Care Quality Commission

Dipton Care Home Limited

Dipton Manor Care 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

Overall summary

The inspection took place on 30 November and 3 December 2015 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Dipton Manor Care Home on 16 September 2013, at which time the service was compliant with all regulatory standards.

Dipton Manor Care Home is a residential home in Dipton providing accommodation and nursing care for up to 71 older people who require nursing and personal care. There were 68 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service and call bells were answered promptly.

Summary of findings

We saw that individual risks were managed through risk assessments and associated care plans in each person's care file. These risks were reviewed each month. We observed behaviours that could be perceived as challenging supported sensitively.

We found the service had systems in place for ordering, receiving, storing and disposing of medicines. We looked at how the service managed controlled medicines and found that safe storage, administration and recording was maintained.

Safeguarding information such as types of abuse to be mindful of and contact telephone numbers were prominently on display and staff displayed a good knowledge of safeguarding issues.

There were effective pre-employment checks of staff in place and we saw the disciplinary policy was adhered to when a potential safeguarding concern was raised recently.

The service was clean throughout, with a range of infection control measures in place and working effectively.

Staff completed training to meet people's individual needs in areas such as: catheter care, dementia awareness and PEG feeding (PEG feeding is a way to care for someone who can't have foods orally). This was in addition to training the provider considered mandatory, such as safeguarding, health and safety, moving and handling, dignity and respect, food hygiene and infection control. When we questioned staff about the practicalities of a range of these areas, they were able to give detailed and informed answers.

Staff also had a good knowledge of people's likes, dislikes and life histories.

Staff were well supported through formal supervision and appraisal processes as well as ad hoc support when required.

Meals were varied, prepared by kitchen staff passionate about their work and people told us they enjoyed the food. People had choices at each meal as well as being offered alternatives if they did not want the planned meal options. We saw the service had successfully implemented a tool to manage the risk of malnutrition and people requiring specialised diets were supported.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

We observed a range of dignified and thoughtful interactions during our inspection, with people who used the service and staff sharing jokes; the atmosphere was welcoming and homely. Relatives and external stakeholders unanimously agreed that the service was caring and we saw people's rights were respected and upheld.

Person-centred care plans were in place and daily notes were comprehensive. Regular reviews ensured relatives and healthcare professionals were involved in ensuring people's medical, personal, social and nutritional needs were met.

The service had four activity co-ordinators who facilitated a range of group and individual activities. We saw some of these activities during our inspection and evidence that activities were planned on the basis of suggestions made at resident and relative meetings, as well as the ongoing programme of optional group activities.

People's religious beliefs were respected and encouraged through liaison with the local church and a flexible approach to person-centred care provision.

Staff confirmed they were well supported to pursue their own career progression. All people using the service we spoke with, relatives, staff and external professionals were complimentary about the approachability of the

Summary of findings

registered manager. Strong community links had been made to ensure the service was part of the community and that people who used the service were able to remain part of their community.

Summary of findings

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.

People using the service, relatives and healthcare professionals told us people were safe living at the home.

Safeguarding training had been completed and staff displayed a good understanding of risk and the types of abuse people could be at risk of, as well as their prospective actions should concerns arise.

Appropriate pre-employment checks were made, supported by a checklist system that had ensured no one had been employed without these checks being completed.

Medicines were generally administered, stored and disposed of safely and securely and in line with the National Institute for Health and Care Excellence (NICE) guidance.

Is the service effective?

Good

The service was effective.

All staff had received training, or training had been scheduled, relevant to their role. Additional training such as dementia training and PEG feed training where people's individual needs required it.

People experienced good healthcare and wellbeing outcomes through the regular involvement of a range of healthcare professionals in their care.

People's nutritional and hydration needs were met through the effective monitoring of potential malnutrition, specialised diets and a range of mealtime and snacking choices.

Is the service caring?

Good

The service was caring.

Staff interacted warmly with people who used the service and had formed meaningful, trusting bonds with people.

People's dignity was maintained and promoted through involving them and their relatives in decision-making, including when advanced care plans were in place.

The registered manager and all staff we spoke with had a good understanding of people's needs, preferences, likes and dislikes.

Is the service responsive?

Good

The service was responsive.

