Whytecliffe Limited

Glentworth House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Glentworth House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Glentworth House is registered to provide accommodation and nursing care for up to 33 people. At the time of the inspection there were 28 people living at the home.

What life is like for people using this service:
• People told us they felt safe living at Glentworth House. However, we found some improvement was needed to reduce the risk of cross infection between people, to ensure medicines were managed in accordance with best practice guidance and to ensure safe recruitment practices were followed consistently.
• Quality assurance processes were not always effective. They had not identified concerns we found during the inspection, relating to the management of medicines, infection control and recruitment practices. Updates identified during care plan reviews were not always completed.
• People's needs were met in a personalised way by staff who were highly competent, kind and caring. Individual and environmental risks were managed appropriately.
• People's rights and freedoms were upheld. Staff acted in the best interests of the people they supported.
• People were empowered to make their own choices and decisions. They were involved in the development of their personalised care plans.
• People felt listened to and knew how to raise concerns. They, and healthcare professionals told us they would recommend the home to others.
• Staff respected people's privacy and protected their dignity.
• People and staff were engaged in the running of the home.
• The home experienced low levels of staff turnover, which enabled staff to develop meaningful relationships with people and a comprehensive understanding of their needs.
• Everyone we spoke with, including external professionals, had confidence in the management and felt the home was run well.

The service has been rated Requires improvement it met the characteristics for this rating in two of the five key questions. More information is in the full report, which is on the CQC website at: www.cqc.org.uk

Rating at last inspection:
The service was rated Good overall at the last full comprehensive inspection, the report for which was published on 9 September 2016.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-led findings below.	**Requires Improvement**

Glentworth House

Detailed findings

Background to this inspection

The 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 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.

Inspection team:
The inspection was conducted by an inspector, a specialist advisor in nursing care 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.

Service and service type:
Glentworth House is a care home registered to accommodate up to 33 people who need support with personal care. Accommodation is spread over two floors in a converted and extended detached house. 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 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:

• 14 people who used the service

- Four relatives of people who used the service
- Four healthcare professionals who had regular contact with the service
- Eight people's care records
- Records of accidents, incidents and complaints
- Audits and quality assurance reports
- The registered manager
- Three nurses
- Seven members of care staff
- Three housekeepers
- Two kitchen staff
- The activities coordinator
- The maintenance person

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection:
• Staff had been trained in infection control techniques and usually followed safe operating procedures to reduce the risk of infection; for example, they used personal protective equipment, including disposable gloves and aprons, when delivering personal care to people.
• However, we found the covering fabric on three mattresses was no longer waterproof. This meant bodily fluids could leak through to the foam core and pose an infection control risk. We raised this with the registered manager, who immediately replaced the affected mattresses, checked all the other mattresses and directed staff to increase the frequency of mattress checks.
• Staff told us that hoist slings and slide sheets used to reposition people were usually allocated to people individually; however, we found these were sometimes shared between people which posed a risk of cross contamination. We raised this with the registered manager, who assured us they would address the issue without delay and order more slings if needed.
• The home was clean and staff completed regular cleaning in accordance with set schedules. The laundry was well organised with systems in place to prevent cross contamination.

Using medicines safely:
• Arrangements were in place for managing medicines. Oral medicines were administered by nurses who had been assessed as competent to administer medicines. Topical creams were usually applied by trained care staff.
• Medication administration records (MARs) showed that people had received their regular medicines as prescribed. One person confirmed this and said, "I get my pills every morning, they make sure I swallow them."
• However, we found best practice guidance was not always followed. For example, risk assessments had not been completed for people who were prescribed blood thinning medicines. These are required due to an increased risk of bleeding. Although the nurses were aware of these risks, the absence of risk assessments meant care staff might not have known to take additional precautions if the person had experienced a fall or an injury.
• Information about when and in what dose to administer PRN ("as required") medicines was not always recorded. This included for people who were prescribed medicines to reduce anxiety. On two occasions, a person had received anxiety-reducing medicines without the reason for the administration being recorded on the MAR chart, as required by best practice guidance. The lack of clear PRN guidance meant people might not receive their PRN medicines in a safe and consistent way.
• The arrangements for recording and monitoring the use of boxed medicines was not robust. Staff did not always record the number of tablets in stock and carry this forward from month to month. This meant they were unable to account for the number of boxed medicines in stock at any one time, so would not know

whether any had gone missing.
• We raised the above medicines issues with the registered manager and by the end of the inspection they had taken appropriate action to amend the relevant systems and protect people from identified risks.

