative told us, "The staff answer questions directly, they never just fob you off".

The registered manager had a commitment to staff's learning and development from the outset of their employment. New staff were supported to learn about the provider's policies and procedures as well as people's needs. An induction was completed to ensure that all new staff received a consistent and thorough induction. The registered manager was aware of the introduction of the care certificate and explained that new staff, who didn't hold diplomas in health and social care would be working towards this. The care certificate was used by all staff to refresh their knowledge and ensure they worked to current best practice.

The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. Staff that were new to working in the health and social care sector were able to shadow existing staff to enable them to become familiar with the home and people's needs, as well as to have an awareness of the expectations of their role. One member of staff told us, "It was brilliant. I never felt left alone and I shadowed staff until I felt comfortable". Another member of staff told us, "I've worked in health care for a long time but I was still given enough time to settle in".

Staff had completed training which the registered manager considered essential and this was updated regularly. The registered manager had ensured that staff, with roles other than providing care to people, completed the essential training to enable them to have a better understanding of people's needs.

There were links with external organisations to provide additional learning and development for staff, such as the local authority, the local hospice, community matrons, private training providers and the living well with dementia team. The living well with dementia team provides support and guidance to homes to enable them to continue to deliver high quality care for people living with dementia. Staff told us that the training they had undertaken was useful and that their learning and development was supported. One member of staff told us, "Yes, there is training which we do regularly. If you need it, you can do it". Registered nurses were also supported to keep their knowledge and skills up-to-date. They confirmed specific training, to meet people's needs, was available. One member of staff told us, "Yes, I've done quite a lot of training over the past year. I've done training for male catheterisation and venepuncture and I know there are updates available". Most care staff held diplomas in health and social care. Staff, who held roles other than providing care to people, were also supported to achieve a diploma related to their role. People were cared for by staff who had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive.

People's communication needs were assessed and met. People had access to relevant healthcare professionals to maintain or improve their communication, such as opticians and audiologists and we observed people wearing the spectacles and hearing aids that had been provided. Effective communication also continued amongst the staff team. Regular handover and team meetings ensured that staff were provided with up to date information to enable them to carry out their roles. Observations of a handover meeting showed that staff were provided with information about each person's healthcare needs from staff that had worked during the previous shift.

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 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered manager was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was in the process of seeking advice from the DoLS team at the local authority to identify if a DoLS was appropriate for some people. Staff had a good understanding of MCA and DoLS. One member of staff told us, "Some people without mental capacity have to have decisions made for them in their best interests. There is a process around this which is part of the Mental Capacity Act". Another member of staff told us, "We always assume people have capacity unless we are sure they don't".

People's health needs were met by registered nurses who made referrals to external healthcare professionals when required. These included GPs, dentists, falls prevention team, memory assessment nurses, consultants, tissue viability nurses, speech and language therapists (SALT) and dieticians. It was apparent that staff knew people well and staff told us that they were able to recognise any change in people's behaviour or condition if they were unwell to ensure they received appropriate support. People told us that staff ensured that they had access to medicines or healthcare professionals when they were not well. One person told us, "Doctors come if we want them. I see a chiropodist every six weeks. The dentist doesn't come here because of all the equipment, we have to go out to see them".

People had a positive dining experience. Most people chose to eat their meals in the main dining area, whilst others preferred to eat their meals in their rooms and this was respected by staff. People had a choice of meals and told us they were happy with the food available. Observations showed staff taking to time to ensure people were happy with the meals that had been provided. One person, who had chosen to have fish for their lunch, indicated that they were not happy with the sauce on their meal. A member of staff noticed this and asked the person if they would like another meal without sauce, the person did and the member of staff collected another meal to enable the person to enjoy their meal. One person told us, "The meals are excellent". Another person told us, "'The food is not bad. Oh dear, I thought when I came here, rice pudding every day, but there is lots of choice". The dining room created a pleasant environment for people to have their meals, tables were laid with napkins, vases of flowers and condiments. People were able to choose where they sat and we observed people enjoying conversations with one another.

Good

Is the service caring?

Our findings

People were supported by staff that were kind and caring. There was a caring, friendly and relaxed atmosphere within the home. One member of staff told us, "I am new to working here and I love it. It's such a caring place". Another member of staff told us, "I would place any of my relatives here if they needed to go into a home. People are treated with such respect". Comments within thank you cards that staff had received stated, 'Your care and compassion is outstanding and we will always be grateful' and 'To all the staff that have been so lovely and kind to our relative, thank you from the bottom of our hearts, you are all true angels'.