The service had four activities co-ordinators dedicated to ensuring people were able to participate in a range of activities and pursued interests meaningful to them.

Regular meetings with people and their relatives determined what activities would happen and resident newsletters kept people updated regarding upcoming events.

Care plans were reviewed regularly and the service sought prompt support from external healthcare professionals where necessary.

Summary of findings

Is the service well-led?

Good

The service was well-led.

A wide range of positive links had been made in the community which contributed to the wellbeing of people who used the service and ensured a diversity of interests were supported.

The registered manager took a leading role in quality assurance and auditing, identifying potential risks and areas for improvement on a day-to-day and more strategic basis.

All people who used the service, staff, relatives and healthcare professionals agreed the atmosphere of the service was welcoming and homely and that the visibility and approachability of management was reassuring.

Dipton Manor 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.

We visited the service on 30 November and 3 December 2015 and the inspection was unannounced. The inspection team consisted of two Adult Social Care Inspectors and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service, in this case nursing.

We spoke with seven people who used the service and 14 relatives of people who used the service. We spoke with 14 members of staff: the registered manager, two nurses, five care staff, three activities co-ordinators, the handyman, the cook and the receptionist. We spoke with a visiting nurse and two external professionals visiting the home for accountancy reasons.

During the inspection visit we looked at seven people's care plans, risk assessments, seven staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

We spent time observing people in the living rooms and dining areas of the home and spoke with people in their rooms where they were happy to do so.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

Good

Is the service safe?

Our findings

All people we spoke with who used the service, relatives, staff and external professionals told us they had no concerns with regard to people's safety. One relative said, "[Person] is happy because they feel safe." Another said there was, "No single word of complaint."

We saw that individual risks were managed through risk assessments and associated care plans in each person's care file. These risks were reviewed each month and we saw detailed instructions in care plans regarding how staff should support people to minimise risk, for example through clear instructions about how to communicate and physically support a person whilst bathing. Visiting healthcare professionals told us that the service contacted them where they identified any concerns. This meant the service had a structured approached to reviewing individual risks and was able to identify concerns at an early stage.

We observed behaviours that could have been perceived as challenging. We saw staff support people calmly and de-escalate these behaviours. We saw a number of staff had received training in Challenging Behaviour Management and a range of indicators to look out for were clearly displayed in the nurse's office. We also reviewed people's relevant care files and saw more detailed information regarding why people may behave in a certain way and how staff could more safely support them. This meant people were protected from the risk of the mismanagement or misinterpretation of challenging behaviours, which were managed in the least restrictive manner practicable.

Safeguarding information was prominently on display and included types of abuse to be mindful of and relevant contact telephone numbers should people have concerns. We spoke with four members of staff about their knowledge of safeguarding issues and all were able to articulate a range of abuses and potential risks to people using the service, as well as their prospective actions should they have such concerns. We also saw a recent safeguarding concern had been appropriately escalated and managed, with multi-agency involvement. This meant appropriate safeguarding training had been delivered and staff were able to implement this training if required.

We reviewed a range of staff records and saw that in all of them pre-employment checks, including Disclosure and Barring Service checks, had been made. We also saw the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees' prior to employment. This meant that the service had in place a robust and consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We saw there were ongoing disciplinary investigations and that these had been conducted in line with the disciplinary policy, which was current and clear. When we spoke with staff, they were clear about how to whistleblow (this means telling someone about concerns) and we saw the service had a whistleblowing policy in place.

All people using the service, their relatives, staff, health and social care professionals we spoke with felt staffing levels were appropriate. One relative stated staff were, "Overworked and underpaid" but acknowledged they had never witnessed a detrimental impact on people who used the service as a result. The registered manager showed us how they calculated staffing levels, which included always having a 'floating' member of staff who could respond to whichever floor had the greater need. During our observations we saw that people were supported promptly and call bells were answered without delay. This meant people using the service were not put at risk due to understaffing.

We found the service had systems in place for ordering, receiving, storing and disposing of medicines. We looked at how the service managed controlled medicines and found that safe storage, administration and recording was maintained. The medicine store room we observed was secure, clean and organised, whilst room and fridge temperatures were checked daily and showed medicines were stored at a safe temperature.

