Portsmouth City Council

Shearwater

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Shearwater is a care home registered to provide accommodation for up to 60 people. The service provides care to older people living with a cognitive impairment. Care was provided in a safe and dementia friendly environment. At the time of our inspection there were 48 people living in the home. The home provided support to people within smaller environments over three floors, with each floor having its own dining area, lounge and quiet social space. Regular staff and an assistant unit manager worked on each floor. However, people living at the service could access all three floors of the home if they wished to.

People's experience of using this service:
The environment was warm and homely. Communal areas of the home had recently been re-decorated using calming colours and photographic wall paper to provide an environment that promoted people's wellbeing.

People told us they were happy living at Shearwater. The staff team worked well together and knew people well. One person told us, "The staff are great."

Appropriate recruitment procedures were in place to help ensure only suitable staff were employed.

Individual and environmental risks were managed appropriately. People had access to appropriate equipment where needed, which meant people were safe from harm.

People received their medicines safely and as prescribed. Appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

Staff had received appropriate training and support to enable them to carry out their role safely. They received regular supervision to help develop their skills and support them in their role.

Staff recognised people's individual needs and supported them to make choices in line with legislation.

Staff were motivated and proud of the home. Continuous learning was embedded in the home's culture.

There were meaningful activities available to people and research had been used to develop new ways of working that enhanced people's wellbeing.

People and their families were involved in the development of personalised care plans that were reviewed regularly.

The registered manager and provider carried out regular checks on the quality and safety of the service.

Rating at last inspection:
The service was rated as Requires Improvement at the last full comprehensive inspection, the report for which was published on 27 June 2018.

Why we inspected:
This was a planned inspection based on the previous inspection rating.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-Led findings below.

Shearwater

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was conducted by two inspectors and an expert by experience [ExE] on the first day and one inspector on the second day. 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 ExE had experience of care for older people and those living with dementia.

Service and service type:
Shearwater is a care home registered to accommodate up to 60 people who need support with personal care. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection.

What we did:
Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered 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.

During the inspection we gathered information from:
Observations of care staff and all people using the service.
12 people using the service.

Five relatives of people using the service.
Seven people's care records.
The registered manager.
The deputy manager.
Six members of staff.
Records of accidents, incidents. Records of compliments and complaints.
Audits and quality assurance reports.

Following the inspection, we requested feedback from four external health and social care professionals. We did not receive any feedback.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
• There were appropriate policies and systems in place to protect people from the risk of abuse.
• Staff had received training in safeguarding adults and knew how to recognise abuse and protect people. All staff we spoke with demonstrated a good understanding of their safeguarding responsibilities. One staff member told us, "I would report any concerns to the manager and go to the local safeguarding team if I needed to."
• People and their families told us they felt safe. When asked if they felt their relative was safe, one relative said, "Yes, I do definitely. If there is anything wrong, they will phone me."
• There were robust processes in place for investigating any safeguarding incidents that had occurred, in liaison with the local safeguarding team.

Assessing risk, safety monitoring and management:
• Risks to people had been assessed as part of the care planning process. These were recorded within people's care records and clearly identified how staff should support people and what equipment, if any, was needed. For example, one person had been assessed as being at risk of falling out of bed. Bed rails were assessed as not appropriate for the person, and therefore a pressure alarm mat was in place with a soft floor crash pad, in case the person fell.
• Risk assessments in place included, moving and positioning, skin integrity, medicines management and the use of bed rails. Risks were reviewed regularly and updated when required.
• People who required their food to be prepared in a specific way or who were at risk of malnutrition and dehydration had clear and up to date information within their risk assessment of how this should be monitored and managed by staff. This included information about their likes and dislikes of certain food and the implementation of food and fluid charts, so that their intake could be closely monitored.
• The environment and equipment was safe and well maintained. Risks from the environment had been assessed and each person had a personal emergency evacuation plan (PEEP). These identified what assistance each person would need to safely leave the building, in the event of an emergency.
• The assistant managers for each floor had a handover at the start of each shift, which informed them of any important information they needed to meet people's needs. For example, information in relation to people's health, any professional visits and if they had declined care. This was then handed over to the care staff and meant that staff were fully up to date with essential information.
• Contingency plans were in place, which helped to ensure that people were provided with consistent care and support in the event of an emergency or disruptive conditions.