People were cared for by a majority of staff who had worked at the home for a number of years. They communicated with people using their preferred name and adapted their approach to meet people's needs and preferences. Staff appeared to know people well and showed a good knowledge of people's lives before they moved into the home. It was apparent that positive relationships had been developed. There were warm and friendly interactions between people and staff and people told us that staff were liked and that they were happy living at the home. One person told us, "They are very good indeed, no complaints there, very, very caring staff. We have a laugh". Another person told us, "The staff are very jolly. I can't choose between them". People were encouraged to maintain relationships with their family and friends. Observations showed people enjoying visits from family and friends, who told us that visiting was not restricted and that they were welcomed at any time.

People's differences were respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regard to people's religion and care plan records showed that people were able to maintain their religion if they wanted to and were supported to attend religious services.

People were involved in decisions that affected their lives. Records showed that people and their relatives had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. People and relatives confirmed that they felt involved in the delivery of care to people and could approach staff if they had any questions or queries relating to it. Regular joint relatives' and residents' meetings were held enabling people to be kept informed of information relating to the running of the home, as well as being able to share their feelings and opinions. Records showed that people had made suggestions about the type of activities they would like to participate in.

People were asked their opinions and wishes and staff respected people's right to make decisions. Staff explained their actions before offering care and support and people felt that staff treated them with respect. The registered manager had recognised that people might need additional support to be involved in their care, they had involved people's relatives when appropriate and explained that if people required the assistance of an advocate then this would be arranged. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and

options and defend and promote their rights.

People's privacy was respected and maintained. Information held about people was kept confidential, records were stored in locked cupboards and offices. Handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People confirmed that they felt that staff respected their privacy and dignity. Staff were observed knocking on people's doors before entering, to maintain people's privacy and dignity and there were signs on people's doors that could be used to advise that people required privacy and did not want to be disturbed. To maintain people's privacy when they were being assisted to move and position using a hoist, staff ensured that they placed a privacy screen around the person to ensure that other people could not see what was happening.

People were encouraged to be independent. Observations showed people, including people who had been assessed as being at greater risk of falls, independently walking around the home and choosing how they spent their time. One person accessed the local community independently with the use of their mobility aid. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves and records and observations confirmed this.

People were able to stay at the home until the end of their life. People and relatives, if they were comfortable doing so, were asked their preferences in relation to their end of life care wishes. Records showed that people's end of life care had been discussed and advance care plans devised. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. Staff had received training on end of life care and there were links with local hospices that provided practical support and advice to ensure that people received appropriate end of life care. The provider had achieved 'Beacon' status, the highest quality hallmark that is awarded, with the Gold Standards Framework (GSF). The GSF provides training, assessment and accreditation to care homes. It aims to change the culture in care homes to ensure that people receive appropriate and dignified care when they are approaching the end of their lives. Feedback had been gained from people's relatives when their loved ones had received end of life care. Comments included, 'My relative was in safe hands, their care confidently managed by very experienced and responsive staff. Their confidence gave us confidence' and 'By the time my relative died you knew them well and treated them exactly as they would have wanted to be treated'.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that they were involved in decisions that affected people's care and that staff were responsive to their needs. However, despite this we found an area of practice that was in need of improvement.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. There was an activities timetable, newsletter and photographs displayed that showed people's involvement in some activities such as external entertainers, coffee mornings, lunches at a local village hall and enjoying visits from pets. Records showed that people had enjoyed the organised activities that were provided. One person told us, "I can't do anything too active now, but I do the quizzes. The entertainment is quite good". However, observations showed that there was a lack of consistent stimulation and meaningful activities for people who wanted to participate. The registered manager informed us and records confirmed that the activities coordinator worked three to four days per week, sometimes including weekends. On the activities timetable there were no other planned activities available to people on other days when the activities coordinator was not working. Records of recent residents' meetings contained comments from people, these stated, 'I would like more activities when the activities coordinator is not on duty'. Another comment, raised by a member of staff on a person's behalf, stated, 'When the activities coordinator isn't working they would like to go to the village hall for lunch and would like someone else to take them if the activities coordinator isn't on duty'. Records of an action plan showed that the need for an additional activities coordinator had been recognised and there were plans in place for the post to be recruited to. When asked about activities and stimulation provided to people and the fact that there had been no provision of activities throughout the entire day, the registered manager told us, "It has been identified that we need to recruit an additional activates coordinator as the one we have doesn't work full time. Staff usually take time to spend with people but may be a little nervous today as you're here". Observations showed people spent extended periods of time, alone in their rooms, or other areas of the home with minimal interaction from staff, other than to provide personal care or to provide food and drink. Records showed that some people declined to take part in activities and preferred their own space. However, the lack of meaningful activities, interaction and one to one time with staff meant that there was a lack of stimulation for some people and this is an area of practice in need of improvement.