We looked in detail at people's Medicine Administration Records (MARs). We found a small number of errors and raised these with the nurse, who was able to explain all but one of the errors. Later in the inspection we saw the registered manager had reviewed this error with the person involved and put in place measures to protect against similar occurrences.

Good

Is the service safe?

The nurse on duty demonstrated a good understanding of people's needs and pain relief regimes but we saw 'as and when' medicines were not supported by plans that guided staff as to when to consider administering such medicines, for example when people were unable to verbalise they were in pain. This was an area the service could improve with regard to medicines management. Similarly, not all MAR sheets we looked at had people's photographs and allergy information attached. The inclusion of these provides additional safeguards against the risks of medicines errors and was another area the service needed to improve.

We observed medicines being administered and saw how safe practice was maintained throughout. The nurse communicated effectively and patiently with people explaining what their medicines were for and sought consent before administering medicines.

The management of infection control was strong, with two infection control champions in place, clear signage and embedding of good practice. We looked at a cleaning rota and saw no gaps. We found all communal areas, bathrooms and bedrooms were clean. One person who used the service said, "It's immaculate – it never smells."

The Food Standard Agency (FSA) had given the kitchen in the home a 5 out of 5 hygiene rating, meaning food hygiene standards were "Very good." This meant people were protected from the risk of acquired infections.

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans (PEEPs) were in place, easily accessible in the entrance. This meant people could be supported to exit the building by someone who would have access to their individual mobility needs. We noted that these were not accompanied by people's photographs and the registered manager agreed to include these in the PEEPs file.

Maintenance was largely managed by a full time on-site handyman. Records showed that Portable Appliance Testing (PAT) was being undertaken, whilst all hoisting equipment and lifts had been serviced recently. There was documentation in place evidencing the servicing of the gas boiler and the air conditioning system. We saw that fire extinguishers had been checked recently, fire maintenance checks were in date and the nurse call bell systems were regularly tested and serviced. We saw the registered manager also undertook a twice-daily 'walk around audit', which served to identify any aspects on the premises in need of repair. This meant people were prevented from undue risk through poor maintenance and upkeep of systems within the service.

Good

Is the service effective?

Our findings

We saw a number of people had experienced improvements in their health and wellbeing since moving to the service. For example, one person who had suffered falls and had a range of complex needs had recently moved into the service. Their relatives told us, "I cannot believe the improvement, [person] is getting champion – it's brilliant." We saw this person's health needs and the risks their complex needs presented were managed through individualised care planning, risk assessments and multi-agency involvement.

We found evidence in all care files we reviewed that people were supported to maintain their health through accessing external healthcare professionals such as opticians, dentists, tissue viability nurses, speech and language therapy, District Nurse and GP visits. When we spoke with one of these professionals regarding staff, they said, "They generally have a good knowledge of people's needs." Another commented in a questionnaire, "Staff were professional and knowledgeable regarding clients at all times." People who used the service and their relatives were unanimously confident in the capability of staff. One relative commented that they were always given a prompt update on a person's wellbeing on arrival. Another said, "We have a lot of confidence in the care given."

Staff told us they felt equipped to carry out their roles. We saw that training was relevant to people's needs, with staff having completed dementia training, catheter care training and PEG feeding training, in addition to training the provider considered mandatory, such as safeguarding, health and safety, moving and handling, dignity and respect, food hygiene, infection control. When we questioned staff about the practicalities of a range of these areas, they were able to give detailed and informed answers. We saw that staff who administered medicines were appropriately trained and had their competence assessed regularly. This meant staff had the knowledge and skills to carry out their role and provide high levels of care to people using the service.

We saw staff supervisions occurred regularly along with annual appraisals. There were superficial inconsistencies in the paperwork used to document supervisions but all staff we spoke with were positive about the support received through these meetings and told us they had ample opportunity to identify any training needs or concerns. One said, "I enjoy working here. I feel well supported and the staff team is really hardworking." This meant people could be assured they were cared for by staff who were adequately supported.

Kitchen staff we spoke with had a passion for preparing varied meals for people and we saw food being freshly prepared. We saw specialised dietary requirements, such as gluten-free diets and diets for people with diabetes, were catered for and clearly on display in the kitchen, as well as anyone noted as at high risk of malnutrition via the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. One person told us, "The food is always good" and told us about their favourite meals, some of which we saw on the menu. Throughout our inspection we saw people were offered snacks, fruit and drinks. One relative told us, "They always make sure there's a drink by [person's] side and they're always making sure [person] drinks."

