West Bank Residential Home Limited

Dunmore Residential Home

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

Dunmore is registered to provide accommodation and personal care for up to 25 older people who may have a physical disability or who are living with dementia. Nursing care is not provided at the home. For those people who require nursing care, this is provided by the community nursing teams. At the time of the inspection 24 people were living in the home.

Although Dunmore had a change to their registration status in 2016, the home has been long established with the same owners and registered manager in place. 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 and relatives told us the home was very well managed. The registered manager, deputy manager and several of the staff had worked at the home for many years and they knew people well. People spoke positively about the registered manager. One person said, "Yes, she is very good. If you want to, just call for (registered manager's name). She's very caring", and another said, "You can talk to her, definitely." Throughout our inspection we saw people, their relatives and staff freely approached the registered manager to speak with them. The atmosphere in the home was friendly and we saw positive interactions between people using the service, their family and staff.

Staff told us they were well supported by the registered manager. Regular staff meetings and staff supervision and appraisals ensured staff were provided with information important in their role as well as ensuring their care practices were in line with the home's procedures and the manager's expectations.

People told us they felt safe living at Dunmore and commented, "Yes, perfectly alright. No trouble at all" and "I don't have any worries. I am pleased to be somewhere safe." Relatives also told us they felt their family members were safe at the home. Staff confirmed they had been provided with safeguarding adults training and they had an understanding of their responsibilities to protect people from harm. Staff were clear of the actions they would take if they suspected people were at risk of abuse.

People said there were enough staff on duty to meet their needs, however at busy times during the morning they sometimes had to wait a few minutes for staff to attend to them. No one said this had caused them any distress or caused any care needs to go unmet. People and staff confirmed routines were flexible and people could get up and go to bed when they wished. Robust systems were in place to ensure staff were recruited safely. Staff files contained the necessary pre-employment checks including references from previous employers and disclosure and barring service (police) checks. This ensured as far as possible, only suitable staff were employed at the home.

People received their medicines as prescribed. Medicines were being safely administered, stored and disposed of. Regular audits of medication administration records (MAR) were undertaken by the registered

manager and the provider's general manager to look for gaps or errors and to make sure safe procedures had been followed. Senior care staff with the responsibility to administer medicines had received training and had their competence to follow safe practices assessed by the registered manager.

Care plans showed risks to people's health and safety had been assessed and staff were provided with information about how to minimise these risks. Assessments included the risk of falls, skin damage and poor nutrition and hydration, as well as those associated with healthcare conditions such as diabetes. Should an accident occur these were documented and reviewed by the registered manager to identify how the accident came about and what actions could be taken to reduce the risk of a reoccurrence. Regular checks of the building were carried out to keep people safe and the home well maintained. Equipment such as hoists were serviced to ensure they were maintained in a safe working order.

Staff were knowledgeable about people's care needs and had the skills to support them. People told us they were happy and well cared for by staff who knew them well. One person said, "I like the people who look after me. They are very kind and nice." Another said, "It's very friendly, and I like it." Relatives also shared this confidence that people were cared for by well-trained staff. One relative said, "We are very, very happy with the home." People were encouraged to do as much for themselves as possible and staff promoted their independence. One person told us, "I feel I want to be independent" and went on to say they did as much for themselves as they could, for example, making their own bed and tidying their room. People said they were involved in planning their care and relatives confirmed they were also involved in discussions about how their relatives were cared for. Each person had a care plan detailing their care needs and guiding staff about how to meet these safely and in line with their preferences. Regular 'residents' meetings' were held to invite people and their relatives to share any concerns and suggestions were welcomed about how to improve the home.

Staff had a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and people's right to make decisions about their care and treatment and to say how and where they wished to be supported. Staff confirmed a number people living at the home lacked the capacity to make decisions about their care. Care plans showed evidence of capacity assessments and best interests decision outcomes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered manager confirmed that some people, due living with memory loss, would be unsafe if they left the home without supervision from a family member or a member of staff. Because of this all exit doors were locked with a keypad to prevent people from leaving unnoticed. Applications had been made to the local authority for authorisation of this restriction.

Staff told us they enjoyed working at the home and said they all worked well together as a team.
During our inspection we spent time observing interactions between staff and people living at the home. It was clear staff had built positive relationships with people and they demonstrated care in the way they communicated with and supported people. Staff were kind, patient and respectful towards people.