Staffing and recruitment:
• There were sufficient staff deployed to meet people's needs and keep them safe. The registered manager told us they used a dependency tool, observed care, reviewed people's needs and spoke to people and staff

regularly about the levels of staff available. We observed that people were given the time they required and were not rushed by staff.
• Agency staff were used to ensure there were enough staff to meet people's needs. However, the registered manager told us they used regular agency staff that knew people living at the home and could safely meet their needs.
• Staff told us they felt that they had enough time to meet people's needs. A staff member said, "It can be busy, but we have enough time to spend with people and we work well as a team."
• Recruitment checks had been completed to ensure that new staff employed were suitable to work at the service. This included disclosure and barring service (DBS) checks, obtaining up to date references and investigating any gaps in employment.

Using medicines safely:
• People were supported to take their medicines safely and as prescribed. Each person had a medicines profile which included details about what medicines they were prescribed, any allergies they had and how they preferred to be supported to take their medicines.
• There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely and in accordance with best practice guidance.
• Medicines administration records (MAR) were completed correctly and indicated that people received their medicines as prescribed. MAR checks were completed daily to help ensure that no medicine errors had occurred.
• Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved.
• Safe systems were in place for people who had been prescribed topical creams.
• Medicines subject to additional controls by law were stored in accordance with legal requirements.

Preventing and controlling infection:
• The home was clean and well maintained. There was a team of domestic staff who worked every day and completed regular cleaning tasks in line with schedules.
• Relatives of people commented positively on the cleanliness of the service. Comments included, "It's always clean" and "It's spotless here and there is never a smell."
• There were processes in place to manage the risk of infection and personal protective equipment (PPE), such as gloves and aprons was available throughout all areas of the home. Staff were seen using these when appropriate.
• Staff had attended infection control training.
• The registered manager was aware of the action they should take if there was an infection risk at the home.
• The local environmental health team had awarded the home five stars (the maximum) for food hygiene.

Learning lessons when things go wrong:
• Accidents and incidents were recorded. The registered manager and deputy manager had procedures in place to investigate the cause, learn lessons and take remedial action to prevent a recurrence. This included, reviewing internal processes, updating people's risk assessments and seeking external healthcare professionals support and guidance if appropriate.
• Assistant unit managers and care staff were given information about any incidents that had occurred during the handover between shifts. This meant that staff could provide support to people that recognised any impact on their wellbeing.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Pre-admission assessments were completed before people moved into the home, to ensure their needs could be met. This included considering any risks and assessing for any specific equipment that people may require.
• A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used nationally recognised tools to assess people's pain levels and risks of developing pressure injuries.
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed. Pressure relieving equipment was used safely and in accordance with people's needs.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their assessments. People's diverse needs were detailed in their care plans which included their preferences in relation to culture, religion, diet and gender preferences for staff support.
• Staff completed training in equality and diversity and the management team and staff were committed to ensuring people's equality and diversity needs were met. One staff member told us, "We would support and embrace anyone whatever their needs."
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.

Staff support: induction, training, skills and experience:
• People received effective care from staff that were skilled and competent. One person, when asked if they felt the staff were skilled said, "I would say so, yes."
• New staff completed an induction programme before supporting people on their own. This included a period of shadowing a more experienced member of staff, learning about key documents and the completion of essential training.
• Staff received training that enabled them to meet the needs of people living at the service. One staff member told us, "I'm up to date with all my training, we get loads but it's good."
• In addition, the management team carried out observations and spot checks to ensure that staff were following procedures and were competent in their roles.
• Staff told us they felt supported by the registered manager and deputy manager. One staff member said, "The management are approachable and supportive, and they have helped a lot with and answered any questions I had."
• Staff received regular one-to-one sessions of supervision, which they told us they found useful. These provided an opportunity for the registered managers to meet with staff, discuss their training needs, identify any concerns, and offer support.

Supporting people to eat and drink enough to maintain a balanced diet:
• People had access to sufficient food and drink throughout the day; food was freshly cooked and there were several options for people to choose from. We observed staff supporting people with meals and offering alternatives if people were not eating. One staff member said to a person, "I can take that away if you don't like it and get you something else."
• Where people required their food to be prepared differently because of a medical need or problems with swallowing, staff were aware of the associated risks. Staff followed guidance
from healthcare professionals in relation to these.
• Mealtimes were a sociable experience for people who chose to sit in the dining areas.
• People were supported to be independent and were provided with adapted cutlery and plates, where required, to enable independence.
• Where people were supported to eat, this was done in a relaxed and supportive manner.