We noted there was only one dessert/pudding during lunchtime but, when we asked, people who used the service and relatives were clear they could have alternatives if they wished. Relatives we spoke with were particularly positive about the attention to detail paid to people's nutritional needs. One told us, "They always lets me know how [person] gets on food-wise. They'll tell me, without asking, if [person] has had a full plate of porridge. I appreciate that." Another relative told us how the service had incorporated the person's favourite breakfast (treacle sandwiches) into their day.

We observed unrushed, calm dining experiences across two floors of the service. Where people required additional time and support to eat and drink, this was given sensitively and in a dignified fashion. Coloured crockery contrasting with tablecloths meant people with sight loss or living with dementia were supported to have a more independent dining experience. This meant the service provided sufficient staffing support and resources for people to experience mealtimes at their own pace.

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

Good

Is the service effective?

make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of Mental Capacity issues, including DoLS. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

With regard to the premises, the building was newly built in 2013 and met the needs of people who used the service through the design of the building. For example, dining areas had additional work surfaces/plumbing to make dining experiences more efficient, whilst all rooms had an en suite w/c. Additional dining spaces meant people who were uncomfortable sitting in large groups but did not want to eat in their room could still have a pleasurable dining experience. We saw these spaces in use during our inspection. Each floor also had a bath and a Jacuzzi bath suitable for people requiring the use of hoists. One relative we spoke with said this Jacuzzi bath was their relative's favourite and that they frequently chose this option. Carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. This meant the building was designed with the needs of people who used the service in mind and had regard to environmental aspects that could be made more dementia friendly. We saw 'memory boxes' were in place outside some rooms on the floor where people lived with complex needs such as dementia. We also saw further memory boxes in progress in the craft area, meaning that people were involved in creating personalised additions to their environment.

Good

Is the service caring?

Our findings

People who used the service were consistent in their praise for care staff they described as caring, compassionate and dedicated. One relative said, "They're so dedicated." Another said, "What I like is, it's not about the staff routine, it's about the person." One person who used the service said of the staff, "I'm very happy – give them a stripe. Give them three stripes! You get to know them. Sometimes they have a bit of a natter after they've finished their shift." This meant meaningful relationships had been established, such that staff took time to chat to a person who used the service after their shift had finished. Likewise, relatives confirmed that a number of staff had attended the Christmas Fayre on their day off. This meant staff engaged with people they cared for on a level that went beyond the provision of tasks as set out in their job description. All people we spoke with commented on the personable, trusting relationships they had been able to form with staff and we observed a range of such interactions during our inspection.

We also reviewed a range of thank-you cards which consistently described a positive caring environment and attentive, "Kind" staff.

The homely atmosphere was commented on by a range of visitors, professionals and families alike. One relative said, "Even if they see you at the other end of the corridor, they'll wave and welcome you. The atmosphere is tremendous." Numerous relatives we spoke with visited daily and at differing times of the day; they were consistent in their portrayal of a welcoming environment. This meant people using the service and their families felt more able to consider the service a home and were not restricted in their visiting hours.

We observed a range of dignified and patient interactions during the inspection. For example, we saw care staff address people by their preferred names, knock on people's doors and wait for a response before entering. When we asked people about the care they received, one person said, "They treat you with respect. They treat people like family." Another said, "The care is excellent – lovely girls." One family member stated they felt the care received could be more attentive but, through speaking to a number of people who used the service, relatives and healthcare professionals, we found the consensus to be that people were cared for in a dignified, attentive manner.

We saw that people who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place had been involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. We saw that people with a DNACPR in place had this reviewed regularly. We also saw one person had an advanced care plan in place and that this similarly involved the person and their relative. Their relative told us they had been involved in all aspects of the process and that the person's wishes regarding their end of life care, including where they chose to die, were respected.