People were provided with support from a range of health care professionals to maintain their health. Where people had been identified at risk of a deterioration in their health, such as being at risk of infections, staff were guided with information about what to be observant for and what actions to take should they have concerns over people's health conditions. Care plans included a nutritional risk assessment which was regularly reviewed to assess how well people were eating and drinking. People's weights were regularly monitored to identify any weight loss quickly. People told us they liked the food and had a good choice available to them. Comments included, "I love it. We get lots of choice" and "It's very good. I have a choice, (name of cook) will always change it if I don't like it." Menus were planned around people's likes, dislikes and dietary needs, and people were invited to contribute to the menu planning.

At the time of the inspection, the conservatory previously used as the dining room was no longer available. Dining areas had been established in the two lounge rooms, and although staff had to rearrange the tables to enable people to walk around these, people told us meals times were being managed well in the circumstances. In addition, access to the patio areas was restricted to a small area outside the kitchen. We heard some people asking for reassurance from the staff that once the building work was completed they would have more accessible outside space. Staff confirmed a patio area would be available outside the main lounge room.

The home had employed an activity co-ordinator who consulted with and supported people to be involved in a variety of activities, in and out of the home. They involved people in group or one to one discussions about topics of interest, such as people's hobbies as well as supporting people to visit the shops or local garden centre. Recent activities included exercises, card games, discussions as well as visiting entertainers, such as singers and keyboard players. Records showed the activity coordinator spent time with people who were being cared for in their rooms either through choice or ill health.

People and relatives were aware of how to make a complaint and all felt they would have no problem raising any concerns. One person said, "They (staff) have always been very helpful to me, if something worried me." The home had received three complaints in the past 12 months which had been investigated and resolved. They had also received many letters of thanks. People, relatives and staff were asked for their views about their care and support provided at the home. Surveys had been sent in May 2017 and results had been audited by the activity co-ordinator who prepared a report for the registered manager. This report showed people felt positive about the home. The registered manager used a range of quality monitoring systems to continually review and improve the service and made a report to the provider each month. The registered and deputy managers regularly attended local meetings with other care home managers and the community nurses to share good practice. The provider and registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC) and their duty of candour. The duty of candour places requirements on managers to act in an open and transparent way in relation to providing care and treatment to people. Notifications had been submitted to us, in a timely manner, about any events or incidents they were required by law to tell us about.

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.

People told us they felt safe in the home.

Staff had received training in safeguarding vulnerable adults and had a good understanding of how to keep people safe.

Risks to people's safety and well-being had been assessed prior to their admission to the home, regularly reviewed and were well managed.

People were supported by sufficient numbers of safely recruited staff.

Medicines were stored and administered safely. People received their medicines as prescribed.

Is the service effective?

Good

The home was effective.

Staff had the skills and support they needed to ensure people's care needs were met. Staff worked well as a team.

People's rights were respected. Staff had a clear understanding of the Mental Capacity Act 2005 and how to support people's rights to make decisions about their care.

Where people lacked capacity to make an informed decision about their care, staff acted in their best interests, and this was recorded.

People were provided with food they enjoyed. Those at risk of not eating or drinking enough to maintain good health were closely monitored by staff.

People saw a range of healthcare professionals to maintain their health.

Is the service caring?

Good

The home was caring.

People spoke highly of the care they received. They told us the staff were kind, caring and friendly.

Staff respected people's privacy and dignity and knew people's preferences well.

People were supported to be as independent as possible and were involved in making decisions about their care.

Is the service responsive?

Good

The home was responsive.

People and their relatives where appropriate, were involved in planning their care. Care plans detailed people's specific care needs.

People were encouraged and supported to participate in leisure and social activities.

The registered manager had an "open door" policy for people, their relatives and staff to discuss any issues of concern or to make suggestions about improvements in the home. A policy was in place for dealing with any concerns or complaints in a timely manner.

Is the service well-led?

Good

The home was well-led.

People and their relatives as well as the staff told us the home was well managed.

The registered manager used quality assurance systems effectively to ensure people received safe and high quality care and support in a safe environment.

Dunmore Residential 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 10 July 2017 and the first day was unannounced. This was the first inspection of this home since a change to their registration in January 2016. One social care inspector and an expert-by-experience undertook the inspection on the first 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 expert had experience of the care needs of older people and those living with dementia. One social care inspector completed the inspection on the second day.

Before our inspection, we reviewed the information we held about the home. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned as requested. We also contacted Devon local authority and the community nursing team for their feedback regarding the quality of the care and support provided at the home.