Adapting service, design, decoration to meet people's needs:
• The building had been adapted to meet the needs of the people living there had been designed to be a relaxing, homely and comfortable space. A great deal of care had been taken to consider the colours used to decorate the home, so they were conducive to people living with a cognitive impairment. For example, there were large walls which had been decorated using wall paper that looked like a photograph. There were walls that looked like forest scenes and beaches. We observed one person standing in front of the beach scene and touching it with a smile on their face.
• In addition, there were rooms that had been designed for leisure use. There was a 'garden room' which had green plants and sounds of running water and birds playing through speakers, and a room that had been designed as a café. We observed people sat in the café having tea and cake, whilst chatting to each other and the volunteers who were working there. One person said, "There is now a coffee shop [café] upstairs which is lovely".
• All bedrooms were for one-person use with en-suite facilities and were personalised to the individual. Should they wish to do so, people could have their own furniture and personal fixtures and fittings.
• The garden was accessible to people and had flat walkways that could be safely accessed by people with impaired movement or wheelchair users.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care:
• When people were admitted to hospital, staff provided written information about the person to the medical team, to help ensure the person's needs were known and understood.
• People had access to community healthcare professionals when required. The home held regular multi-disciplinary meetings with health and social care professionals including nurses, doctors and occupational therapists. This meant that any support, medical intervention or equipment needed for people could be put in place quickly. Advice given by health professionals was followed, documented and communicated across the whole staff team.
Systems were in place to share information with other agencies if people needed to access other services such as hospitals. For example, the service used the 'red bag scheme', which ensured all essential information about people's health and care needs were sent with a person to hospital.

Ensuring consent to care and treatment in line with law and guidance:
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in May 2018, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that best interest decisions were made in accordance with the Mental Capacity Act 2005. At this inspection we found action had been taken and there was no longer a breach of this regulation.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Staff were knowledgeable about how to protect people's human rights in line with the MCA.
• Mental capacity assessments were completed when there was any question of a person's capacity to independently make important decisions.
• Where people could not make their own decisions, the best interest decision making process was used and appropriate documentation completed.
• Staff told us they sought verbal consent from people before providing care and support. One staff member told us, "We always ask people what they want and show them things like clothing to help them make a decision."
• Where people were able to, consent forms had been signed and recorded in their care plans regarding the care and support they received.
• Applications for DoLS had been submitted to the appropriate authorities by the management team, as required.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
• Care plans identified people's preferences and protected characteristics.
• We observed people were supported by staff who knew them well and treated them with kindness and compassion. For example, we saw one staff member approach a person with a friendly greeting and a hug. They said, "Hi [person's name] how are you? How are your nails looking?" Another staff member was approached by a person who started singing. The staff member joined in and they smiled and sang together.
• Each person had details of their life history recorded, which staff used to get to know people and to build relationships with them. Interactions between staff and people were natural and showed positive relationships had been developed.
• People's unique needs were recognised, and the management team and staff worked to develop the support they provided to fit with each person's needs. For example, one person did not use English as their first language. The registered manger and had introduced 'word of the day' for staff to learn some simple words in the person's language. This meant that staff were able to have improved communication with the person and we observed staff communicating positively with them.
• People's relatives were positive about the staff. Comments included, "I always find staff really friendly" and "There is a nice atmosphere and they [staff] always chat." A person told us, "They [staff] are nice people."
• Staff told us they enjoyed working at the home and supporting people to receive the care and support they needed. One staff member said, "I feel we are really good at dementia care, and we do amazing things." Another staff member said, "I like it here, we talk to people and ask them about their life, so we know what they like."

Supporting people to express their views and be involved in making decisions about their care:
• Staff showed a good awareness of people's individual needs, preferences and interests. People's care records included information about their life histories and their preferences.
• Staff spoke to people in a way they could understand and showed patience when supporting people living with dementia. Where people had limited ability to verbally communicate, staff observed people's body language and general presentation to interpret what they needed.
• Staff provided people with choice and control in the way their care was delivered. We observed staff offering people choices throughout the inspection, in a patient and attentive manner. One staff member described how they respected people's choices when supporting them to get dressed, they told us, "I will get things out of their wardrobe and show them options, so they can see and choose for themselves." Another staff member said, "We ask people what they want and help them to be involved and make choices as much as possible."
• A group of people had recently been supported to move into the home from another of the provider's

services. A great deal of thought and care had gone into supporting people in the move. For example, people were supported to visit Shearwater and be shown around by other people living there. They stayed for meals and were shown the rooms they would move into and were asked what colours they would like their room painted. The registered manager told us that they had worked with people to find out who they already knew and had friendships with, so their room could be on the same floor of the home. In addition, the management team had made a brochure and a video of the building and staff, for people moving in to watch. This assisted them to get used to everyone prior to moving in and demonstrated a good person-centred practice.