With regard to people's religious beliefs, we saw the service had a dedicated chapel, which people confirmed they had used regularly. One relative told us they and their partner enjoyed this aspect of the service and that staff respected their religious beliefs. They told us how, on a Sunday evening, staff ensured their relative could be back in their bedroom so they could watch 'Songs of Praise' as they had always done. More recently, the local church had closed and we saw the home now used its activities room to regularly host masses that people who used the service and the local community could attend. This meant the service had regard to people's religious beliefs and ensured they were met through individual and service-wide flexibility.

We saw that information regarding advocacy services was readily available and the registered manager had a good understanding of formal and informal advocacy. At the time of our inspection no one who used the service had an advocate but we saw more informal means of advocacy through, for example, monthly resident and relative meetings. This meant that people were invited to be supported by those who knew them best.

Good

Is the service responsive?

Our findings

We found the service to provide care that was responsive to the needs of people, alongside promoting and enabling a range of activities that were informed by people's interests and histories. Some activities were planned via regular resident and relative meetings, whilst some formed part of an ongoing optional activities programme that was shared with people through a 'Residents' Newsletter'. Activities were well resourced, with four activities co-ordinators working at the service, one of whom would always be on duty until 8pm.

Recent activities included a visit by a pony, bingo, coffee mornings, crafts, shopping trips, hairdressing, pamper days, carol singing, film nights and a Christmas Fair, where craft items people who used the service created were sold to members of the local community.

We saw the activities co-ordinators had converted an old medicines trolley into a mobile craft trolley. We saw the positive impact of this on people's day-to-day activities, with people creating such crafts as cushions, which they then kept in their rooms, or the memory boxes which were to go outside people's rooms. This meant the service had found a way to enable as many people as practicable to engage in a range of interests meaningful to them.

When people were unable to engage in such activities, the activities co-ordinators offered a 'News Review' service, whereby they would sit with a person and update them on current affairs. One member of staff said, "We can spend one to one time; we can spend time chatting with people. It's excellent." Another said, "We are supported to spend one to one time with people." People who used the service confirmed they were supported by way of one-to-one visits from staff.

We saw the service had recently secured funding for various garden equipment. This would be used in the summer by people who used the service and people from the local community. This idea was one taken forward from the resident and relative meetings. We saw the service also used questionnaires to gather ideas from people who used the service and relatives about their preferred interests. This meant the service had regard to peoples' preferences and needs, as well as planning activities throughout the year to ensure people had a variety of options to engage with.

The service had two resident guinea pigs, 'Fred' and 'Ginger', who were brought into the service following consultation with people who used the service, who also chose their names. The service had a dedicated cinema room, a large activity room on the ground floor and another on the top floor, communal areas with floor-to-ceiling windows allowing ample light and views of the surrounding countryside, along with a dedicated hairdressing studio and numerous quiet areas for people and relatives to have more privacy. We saw the hairdressing service was popular with a number of residents during our inspection and that the quiet areas were used by relatives when visiting people.

We saw positive impacts of this comprehensive approach to person-centred activity planning. For example, one person had a history of social isolation but, since moving to the service and through ongoing liaison with their relative to gently encourage more and more social interactions, they now enjoyed socialising with other people in the service.

The registered manager acknowledged turnout at the resident and relative meetings was lower than hoped and, to try and counter this, they were introducing a 6:30pm meeting alternately in the hope that relatives who could not attend due to work commitments would now have an opportunity to do so. This meant the service was flexible regarding the means by which it routinely sought feedback from people who used the service and their relatives to ensure a broader range of opinions on how to personalise care and activities.

With regard to supporting people's healthcare needs we saw care plans were comprehensive and person-centred, taking into account people's likes, dislikes and personal preferences. We saw there were slight inconsistencies between the way different floors of the service ordered care files but, in practice, this had no impact on the content therein or the delivery of care. Daily notes and records of care were comprehensive and informed by a pre-assessment document that included the person's photograph, medical history and immediate risks.

One person told us how, following a leg injury, the service had liaised well with the physio to ensure they could provide the person with ongoing support as they rehabilitated. The person said, "They encouraged me and took over from the physio. They were great." One relative told us how the service ensured they could support their

Good

Is the service responsive?

partner by using the activities room to do physio exercise with the person. This meant the service sought and acted on the advice of relevant healthcare professionals in order that people received relevant, quality care. It also meant the service encouraged and supported involvement from people's relatives in the delivery of their care, where this was in line with people's wishes.

