

Balcombe Care Homes Limited

Wellcross Grange Care Home

Inspection report

Five Oaks Road
Slinfold
Horsham
West Sussex
RH13 0SY

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Tel: 01403790388

Website: www.balcombecarehomes.co.uk

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

We inspected Wellcross Grange Care Home on 19 December 2018. Wellcross Grange Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Wellcross Grange Care Home is registered to provide care for up to 45 people, with a range of health conditions and some who were living with dementia. On the day of our inspection there were 34 people living at the service, who required varying levels of support. We previously inspected Wellcross Grange Care Home on 8 and 9 November 2017 and found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, caring and well led to at least good. At this inspection we saw that they provider had followed their action plan and improvements had been made.

A registered manager was in post. 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 and associated Regulations about how the service is run.

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights.

Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were treated with dignity and respect and felt well looked after and supported. We observed friendly relationships had developed between people and staff.

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with dementia and palliative care (end of life). Staff had received both supervision meetings with their manager, and formal personal development plans were in place.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people in their rooms, bingo, exercise, quizzes and themed events, such as reminiscence sessions and visits from external entertainers. People were also encouraged to stay in touch with their families and receive visitors.

Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People's end of life care was discussed and planned and their wishes had been respected.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision. People's individual needs were met by the adaptation of the premises.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

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.

Medicines were managed and administered safely.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good ●

The service was effective.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good ●

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their

independence was promoted.

Is the service responsive?

The service was responsive.

The service had arrangements in place to meet people's social and recreational needs. Comments and compliments were monitored and complaints acted upon in a timely manner.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People's end of life care was discussed and planned and their wishes had been respected.

Good ●

Is the service well-led?

The service was well-led.

People, relatives and staff spoke highly of the service. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Staff had a good understanding of equality, diversity and human rights.

Systems were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

Good ●

Wellcross Grange Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 December 2018 and was unannounced. The inspection team consisted of one inspector 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.

The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounges and dining areas of the service. Some people could not communicate with us because of their condition and others did not wish to talk with us. However, we spoke with four people, seven visitors, four care staff, the chef, a registered nurse and the registered manager. We spent time observing how people were cared for and their interactions with staff and visitors, in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We

also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Is the service safe?

Our findings

At the last inspection on 8 and 9 November 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not routinely acted swiftly and appropriately after accidents and incidents. We also found areas of the environment of the service that were not safe. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At our last inspection we found examples where staff had not acted suitably or carried out a comprehensive investigation after people had sustained injury, or there was other information of concern regarding people's welfare. The registered manager told us how new processes had been implemented and that the importance of ensuring that all incidents and accidents were reported, recorded and acted upon appropriately had been reiterated to staff. We saw this was the case. Staff now took adequate action following accidents and incidents to ensure people's safety. Specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Furthermore, the registered manager gave us examples of when after specific incidents, they had liaised appropriately with the local authority in respect to safeguarding. Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people.

At the last inspection, we identified issue with the environment at the service that placed people at risk. For example, some windows did not have restrictors on them, some rooms had loose wires and water temperatures were not always regulated to prevent scalding. At this inspection we saw that improvements had been made and the previous issues had been rectified. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan (PEEP). There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "I've no safety issues at all". Another person said, "I need to be moved around in my wheelchair and they do that well". A relative added, "I believe [my relative] is safe in the place".

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained and regular 'deep' cleaning of the service had taken place. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. One person told us, "It's always kept very clean and tidy". A relative said, "The home is kept very clean, rooms are done every day". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves were readily available. We observed that staff used PPE appropriately and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed to remind people and staff of their responsibilities in respect to cleanliness and infection control. The registered manager told us that infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

We looked at the management of medicines. Registered nurses were trained in the administration of medicines. A registered nurse described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed a registered nurse giving medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "I do receive my medication when I should and they always check the GP is up to date with my medication". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that agency staff were used when required. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "There seem to be enough staff. They come quite quickly when I call". A relative said, "There are enough staff, generally responses to calls are good". Documentation also helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had an up to date registration with the nursing midwifery council (NMC).

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "Staff seem to be well trained". Another person said, "I am asked before staff attend to me". A relative added, "Staff do seem well trained and they do have training days on site. They do a difficult job well".

Staff had received training in looking after people, including safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the care of people with dementia and those at the end of their life. Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff and the registered manager confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessments were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people ate in the dining areas or could choose to eat in their bedroom or a lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People were complimentary about the meals served. One person told us, "Meals are very good, but I can have a piece of salmon if I want". Another person said, "I like all the meals, they feed you well". A further person added, "The food's fantastic, you get a choice of two meals and a vegetarian one". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Specialist diets were catered for and staff stated that any specific diet would be accommodated should it be required.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, chiropodists and social workers. Access was also provided to more specialist services, such as opticians and podiatrists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare

professionals. One person told us, "If I was not well, they would get the doctor in". A relative added, "[My relative] has had a visit from the chiropodist, dentist and optician. The GP visits regularly but would be called if required". We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and understood. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics`. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected.

People's individual needs were met by the adaptation of the premises. Hand rails were fitted throughout the service with bumps at each end to alert people who were visually impaired where the hand rail stopped. There were slopes for wheelchairs and other parts of the service were accessible via a lift. There were adapted bathrooms and toilets.

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). 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 had the appropriate legal authority and were being met. We saw this was the case and staff knew the correct procedures to follow and were aware of their responsibilities under the Act.

Is the service caring?