Staffing and recruitment:
• There were clear recruitment procedures in place and records showed these were usually followed. They included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions.
• However, we found the reason for gaps in the employment history of one staff member had not been recorded and an assessment of the potential risks posed by a staff member with a positive DBS check had not been completed. The registered manager explained the rationale for recruiting each of these staff members and assured us they would ensure written explanations would made in the future.
• People told us there were enough staff to support them and to meet their needs in a timely way. One person said of the staff, "They come quickly when you ring your bell."
• The registered manager told us staffing levels were based on people's needs, which they assessed using a dependency tool.

Assessing risk, safety monitoring and management:
• Risk assessments were in place for individual risks to people, such as the risk of skin breakdown, falling and choking. Chairs in the home had built in pressure-relieving gel to reduce the risk of people getting pressure injuries and 'turn charts' confirmed that people were supported to reposition when needed. An occupational therapist told us staff had "managed risks well" in relation to a person who wished to mobilise independently.
• Environmental risks were also managed effectively. For example, fire detection systems were monitored regularly and people had individual evacuation plans in place. Staff were clear about the action to take in the event of a fire and had been trained to administer first aid.
• Checks of the water quality and temperature were conducted regularly, which confirmed they were within acceptable safety limits. Lifting equipment, such as hoists, were maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly.

Systems and processes to protect people from the risk of abuse; Learning lessons when things go wrong:
• People said they felt safe at the home. One person told us, "I am safe living here because I have people around me all the time."
• Appropriate systems were in place to protect people from the risk of abuse. Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse. One staff member told us, "If I had any concerns, I'd be straight upstairs and [the registered manager] would be on it."
• There were robust processes in place for investigating any safeguarding incidents.
• The registered manager described how they constantly monitored incidents, accidents and events to identify any learning which may help keep people safer. For example, they had provided extra information to staff about the use of thickening agents for people's drinks when a new product had been introduced; this had helped ensure people received drinks at the correct consistency to keep them safe.

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.

Ensuring consent to care and treatment in line with law and guidance:
The 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.
• Where people did not have capacity to make decisions, staff had consulted with those close to the person and had made decisions in the best interests of the person. However, we found the recording of mental capacity assessments and best interests decisions was inconsistent. They had been completed fully for some people but had not been completed at all for three people we tracked.
• We discussed this with the registered manager who assured us they would review people's care needs and complete assessments as necessary. Following the inspection, they provided evidence to show this had been done.
• Throughout the inspection, we heard staff seeking verbal consent from people, in an appropriate way, before providing support. One person told us, "Staff always ask for permission before they carry out their tasks and explain things to me."

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA and found they were. DoLS authorisations had been made when needed. Where conditions had been attached to authorisations, these had been followed. Staff knew which people were subject to DoLS authorisations and the support they needed as a consequence.

Adapting service, design, decoration to meet people's needs:
• Some adaptations had been made to the home to meet the needs of older people with reduced mobility. For example, a passenger lift gave access to the first floor, corridors were well-lit and painted in bright colours, and bathrooms had non-slip flooring fitted. There was a range of chairs in the lounge, including some that had been raised to suit taller people.
• There was an ongoing re-decoration programme in place and a clear system to help ensure any maintenance issues were resolved promptly.
• Should they wish to, people could have personal fixtures and fittings in their bedrooms to make their rooms feel more homely.
• People had level access to a flat, enclosed garden area which we were told some people enjoyed using in warmer weather.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Comprehensive assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they received.
• Staff followed best practice guidance. For example, they used nationally recognised tools for assessing pain, the risk of skin breakdown and the risk of malnutrition. They then acted to achieve positive outcomes for people identified as at risk. Nurses took an evidence-based approach to their practice and followed guidance produced by national bodies, for example in relation to epilepsy management and diabetes.
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed and pressure-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions. People's care plans were computerised and accessible to staff via hand-held devices.