During our inspection we spoke with 14 people living at the home and four of their relatives, as well as the registered manager, six members of staff, the activity coordinator. We also had the opportunity to meet the providers.

We spent time observing the interactions between people and staff, including the care and support being offered to people. We used elements of the short observational framework for inspection tool (SOFI) to help us make judgements about people's experiences and how well they were being supported. SOFI is a specific way of observing care to help us understand the experiences people had of the care at the service.

We looked at records relating to people's care needs and the running of the home. These included three people's care files, three staff recruitment files, staff training records, medicines administration and those relating to quality assurance audits.

Good

Is the service safe?

Our findings

People told us they felt safe living at Dunmore and commented, "Yes, perfectly alright. No trouble at all" and "I don't have any worries. I am pleased to be somewhere safe." Relatives also told us they felt their family members were safe at the home.

Staff confirmed they had been provided with safeguarding adults training and they had an understanding of their responsibilities to protect people from harm. Staff were clear of the actions they would take if they suspected people were at risk of abuse. Staff said they would always report any concerns to the registered manager and they felt confident they would listen to them, take them seriously and take appropriate action to help keep people safe. Staff knew about whistle blowing procedures. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. One member of staff told us they had raised a safeguarding concern at a home they had worked at previously and they would do so again if the felt people were not being cared for well or safely.

People said there were enough staff on duty to meet their needs, however at busy times during the morning they sometimes had to wait a few minutes for staff to attend to them. No one said this had caused them any distress or caused any care needs going unmet. We asked people about the times they got up in the mornings and went to bed at night. One person told us "We are all in bed by 8pm and I can get up what time I want." Other people said they could go to bed when they wished. One person said, "They don't come in and say 'we are going to turn the TV off', and I can go to bed when I want." Staff told us people could get up and go to bed when they wished and people did not have to be in bed before the night staff arrived. They said the night staff were not expected to assist anyone to get up in the morning unless they chose to do so. We saw people's morning and evening routines and preferences were recorded in their care plans.

Staff told us they felt there were enough staff on duty to meet people's care needs but recognised that mornings were a very busy time. At the time of the inspection there were 24 people living in the home of which 11 required the assistance of two members of staff with their personal care and/or mobility needs. The registered manager said they used a dependency tool to identify people's staffing needs and we saw this in the care files we looked at. They said the home had sufficient staff on duty to support people safely and to meet their care needs. Duty rotas showed that in addition to the registered manager and deputy manager, there were six care staff on duty during the mornings and four during the afternoons and evenings until 8:30pm. These numbers included a senior member of staff responsible for administering medicines. Overnight there were two waking care staff on duty. The home also employed catering and housekeeping seven days a week as well as an administrator three days a week. During the inspection we saw people's requests for assistance attended to promptly and staff were available in the communal areas.

Robust systems were in place to ensure staff were recruited safely. We looked at three staff files, two of which were for staff recently recruited to the home. Each file contained the necessary pre-employment checks including references from previous employers and disclosure and barring service (police) checks. This ensured as far as possible only suitable staff were employed at the home. Staff new to the home told us they had received an induction and had worked alongside experienced staff. One member of staff told us

the staff team had been very supportive and gave them lots of information about how people liked to be assisted with their personal care.

People told us they were happy with how the home supported them to take their medicines. One person told us, "They have a certain time and they stick to that time. They bring the medication with a glass of water and stay until I have had them." Medicines were being safely administered, stored and disposed of. Records gave staff information about how they prefer to take their medicines. On the morning on the first day of the inspection we observed some people being given their medicines and this was done safely and in people's preferred way. Regular audits of medication administration records (MAR) were undertaken by the registered manager and the provider's general manager to look for gaps or errors and to make sure safe procedures had been followed. Senior care staff with the responsibility to administer medicines had received training and had their competence to follow safe practices assessed by the registered manager.

Care plans showed risks to people's health and safety had been assessed and staff were provided with information about how to minimise these risks. Assessments included the risk of falls, skin damage and poor nutrition and hydration, as well as those associated with healthcare conditions such as diabetes. For example, one person had been identified as being at risk from falls. Staff were provided with information about how to minimise the risk of them falling. A sensor mat was in place to alert staff to their movements to enable them to attend to the person quickly, and staff were guided to ensure the person used a walking frame for short distances and a wheelchair for longer distances and when outside. The person told us they had fallen previously and was happy to have the sensor mat in place. Another person was at risk of skin breakdown. Their care plan identified the need for pressure relieving equipment and guided staff to encourage the person to keep their legs elevated when siting. We saw this person had an air mattress in their bed set to the correct setting for their weight and staff supported this person to raise their legs on a stool when sat in the lounge room. Should an accident occur these were documented and reviewed by the registered manager to identify how the accident came about and what actions could be taken to reduce the risk of a reoccurrence. Risk assessments were reviewed each month, or following an accident, to ensure all necessary steps were being taken to protect people.