People's social, physical, emotional, and health needs were assessed when they first moved into the home and care plans had been devised. These were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. Records showed, and people and relatives confirmed, that they had been involved in the development of the care plans. People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes with regard to what time they wanted to get up, what clothes they wanted to wear, what they had to eat and drink and what they needed support with.

Assessments in relation to people's healthcare needs were completed. People's skin integrity and their risk of developing wounds were assessed using a Waterlow Scoring Tool, this took into consideration the

person's build, their weight, skin type and areas of risk, age, continence and mobility. This assessment was used to identify which people were at risk of developing wounds. None of the people had pressure related wounds, however, for people who had other wounds, wound assessment charts had been completed providing details of the wound and the treatment plan recommended. Photographs of wounds had been taken to monitor their improvement or deterioration and these were regularly reviewed. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushion and mattress that was appropriate as well as the setting that the mattress was required to be on. Records showed that checks to ensure that settings for mattresses were correct had been carried out and were further confirmed by our observations. People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk and they were weighed each month to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP, speech and language therapist (SALT) and dietician. Advice and guidance provided had been followed. For example, the need for soft diets and the use of nutritional supplements. Observations showed that the advice given had been followed and people were supported to consume nutritional supplements and have food and drink that was prepared according to their needs.

Care plans contained information about people's interests, hobbies and employment history and provided staff with an insight into people's lives before they moved into the home. Staff told us that this was helpful and provided them with useful information that helped them to care for people in a way that was specific to them. There were regular reviews of people's care based on observations of their health and welfare and through feedback gained from people and relatives. These reviews took into consideration changes in people's needs and care was adapted accordingly.

There was a complaints policy in place, however, there had been no complaints made since the previous inspection. The registered manager encouraged and welcomed feedback from people and their relatives. Regular meetings as well as annual surveys were sent to gain people's feedback and leaflets advising people of a website that they could access to make their compliments or concerns known were displayed. The registered manager told us, "In a way I wish people would complain as we want to continually improve and need people's feedback". People told us that they knew how to make a complaint but were happy with their care and didn't feel the need to complain. One relative told us, "The staff are always available and the matron is available in person and on the phone".

Good

Is the service well-led?

Our findings

People, relatives and staff were complimentary about the leadership and management of the home. They told us that the registered manager was supportive and approachable. One relative told us, "Matron is very good. The staff are very happy, they stay for a long time.' One member of staff confirmed this, they told us, "This is by far the best run home I've ever worked in. I'd heard about it before I came here. I'm so happy to work here". Another member of staff told us, "The manager and the team are great. If you need anything, like equipment for example, it's there".

The management team consisted of a board of trustees, a registered manager, two deputy managers and a business manager. A majority of staff had worked at the home for many years and told us that this, in addition to the management, is what made the home run so smoothly. The provider had a philosophy of care, it stated, 'To provide residents with a secure, relaxed and homely environment in which their care, well-being and comfort is of paramount importance'. It was evident that this was embedded in the culture and implemented in practice. The registered manager echoed this within their comment, when they told us, "I know the other things are important but the residents and staff come first to me".

There were rigorous systems in place to ensure that the home was able to operate effectively and to ensure that the practices of staff were meeting people's needs. There were quality assurance processes such as surveys that were sent to gain feedback. Regular audits were conducted that provided the registered manager with an oversight and awareness of the home and ensured that people were receiving the quality of service they had a right to expect. Records showed that action had been taken with regard to the findings of the audits that had been completed. For example, the registered manager monitored and analysed the amount of accidents that occurred each month and had ensured that actions were taken to minimise the risk of these occurring again. They did this by completing a falls risk assessment and being aware of the factors that may contribute to the falls, such as times of the day when a person was more susceptible to falls. There were regular meetings between all departments within the home to ensure effective communication. Records showed that actions arising from each meeting were taken forward to the next to ensure that the action was acted upon. For example, in one meeting staff had explained that some people were finding certain foods too hard to eat. This had been taken forward and fedback within a meeting with the kitchen staff to ensure that this was resolved.

The registered manager ensured that links with the local community were maintained. People were supported to go on outings in the warmer weather and enjoyed visits to a monthly lunch club within the village. The registered manager ensured that there were links with external organisations and professionals to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. The manager attended regular meetings with other registered managers within the area to share best practice and also worked closely with external health care professionals to ensure that people's needs were met and that the staff team were following best practice guidance.

The manager was aware of their responsibility to comply with the CQC registration requirements. They had

notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.