Staff support: induction, training, skills and experience:
• People and family members told us staff were highly competent. For example, one person said of the staff, "They know what they are doing so I expect they have been well trained." A GP told us, "I am very happy with how Glentworth cares for its patients. It is a well managed home with excellent clinical staff. The quality of the nursing team is high, clinically and professionally. They also seem to have the same carers who know the patients well and clearly care for them."
• Staff completed a range of training to meet their needs, which was refreshed and updated regularly. Nurses were also supported to undertake continued professional development to meet the needs of their registration; for example, they had completed specialist courses in sepsis, wound care, end of life care and the use of syringe drivers.
• New staff completed a comprehensive induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff. Staff who were new to care were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
• In addition, care staff enjoyed occasional "two-minute training" sessions at the beginning of their shift, where one of the nurses would give a short input about key subjects, such as epilepsy, diabetes or COPD (Chronic Obstructive Pulmonary Disease).
• Staff told us they felt very well supported in their roles by the registered manager and senior staff. Comments from staff included: "I feel comfortable going to [managers] to ask anything", "I feel appreciated and valued" and "I love the team work; you never feel you're on your own".
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Yearly appraisals were also completed, to assess the performance of staff.

Supporting people to eat and drink enough to maintain a balanced diet:
• People's dietary needs were assessed and met effectively. Where people needed a special diet, such as a low sugar diet or required soft or pureed food, this was provided consistently.
• People were offered regular meals and snacks between meals. People could choose their meals and alternatives were suggested if they did not want any of the menu options for the day. One person told us, "I think the food is excellent. I don't like some things and they don't give them to me."
• Staff monitored the amount people ate and acted if people started to lose weight. For example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• A choice of drinks was available and accessible to people throughout the day and we heard staff encouraging people to drink often.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care:

• People told us they received all the support they needed at the time they needed it.
• We observed people being supported in a safe way when staff assisted them to move. When talking to people living with dementia, staff faced people, used short simple questions and gave them time to respond.
• People were supported to access other healthcare services when needed. One person told us, "If I am not well they will send for a GP". Care records confirmed people were regularly seen by doctors, specialist nurses and chiropodists. A healthcare professional told us staff "follow through" on any suggestions they made.
• When people were admitted to hospital, staff provided essential information about the person to the medical team, to help ensure the person's needs were known and understood. For three people living with a learning disability, they also used 'hospital passports' to support their individual communication needs.

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 were involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
• People and family members spoke positively about staff and the care provided. One person told us, "I am not afraid to ask for help from the nurses and carers who are always willing to help me make the right decision." A family member said, "All the staff have been so lovely; genuinely warm and very natural."
• Such comments were echoed by visiting professionals. For example, one healthcare professional told us, "Staff have a lovely relationship with people and are very welcoming" and another health professional said, "The staff seem to be friendly and interested in what I had to say regarding a patient's care".
• We observed people were treated with kindness and compassion. Staff spoke respectfully to people and engaged with them in a friendly, relaxed way. For example, when a person needed to visit the bathroom a staff member showed great patience in supporting them to move at their own pace, giving the person reassurance, encouragement and praise.
• When we spoke with staff, they demonstrated an extensive knowledge of people's individual needs, preferences, backgrounds and interests. A staff member told us, "We get to really know [people]. If they become unsettled, we can use this to talk about things they have done."
• Staff spoke about people with affection. Comments included: "We love to read people's profiles; some have the most interesting lives", "It's very rewarding working with [people], we're like a little family", "I love the residents; I treat them like an extended family" and "I like the personalities of the residents".
• Staff told us they enjoyed spending time with people whenever they were able. For example, on the first day of the inspection, we found one of the kitchen staff playing bingo with people as they had a few minutes to spare. A staff member told us, "I love the interactions with residents. We have time to join in with the quizzes and to get to know family members. It's good to have quality time with people."
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments before they moved to the home. Staff recognised people's diverse needs and there were policies in place that highlighted the importance of treating people as individuals.
• Any identified needs were detailed in people's care plans. These included people's needs in relation to their culture, religion and diet.
• Staff supported people to follow their faith by facilitating visits by religious leaders of relevant faiths. This included a spiritual group who visited to run a non-denominational service for people every month.

Supporting people to express their views and be involved in making decisions about their care:
• Records confirmed that people were involved in meetings to discuss their views and make decisions about the care provided. These included their choice of activities, food and how they wished to be supported. A family member told us, "I was involved in all the decisions. They [staff] asked how [my relative] wanted to be cared for and always acted in her interests."
• Staff ensured that family members and others who were important to people were kept updated with any

changes to the person's care.