Regular checks of the building were carried out to keep people safe and the home well maintained. For example, the fire alarm system was tested weekly and equipment such as hoists were serviced regularly. A fire risk assessment had been undertaken to identify and mitigate any risks in relation to fire. Each person had an emergency evacuation plan detailing their support needs should they need to be evacuated from the building. Equipment necessary to assist with people's evacuation was available on the upper floors of the home and included slide sheets and an evacuation chair. Staff told us the procedure they were to follow should the fire alarm sound and knew whose responsibility it was to alert the emergency services. A business continuity plan as in place should the home be unsafe for people to return to. At the time of the inspection, the home was having two extensions built and the registered manager had undertaken an assessment to ensure the work did not pose any additional safety risks to people or staff.

The home was clean and odour free. Staff had access to hand washing facilities and used gloves and aprons appropriately. The home had received a food hygiene visit in December 2016. They had been awarded a rating of five. This was the highest rating and showed very good hygiene within the service.

Good

Is the service effective?

Our findings

We asked people about the care and support they received and whether it met their needs. They told us they were well cared for and were very complementary about the staff. Relatives also shared this confidence that people were cared for by well-trained staff. One relative said, "We are very, very happy with the home" and another said, "Yes, it's all OK, it's very good."

People were supported by staff who were knowledgeable about their care needs and had the skills to support them. The registered manager and some staff had worked at the home for many years and provided consistency and stability in the staff group. Staff received the training they needed to undertake their role. The registered manager maintained a training matrix which showed when and what type of training was provided. This included a variety of topics such as safe moving and handling, infection control, first aid, pressure area care and caring for people living with dementia. The registered manager was aware a number of training updates were required and had planned for these. Staff new to care were completing the Care Certificate as part of their learning and development. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. The registered manager and deputy manager undertook regular direct observations of staff's interaction with people to ensure they were putting their learning in to practice and supporting people safely. Records of these observations were seen in the staff files we looked at and included the safe use of a hoist, supporting people who required assistance with eating and drinking, infection control practices as well as staff's relationship with people.

People were provided with support from a range of health care professionals to maintain their health. Where people had been identified at risk of a deterioration in their health, such as being at risk of infections, staff were guided with information about what to be observant for and what actions to take should they have concerns over people's health conditions. Care files contained records of referrals to GPs and community nurses and the outcomes of these were documented and any changes to care needs as a result were transferred to the care plans. One person told us, "I have been to the hospital about my eyes. The doctor comes from time to time to check on you", another said, "If I am poorly the doctor comes."

Care plans included a nutritional risk assessment which was regularly reviewed to assess how well people were eating and drinking. People's risk of choking when eating was assessed and where necessary guidance sought form specialist services. People's weights were regularly monitored to identify any weight loss quickly. People at risk of not eating or drinking enough to maintain their health had their food and fluid intake monitored. Records showed that for one person who was at risk of not drinking well their daily intake could fluctuate considerably. The person's GP was regularly involved in reviewing their health and well-being. For example, they had been seen by their GP four times in June 2017.

People told us they liked the food and had a good choice available to them. Comments included, "I love it. We get lots of choice" and "It's very good. I have a choice, (name of cook) will always change it if I don't like it." Menus were planned around people's likes, dislikes and dietary needs, and people were invited to contribute to the menu planning. The minutes of the residents meeting in May 2017 showed people had

been asked their views about the quality of the meals and people had requested a number of meals to be added to the menus: staff confirmed these had been added. During the inspection we observed people enjoying their lunchtime meals. People were offered choices and the mealtime was pleasant and unhurried. People were seen in conversation and laughing together with the staff and each other. Staff provided meals in a manner that promoted people's independence. For example, one person had their meal in a bowl which enabled them to eat without assistance. However, due to the building work, the home no longer had a dining room. Tables were provided in the two lounge rooms but these were not enough to allow everyone to sit at a table and some people remained in their armchairs with a small table pulled up to them. The registered manager explained that once the building work had been completed better arrangements would be in place for people to have a choice of where and how they ate their meals.