Respecting and promoting people's privacy, dignity and independence:
• Care records were held securely in the service and confidential information was respected.
• Staff understood their responsibilities when respecting people's privacy. Staff recognised when people wanted to spend time on their own and always knocked before entering rooms.
• People had keyworkers who were members of staff allocated to provide additional support to one person. Their role included supporting the person to maintain contact with family members and friends and to access activities they enjoyed. One person said, "I know the main staff and they are brilliant."
• People were supported to receive visitors in a way they chose. One relative said, "Everyone is so friendly, it's a lovely home."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People's likes, dislikes and preferences were recorded in person-centred care plans that were reviewed and updated every month or more frequently, when needed. Staff were knowledgeable about people's preferences and could explain how they supported people in line with this information. A person's relative told us, "I think [person's name] is very well looked after. I only wanted a dementia care home, so it would fit in with [person's name]. Everyone is so friendly."
• Each person was respected as an individual, with their own social and cultural diversity, values and beliefs. Christian church services were held in the home every two weeks which people could attend if they wished to. At the time of our inspection there was no one living at the home who practiced different faiths. However, we were told that support would be arranged to meet people's individual beliefs as and when needed.
• A wealth of activities were available to people to enhance and promote positive wellbeing. The home employed an activities coordinator, who was responsible to arranging activities to meet the individual needs of people living there. For example, there were regular craft activities, a nursery school visited regularly to play games and read books with people, keep fit classes, external entertainers such as singers and comedians, gardening activities and therapy dogs visiting.
• In addition, the home had recently cared for an incubator full of eggs. People were supported to look after the eggs until they hatched into chicks. A follow up visit was being arranged where, the chicks who were now hens, were being brought into the home again for people to see.
• Parties and events were regularly arranged to celebrate special occasions or provide a social activity for people, their relatives and staff to enjoy together. For example, a summer festival in the garden was being arranged, with activities and musical entertainment.
• Relative's told us the staff knew people well and provided them with activities that recognised people's individual needs. Comments included, "There is always entertainment. There is now a coffee shop upstairs which is lovely" and "Most [staff] have lovely personalities and bring a smile to people's faces."
• Research had been used to consider how technology could be used to enhance people's wellbeing. For example, the home had recently purchased a virtual reality headset. This enabled people to view images and films as if they were really there. There were films that were relaxing such as forests with waterfalls, and underwater sea life scenes. The management team described to us how they had used research to consider if this technology would enhance the wellbeing of people living with dementia. They told us that they were assessing people individually and working slowly to introduce them to the concept, whilst monitoring their reactions and supporting them to have a positive experience.
• In addition, the home had purchased a special video camera that would enable them to make person centred videos for people that could be played on the virtual reality headset. The registered manager told us they planned to use the camera to film local areas and streets that would have a particular interest for individual people. This demonstrated that the management team and staff were innovative and

enthusiastic about looking for new ways of working that would enhance people's wellbeing.
• New leisure areas had been developed in the home. One area had a chair that provided a massage for people and there were two interactive projectors that displayed images onto tables. We observed people playing interactive games with a group of volunteers with learning disabilities and being positively engaged, smiling and laughing when they touched a spinning top and it whirled across the table. There were positive reactions between people with significant cognitive impairments, volunteers and staff as they laughed and joined in together.
• Other technology was being utilised to enhance people's engagement with others. The home had two interactive speakers that staff and people could speak into and ask questions. These were being used to encourage reminiscence conversations. People could ask the speaker questions about past events in history or to play music that they remembered. The home also provided handheld computers for people to use with support. People were assisted to have video calls with their family members when visits were not possible.
• People were being supported to manage poor sleeping patterns and unsettled behaviour through light therapy. The registered manager and deputy manager told us they undertaken research into how light therapy could have positive outcomes for people living with dementia. A special light therapy unit had been purchased and was being offered to people to assist their sleep pattern and wellbeing. This had been closely monitored and records showed that people who had been receiving the light therapy had improved sleep patterns and a reduction in unsettled behaviours. Where people continued to have difficulty in recognising day from night, the deputy manager told us about a new plan called the 'wide awake club.' This recognised that people living with dementia who have poor sleep patterns and do not always recognise day from night, needed meaningful activities and support, so they would return to bed feeling less unsettled.

Improving care quality in response to complaints or concerns:
• The provider had a complaints policy in place. Complaints were recorded and action was taken where needed. People and their relatives knew who to speak to if they wished to raise any concerns. One relative told us, "I would be happy to go to the manager if I had any concerns."
• The registered manager, deputy manager and staff regularly engaged with people and their families so that any low-level concerns could be addressed quickly. Feedback was sought through formal questionnaires, a comments box, and through daily conversations and observations of people.