Respecting and promoting people's privacy, dignity and independence:
• People were encouraged to do as much as they could for themselves. For example, one person told us, "I wash my front, they [staff] wash my back."
• Some people were offered support to eat at lunchtime. However, if this was declined, staff gave people the opportunity to eat independently before help was offered again. Other people had been given special plates and cutlery to make it easier for them to eat independently. A staff member told us, "We like to give people the opportunity to try things first." A family member told us, "[My relative] had a little fall once, but I prefer that she had a fall than was stopped walking; she was someone who always wanted to be busy."
• Some people told us they preferred to have a staff member of a particular gender to support them with personal care and said this was respected.
• One person said of the staff, "They treat me with dignity and respect my privacy." Staff described how they protected people's privacy and dignity. This included listening to people, respecting their choices and closing doors and curtains when providing personal care. We saw people were asked discreetly if they needed help with anything and tasks were carried out in a dignified manner.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• People told us their needs were met in a personalised way and this was reiterated by family members who made the following comments: "I think Glentworth is good at nursing care. When my [relative] came from hospital she was on oxygen and on food through [a tube]; now she does not need oxygen and she is eating [normally] again. They are wonderful" and "They [staff] have made a difference to both our lives. [My relative] is well looked after and looks upon it as their home now, while I have peace of mind."
• Care plans had been developed for each person. These provided sufficient information to enable staff to provide support in a personalised way. Staff described how they adapted their approach based on people's wishes and preferences, for example by supporting one person to have a late breakfast and a later lunch. A staff member told us, "[One person] is very particular and likes things organised. [Another person] has had a stroke and we know to put her cardigan on the weak arm first."
• People's daily care records confirmed that care and support had been delivered in line with people's needs, wishes and preferences.
• Care plans were reviewed regularly and staff responded promptly to changes in people's needs. For example, when a person experienced increased levels of agitation, they consulted mental health specialists, devised a de-escalation plan and asked the GP to review the person's medicines.
• 'Sensory profiles' had been developed for some people living with dementia. These identified ways to reduce people's anxiety levels and help them relax. For example, one person was anxious about security, so staff took the person around with them when they locked up at night to help them feel secure. Another person gained comfort from having their hair brushed.
• People's communication needs were met. For example, some information was available in accessible, picture based formats with large print and staff also used white boards to aid communication with six people. The registered manager told us they were exploring additional ways of making information even more accessible to people, for example by increasing the use of picture-based formats for people with learning disabilities.
• People were empowered to make their own decisions and choices. One person told us, "My family told them [staff] about all my likes and dislikes before I came to live here."
• Staff described how they supported people living with dementia to make choices, for example by offering a limited number of options and by interpreting the facial expressions who were no longer able to communicate verbally.
• People had access to a range of activities. These included singing, quizzes, interactions with animals and sessions of reminiscence. One person told us, "I like to join in the activities. I enjoy bingo, quizzes, the music and sing songs." The home employed an activity coordinator who described how they had tailored the activities to meet people's individual needs; these included one-to-one time for people with reduced mobility and for those who were unable to take part in group activities.

End of life care and support:
• Staff had extensive experience of delivering end of life care. Most had received relevant training and further training was planned for the coming year. All staff expressed a commitment to supporting people to have a comfortable, dignified and pain-free death One staff member told us they considered it a "privilege" to care for someone at the end of their lives.
• A family member whose relative had recently died at the home said of the staff, "They cared for [my relative] as well as anyone could have cared for her. They were warm to me as well." Letters from the families of people who had died at the home commended staff for the compassion and care they had shown; for example, one thanked staff for their "love, care and kindness".
• People's end of life wishes and preferences were recorded in their care plans, including detailed plans for the final stages of the person's life. For a person who had died recently, staff assured us their end of life plan had been followed fully, although the person's daily notes did not confirm this. We discussed this with the registered manager, who undertook to ensure that accurate daily notes were maintained in the future.

Improving care quality in response to complaints or concerns:
• There was a complaints procedure in place and people told us they felt happy speaking with management if they had any concerns. One person said, "If I had to make a complaint I would tell whoever was responsible and if they did not change I would tell the manager."
• The complaints policy was advertised on the home's notice board and could be made available in large-print format.
• The registered manager described how they used learning from complaints to help drive improvement within the service and gave examples of when they had done so, for example by changing the laundry arrangements to reduce the level of noise pollution.