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. Staff had a good understanding of the principles of the MCA and people's right to make decisions about their care and treatment and to say how they wished to be supported. They confirmed a number people living at the home lacked the capacity to make decisions about their care. Care plans showed evidence of capacity assessments, however these showed a number of care topics had been grouped together, rather than assessed separately. The registered manager said they would review the documentation used to ensure assessments of specific decisions were identified more clearly. Where necessary decisions had been made in people's best interests. For example, one person's plan held evidence of a best interests meeting to agree the decision to administer their medicines covertly, (hidden) in their food. All three of the care plans we looked at contained information that people's consent to receiving care and support had been sought. Care plans held people's signatures to show they had been consulted and had agreed to their plan. Where people had been unable to sign, the plans had been signed by the person's representative. Consent to care and treatment, medicines and photography were included in the files seen.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. The registered manager confirmed that some people, due living with memory loss, would be unsafe if they left the home without supervision from a family member or a member of staff. Because of this all exit doors were locked with a keypad to prevent people from leaving unnoticed. Applications had been made to the local authority for authorisation of this restriction but due to the high level of applications received, the home had not yet had any on these applications authorised.

Some signage was used to guide people around the home to the communal areas and toilets. Staff confirmed these would be renewed once the building work had been completed as the layout of the ground floor would change. Due to the building work, access to outside space was limited. People were able to sit in a small area outside the kitchen. We heard some people asking for reassurance from the staff that once the building work was completed they would have more accessible outside space. Staff confirmed a patio area would be available outside the main lounge room.

Good

Is the service caring?

Our findings

People living at Dunmore and their relatives made positive comments about the home. People told us they were happy and well cared for by staff who knew them well. One person said, "I like the people who look after me. They are very kind and nice." Another said, "It's very friendly, and I like it." Relatives said they were always welcomed in a caring and friendly manner.

We observed staff discussing people's choices with them and obtaining people's consent before they assisted them. People told us staff respected their privacy and asked their permission to enter their rooms. One person said, "Yes, they always knock on the door, always close it when they are seeing to you" and another person said, "They will knock and I will say 'come in'."

People were encouraged to do as much for themselves as possible and staff promoted their independence. One person told us, "I feel I want to be independent" and went on to say they did as much for themselves as they could, for example, making their own bed and tidying their room. People said they were involved in planning their care and relatives confirmed they were also involved in discussions about how their relatives were cared for. People were able to choose where they spent their time, for example, in their bedroom or the communal areas. People were able to bring personal items with them and we saw people had personalised their bedrooms according to their individual choice. Regular 'residents' meetings' were held to invite people and their relatives to share any concerns and suggestions were welcomed about how to improve the home.

Staff told us they enjoyed working at the home and said they all worked well together as a team.
During our inspection we spent time observing interactions between staff and people living at the home. It was clear staff had built positive relationships with people and they demonstrated care in the way they communicated with and supported people. Staff were kind, patient and respectful towards people. We saw staff acknowledge people when they entered a communal room. Staff shared conversations with people and were attentive and mindful of people's well-being. People were addressed by their preferred names and people were relaxed in the company of staff.

Where people had made advanced directives about their future care needs or decisions about whether they wished to receive emergency treatment such as cardio-pulmonary resuscitation, these were clearly recorded in their care files. The home worked closely with the community nursing service and the local hospice to provide end of life care. Feedback recently received by the home highlighted the support and compassion shown by staff to people receiving care at this time.

Good

Is the service responsive?

Our findings

People told us they were happy living at Dunmore and staff were responsive to their needs. One person said, "They [staff] will say 'is there anything I can help with?', and make sure we're alright."
Another person said, "I did have carers at first [at home], but it's much better here, I feel much more confident with the people [staff] who are here." People said routines were flexible and they were offered choices about their daily lives. Relatives also told us they were happy with the care and support provided by the home. One said, "We are very happy with the care mum receives. There are activities mum enjoys and the staff are lovely."

People were encouraged to express their views and be involved in making decisions about their care and support. People confirmed they had been consulted about their care needs, both prior to and since their admission and asked how they wished to be supported. The home had a keyworker system. Each person had a named member of staff to review their care needs and to consult with them about how they wished to be supported. Each person had a care plan detailing their care needs and guiding staff about how to meet these safely and in line with their preferences. For example, one person's care plan described their preferred routine, including breakfast in bed, how they wished to receive support with their personal care as well as their night time routine. Another person's care plan had been reviewed and updated on the day they returned from hospital and staff were provided with very clear information about their change in care needs. Staff told us how this person's needs had changed and how they needed to support them since their return to the home.