End of life care and support:
• Staff were not supporting anyone with end of life care at the time of the inspection. However, people's end of life wishes had been captured within their person-centred care plans. This gave details of people's choices, including considerations to cultural and religious preferences.
• The registered manager told us that they worked closely with external healthcare professionals to respect people's wishes and provide them with the care they required to be pain free and cared for at the end of their life.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:
• People and their families told us that the service was well run. One relative said, "We've been very pleased with everything here." A person told us, "It ticks over quite nicely here. I'm happy with everything."
• The registered manager and deputy manager demonstrated an open and transparent approach to their roles and encouraged staff to do the same.
• The management team and staff demonstrated a commitment to provide person-centred care by engaging with everyone using the service, their relatives and stakeholders. They had worked with people and their families to ensure they had detailed information about people's life histories and needs. This was used to develop person-centred care plans and meant staff knew people well.
• Friends and people's relatives could visit at any time. They were made to feel welcome and were offered refreshments. One relative told us, "I always find staff really friendly."
• The previous performance rating was prominently displayed in the reception area.
• The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred.
• The registered manager understood their responsibilities and had notified CQC about incidents, safeguarding concerns and events, where required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was a clear management structure in place, consisting of the provider, the registered manager, a deputy manager and assistant unit managers. They were clear about their roles and responsibilities.
• Staff understood their roles and communicated well between themselves to help ensure people's needs were met. One staff member said, "I think the teamwork here is great and we work well together."
• Extensive policies and procedures were in place to aid the smooth running of the service. For example, there were policies on safeguarding, equality and diversity, complaints and whistleblowing.
• There was a robust quality assurance process in place, consisting of a range of regular audits, together with daily observations by the registered manager and deputy manager. Where internal audits identified any concerns or trends, detailed action plans were put in place and communicated to the staff team.
• Effective communication between the management team and staff supported a well organised service for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

• Staff told us they felt listened to and the registered manager and deputy manager were approachable. One staff member said, "The managers are very supportive, when they say, 'open door' they mean it, 100%. I can speak to them about anything and they really support me."
• Staff were kept up to date with relevant information about people. Assistant unit managers shared information with staff and discussions included information in relation to people's health, mood, any professional visits and if they had declined care.
• Staff meetings were held regularly. Meetings were used to provide information, such as planned improvements to the environment, training and introducing activity ideas such as the light therapy and virtual reality headsets. Minutes were kept and showed that where issues or suggestions were raised, action was taken. In addition, staff received a newsletter which detailed information and thanked them for their contribution to implementing new ways of working in the home.
• Staff wellbeing was recognised and promoted. The provider had an assistance programme which provided advice and guidance to staff as well as counselling and support if required.
• Friends and family members could visit at any time and felt that their relatives were cared for well. A relative told us, "I feel I can go home and know [relative] is ok and that's the main thing."
• People's individual life choices and preferences were met. The registered manager and deputy were clear how they met people's human rights. People and families were involved in planning care and support and the management team regularly spoke to people and involved them in decisions about the home. For example, developing the café room for people to use and spend time with their families.
• The provider and registered managers sought feedback from people about the service in a range of ways, which included annual quality assurance surveys and one-to-one discussions. One person told us, "They [registered manager] are very good. They do lots of office jobs, but they walk around and stop and chat."
• There was a 'You said, we did' board in the reception area which demonstrated that people's views were listened to and acted on. Regular newsletters were offered to people which told them and their relatives about events and changes that were happening within the home. For example, information about the next residents meeting and church services that were available for people to attend if they wished.

Continuous learning and improving care:
• The registered manager and deputy manager analysed feedback from people, staff and audits. They used the findings to inform their service improvement plan.
• The provider and the registered manager continuously monitored the service improvement plan to ensure improvements were actioned in a timely way.
• As a result of a recent safeguarding concern, the registered manager and deputy had developed a wellbeing survey for people living at the home. This used simple questions and pictures and specifically addressed staff kindness and respect. People were supported by the management team to complete these surveys individually and the registered manager and deputy analysed them and acted where needed.

Working in partnership with others:
• The management team worked effectively with social care professionals, health care professionals and the local authority to develop the service and improve the quality of care provided.
• Regular meetings were held in the home with nurses, occupational therapists, social workers and GP's, so that any changes to people's health and wellbeing could be reviewed and acted upon promptly.
• Staff followed guidance provided by external healthcare professionals to ensure people received good overall care.
• Accident and incident reports were monitored. For example, when people had falls, their mobility assessments were reviewed and updated where needed. Any potential causes were considered, and prompt medical intervention sought.