We saw the service had a complaints policy in place. People and relatives we spoke with were aware of how to make a complaint and we also saw this information clearly displayed in communal areas. We saw three complaints had been received recently and responded to. This meant people were supported by a range of means through which to raise concerns and were confident in doing so.

We saw evidence that people had been promptly referred to external specialists when their needs changed and one visiting healthcare professional told us, "The girls are quick to get in touch if they have any concerns." This meant people's needs were regularly assessed and referrals made to specialists where necessary to ensure those needs were met. We saw all care files contained a log to record contact with external healthcare professionals, which meant anyone supporting the person had a clear record of their previous care, but also made the service accountable. One external healthcare professional commented on the, "Clear and well documented," nature of care records.

A number of relatives commented on the effectiveness of people's move into the service. One said, "The transfer was seamless. It could have been really difficult but the family are delighted." Another said, "It's difficult when someone goes from their own home to somewhere like this but they were very sensitive to that." This meant people's experience of moving into the home from their own home or other services was sensitively handled by the service.

Good

Is the service well-led?

Our findings

We found the culture of the service to be focussed on ensuring people received a high level of attentive care. Staff took pride in their contribution to the wellbeing of people who used the service, whether they were providing personal care, organising activities, or cleaning and repairing the premises. One staff member said, "When I walk out on a night I know I've made a difference."

The registered manager had extensive relevant experience in health and social care. They had a sound knowledge of the day-to-day workings of the service and we observed them assisting people who used the service in a caring manner during our inspection, as well as ensuring staff were able to respond to an emergency call bell. This meant the manager took an active role in the day-to-day service provided, working effectively alongside a receptionist colleague who had extensive experience in social care and evidenced a good understanding of people's needs. One healthcare professional we spoke with stated, "The manager is very knowledgeable and is always quick to sort things out."

Staff members consistently told us they were well supported by their immediate line manager and the registered manager. One staff member said of the latter, "They'll praise you when you need praising and bring you up on things when that's needed, too." This meant staff were supported with praise but challenged where appropriate to ensure they maintained high standards of care.

People who used the service were aware of the manager and praised their attitude, as did relatives we spoke with. One said, "You couldn't get a more dedicated manager." Another said, "The care comes from the top." Through our observations and discussions with people, relatives and external professionals, it was clear the registered manager had successfully established a culture which was focussed on meeting people's individual needs in a homely environment.

During the inspection we asked for a variety of documents to be made accessible to us and these were promptly provided and well maintained. We saw documents were regularly reviewed and some incorporated aspects of recent best practice, for example the MCA file and policy, as well as the Duty of Candour policy, which clearly set out the responsibilities placed on the service regarding its accountability to families and other stakeholders. We found records to be well kept, easily accessible, accurate and contemporaneous.

We saw the registered manager took responsibility for a range of audits, including water temperatures, profiling bed checks, medicines, first aid equipment and infection control. We saw these audits led to additional actions, such as the repair of a tumble dryer or the cleaning of an outdoor storage area. In addition to these audits the registered manager undertook a twice-daily 'walk-around' audit, whereby any environmental or staff issues could be captured. This meant the registered manager embraced accountability for all aspects of the service, but also maintained a presence throughout the service. People we spoke with welcomed the accessibility of the registered manager

The registered manager had established strong links with the local community. These links were further developed through ongoing involvement of local people and services in the home. For example, the home hosted a church service regularly, as well as liaising with local people to implement a community garden on site. This latter project came about through successfully bringing together the interests of people who used the service with relevant local groups (in this case the allotment society) to bring about a scheme that would benefit the community and the people who used the service. These links ensured people who used the service, the majority of whom were from the local area, had the opportunity to remain engaged with their community.

We saw the registered manager had shared questionnaires with people who used the service, relatives and external healthcare professionals. Questionnaires returned were mostly extremely positive and we saw evidence the registered manager had acted regarding concerns raised in one questionnaire. At the time of inspection these questionnaires were not distributed in a consistent manner, nor were there plans to standardise the timings of the distribution of the questionnaires, or how to meaningfully analyse feedback to consistently drive up standards. This meant the service was seeking feedback from a range of people and acting on that feedback but could improve the means by which it gathered feedback from people who used the service, their relatives and other stakeholders.