Requires Improvement

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.

Service management and leadership was inconsistent. The quality assurance system did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There was a quality assurance process in place consisting of a range of audits, including: medicines management, infection control, health and safety, care plans and admissions to hospital. However, this had not been fully effective. It had not identified the concerns we found during the inspection; these included the arrangements for managing medicines safely, the management of infection control risks associated with shared equipment, the frequency of mattress checks and the need to improve the recording of recruitment processes. In addition, care plan reviews had identified the need to complete mental capacity assessments for some people, but these had not always been done.
• There was a management structure in place, consisting of the registered manager (who was also a director of the provider's company), a clinical nurse lead (who also acted as the deputy manager), registered nurses and senior care staff. Each had clear roles and responsibilities.
• Staff were organised and carried out their duties in a calm, professional manner. They communicated well between themselves to help ensure people's needs were met, including during handover meetings at the start of each shift.
• Comments from staff included: "I love it here, we all get on well", "It's a wonderful place to work" and "I like the atmosphere. There's happy and lively staff and happy residents".

Continuous learning and improving care:
• We identified some examples of continuous improvement, which was monitored using a rolling 'improvement plan'. We saw actions detailed in the plan were completed promptly; for example, it had identified the need for sepsis training for nurses and this had been delivered.
• The provider operated another nursing home in the area and the registered manager described how staff in each home learnt from one another and shared best practice. This was enhanced by nurses occasionally working in both homes, which enabled them to pick up good ideas.

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 told us the service was run well and said they would recommend it to others. One person said, "The [registered] manager is good, she often comes in to talk." A family member told us, "I'm very impressed with [the registered manager]; I like her attitude." These views were echoed by health professionals, whose comments included: "The home has a good atmosphere, with staff appearing happy and engaged" and "From my experience of nursing homes, I would highly recommend it and would be happy if any of my family members had to go there".

• The registered manager described their vision for the home, which was build a good reputation with external professionals, "to be known as a good home" and to retain staff. From our observations, it was clear that staff understood and shared this vision.
• A staff member told us, "[The registered manager] is always sure to remind us that this is not our workplace but the clients' home. It is important to be cheerful and positive with clients. Privacy and dignity are also high on the agenda."
• The registered manager was fully involved in the daily running of the home. They were visible and accessible to people and staff and told us they often worked alongside staff to monitor the standard of care delivery. They demonstrated an open and transparent approach to their role and acted promptly to all feedback provided during this inspection.
• They also understood the requirements of their registration. They had notified CQC of all significant events and had displayed the previous CQC rating prominently in the entrance hall. There was a duty of candour policy in place to help ensure staff acted in an open way if people came to harm, although no incidents had occurred that met the threshold for its use.
• Friends and family members could visit at any time and were offered refreshments. One family member told us, "Visitors are always made to feel welcome. Everyone is kept informed and there are no surprises."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The provider consulted people in a range of ways. These included quality assurance surveys, and one-to-one discussions with people and their families. The registered manager had acted on people's feedback, for example by changing the menus to meet people's requests.
• A monthly newsletter was published to keep people and family members up to date with events and activities.
• Staff told us they felt engaged in the way the service was run and enjoyed high levels of morale. They gave examples of where they had made suggestions for improvement which had been adopted.
• The home experienced very low levels of staff turnover, which enabled staff to develop meaningful relationships with people and a comprehensive understanding of their needs.
• One person told us, "Staff talk happily to each other, they never moan. I think they work hard."
• Staff spoke positively about the registered manager, describing them as "approachable" and "supportive". Comments from staff included: "She is good, we are very lucky" and "She is a great boss, very approachable. You can go to her with anything, she's easy to talk to".

Working in partnership with others:
• The service worked in collaboration with all relevant agencies, including health and social care professionals. This helped to ensure joined-up care provision. A health professional told us, "We have a good working relationship [with staff at the home]. They are a solid, consistent team and work well together."
• Staff had developed links with resources in the community to support people's needs and preferences. These included the 'Care home in reach team' that provided advice and guidance in relation to dementia care; tissue viability specialists; and the Older Persons Mental Health team.
• The registered manager had also developed links with a local school of nursing and supported student nurse placements at the home. They told us this was beneficial as it "helps keep standards up and keeps us on our toes".