Our findings

At the last inspection on 8 and 9 November 2017, the provider was in breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's dignity was not upheld at all times. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At the previous inspection we saw examples of people being cared for in an undignified manner. At this inspection we saw that people were attended to with dignity and were supported with kindness and compassion. We saw good interaction between people and staff. People told us caring relationships had developed with the staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. Comments included, "I'm very happy here, they staff are all very nice. The staff here are very good", "The staff are kindness itself, they are always cheerful" and "[My relative] is extremely well looked after. The staff are so nice to them all".

Throughout the day, staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. A member of staff told us, "It's good here, it's like a family. It's all for the needs of the residents". Another member of staff added, "I like working with the residents. We get along, it feels like family". Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. Staff gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food and drink. One member of staff told us, "We get to know the residents well, what they like and what they want".

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way. Staff told us how they adapted their approach to sharing information with people with communication difficulties. Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People looked comfortable and they were supported to maintain their personal and physical appearance. It was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "I am treated with respect, they always draw curtains". A relative said, "Staff do treat [my relative] with dignity".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do what they wanted throughout the day. They said they could choose what time they got up and went to bed and how and where they spent their day. One person told us, "It's a happy place and I feel free to move about with help". Another person said, "If I needed to ask for a bath or a shower, I could have one". A further person added, "Visitors can come anytime and I feel free to move around if I wish". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We ask what people want and if they don't want us to do anything for them, that's fine, we come back later. We would never force anything". Another added, "There are lots of choices for people. This is a good home, we look after them well".

Staff encouraged people to maintain relationships with their friends and families and visitors were able to come to the service at any reasonable time, and could stay as long as they wished. A relative told us, "I am made to feel welcome and I can be here at Christmas for a meal".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. One person told us, "The staff are going to help me put my new dentures in and I have choice to be where I want to be". Care staff informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "We encourage people in line with what they can do. We want them to use it, not lose it". Another member of staff said, "We always encourage people to do things for themselves, even if you know they can't do it, because sometimes they might surprise you".

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "Staff do ask how I am and if I need anything". Another person said, "Staff are very good, they always speak to me". A relative added, "[My relative] is getting the attention she needs. They are getting to know her and her needs and wants". A further relative said, "Communication from the home is good online or mobile".

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. A relative told us, "Reviews of [my relative's] care plan are carried out". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. People were given the opportunity to observe their faith and any religious or cultural requirements were recorded in their care plan.

We saw a varied range of activities on offer, which included, bingo, exercise, quizzes and themed events, such as reminiscence sessions and visits from external entertainers. People told us that they enjoyed the activities. One person told us, "We have one activity co-ordinator, she has done well with these Christmas decorations. She has organised visits from schools and a musician and a singer. We also do arts and crafts". Another person said, "There are activities going on". A relative added, "There seems to be enough to do here, the ladies like to have a sing along and there are some trips out". Staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff set aside time to sit with people on a one to one basis in their rooms.

Technology was used to support people to receive timely care and support. The service had a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time. Staff also took advantage of online training courses to enable them to complete training at a time that suited them.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "No problems, no reason to complain. I do think you can approach staff with any issues". A relative added, "We did make a small complaint but it was sorted out very quickly". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused

to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff ensured that the communication needs of people who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these.

Is the service well-led?

Our findings

At the last inspection on 8 and 9 November 2017, the provider was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems of governance used by the service had not identified issues and concerns we found at the inspection. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At the last inspection the provider's systems of quality monitoring and improvement were not robust and had not identified or prevented the concerns that we saw. We saw that improvements had been made. The provider undertook quality assurance audits to ensure a good level of quality was maintained. The registered manager told us that regular audits for health and safety, accidents and incidents, care planning, infection control and medication took place. Documentation we saw supported this, and the results of these audits were analysed to determine trends and introduce preventative measures. Up to date sector specific information was also made available for staff including details of managing specific infectious conditions. We saw that the service also liaised with the Local Authority, Clinical Commissioning Group (CCG), the Nursing and Midwifery Council (NMC), Macmillan Cancer Support, the Alzheimer's Society and local churches to share information and learning around local issues and best practice in care delivery.

People and staff spoke highly of the service and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. One person told us, "The manager is first class, she's a first class lady". A relative said, "The manager is very helpful and very dedicated. I can approach her, no problem doing that, it seems to be run well". Another relative added, "I know the manager and she is very approachable, her office door is always open. The management seems okay and one of the directors pops in". People felt happy with the care they received and were complimentary of the service. One person told us, "There is nothing they could do better. The best thing for me, is it's like home". Another person said, "This care home is the one I would choose to be in to the end of my days". A relative added, "The care is first class here". Another relative said, "I am contented [my relative] is here and getting the best care she can".

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management, including any issues in relation to equality, diversity and human rights. Management was visible within the service and the registered manager took an active approach. A member of staff told us, "We have very supportive and helpful management". Another member of staff said, "The manager's door is always open for us and we can go and talk". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff told us, "We are a very good team, we always support each other". Another member of staff said, "We pull together and communicate all the time about any changes".

We saw that people and staff were actively involved in developing the service. There were systems and

processes followed to consult with people, relatives, staff and healthcare professionals. Meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided. A relative told us, "They do listen and act on suggestions. There are relatives' meetings and suggestions have been taken up".

We discussed the culture and ethos of the service with people, the registered manager and staff. A relative said, "The place is as near home as can be. We are very pleased [our relative] is here". The registered manager added, "The residents are happy. The care of the residents is the main thing". Staff supported this and a member of staff said, "I think the residents get good care. We are happy, they are happy and their families are too". A further member of staff added, "I like working here because we are big on compassion, have good leadership and we really care". In relation to staff, one person said, "The staff seem happy here". There was also a clear written set of values displayed in the service, so that staff and people would know what to expect from the care delivered.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistle-blowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice, for both people and staff, living and working at the service.