During our inspection we looked at how people were supported to follow their interests and take part in social activities. The home had employed an activity co-ordinator who consulted with and supported people to be involved in a variety of activities, in and out of the home. For example, they involved people in group or one to one discussions about topics of interest, such as people's hobbies as well as reminiscing about past events. They also supported people to visit the shops or local garden centre. Recent activities included exercises, card games, discussions as well as visiting entertainers, such as singers and keyboard players. One person told us, "There's always entertainment in the afternoons." On the first day of our inspection we saw people enjoying listening to a keyboard player: people were singing, clapping their hands and tapping their feet. The keyboard player knew people by name and engaged them in conversation. On the second day we saw people in discussion with the activity coordinator about a film and were playing cards. Records showed the activity coordinator spent time with people who were being cared for in their rooms either through choice or ill health. People's leisure and social interests were recorded in their care files and the activity co-ordinator used these to plan interesting and enjoyable group and individual activities for people. People told us how much they had enjoyed going shopping and out to local places of interest. Family and visitors were welcome to visit at any time and to participate in the activities.

People and relatives were aware of how to make a complaint and all felt they would have no problem raising any concerns. One person said, "They (staff) have always been very helpful to me, if something worried me." The home had received three complaints in the past 12 months which had been investigated and resolved. They had also received many letters of thanks.

Good

Is the service well-led?

Our findings

Although Dunmore had a change to their registration status in 2016, the home has been long established with the same owners and registered manager in place. The registered manager, deputy manager and several of the staff had worked at the home for many years and they knew people well. People and relatives told us the home was very well managed. People spoke positively about the registered manager. One person said, "Yes, she is very good. If you want to, just call for (registered manager's name). She's very caring" and another said, "You can talk to her, definitely."

Throughout our inspection we saw the registered manager greet people by name and they obviously knew them well. We saw people, relatives and staff freely approached the registered manager to speak with them. The atmosphere in the home was friendly and we saw positive interactions between people and staff.

Staff told us they were well supported by the registered manager. Regular staff meetings and appraisals ensured staff were provided with information important in their role as well as ensuring their care practices were in line with the home's procedures and the manager's expectations. For example, records from the most recent staff meeting showed staff discussed the importance of ensuring people were involved in their care planning and that their preferences and wishes were recorded. Reference was also made to "Treating people with dignity and respect, considering the whole person, taking into account each individual's unique qualities, abilities and interests." The registered manager confirmed they provided informal supervisions of staff as they met with and spoke with them each day. The registered manager was advised to record more formally staff supervision to demonstrate they have assessed staff's competence to undertake their role and to provide them with the opportunity to discuss their training and development needs.

People, relatives and staff were asked for their views about their care and support provided at the home. Surveys had been sent in May 2017 and results had been audited by the activity co-ordinator who prepared a report for the registered manager. This report showed people felt positive about the home. Comments included, "Overall very satisfied with the level of service. Dunmore is a very welcoming and comfortable home and the staff are always friendly" and "There is nothing that I can see that would improve what appears to be all round excellent service to residents." Regular residents' meetings allowed the sharing of ideas and improvements to the home. A copy of the most recent meeting was displayed on the notice board for people to read. The home also produced a Newsletter, giving people information about changes within the staff team, forthcoming events and inviting people and their relatives to meet with the registered manager at any time.

The registered manager used a range of quality monitoring systems to continually review and improve the service and made a report to the provider each month. These included regular health and safety checks and audits of medicines, care records and infection control measures. Action plans were developed where needed. For example, a recent audit showed some staff required an update in their first aid training and this had been arranged and completed. The provider employed a general manager to support a number of their care homes. This manager reviewed practices within each home and provided support and guidance to the registered manager. Records showed the general manager had visited Dunmore each month to review

documentation and make observations of care practices. On the second day of the inspection the providers were present at the home. They reviewed the progress with the building work and spent time in the lounge room with the people living in the home.

Prior to the inspection the registered manager completed the Provider Information Return which gave us information about the home's plans to continue to improve the services for people. This included refurbishment of the home once the building work had been completed, a review of staffing requirements and the provision of more equipment in preparation for people's changing care needs. The registered and deputy managers regularly attended local meetings with other care home managers and the community nurses to share good practice. The provider and registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC) and their duty of candour. The duty of candour places requirements on managers to act in an open and transparent way in relation to providing care and treatment to people. Notifications had been submitted to us, in a timely manner, about any events or incidents they were required by law to tell us about.